



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007106

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Simon McGregor
Deceased:	Kai Lun Chok
Date of birth:	23 May 1995
Date of death:	22 December 2023
Cause of death:	1a: Multiple injuries sustained in a motor vehicle incident
Place of death:	Robinvale-Sea Lake Road & Chinkapook-Nyah West Road, Chinkapook Victoria 3546
Keywords:	Motor vehicle accident

INTRODUCTION

1. On 22 December 2023, Kai Lun Chok was 28 years old when he died in a motor vehicle accident. At the time of his death, Kai lived at 13 Buckingham Street, Amaroo, Australian Capital Territory with his girlfriend, Ms Shanjing Xing.
2. Kai was born and raised in Malaysia and was the eldest of five siblings. He finished school at the equivalent of year 10, before working with his father installing electrical wiring in industrial sites. He then moved to Singapore for two or three years, where he worked in hospitality, before moving to Melbourne in March 2017 to study cookery. By 2018, he had moved to Canberra, where he met and moved in with Shanjing during 2019.¹
3. He was generally in good health.²

THE CORONIAL INVESTIGATION

4. Kai's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Kai's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as the eyewitness, friends, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

¹ Statement of Lee Hieok Ng, Coronial Brief.

² Ibid.

8. This finding draws on the totality of the coronial investigation into the death of Kai Lun Chok including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.³
9. In considering the issues associated with this finding, I have been mindful of Kai's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On 22 December 2023, Kai and Shanjing departed by car from their residence in Canberra for a 7 to 10-day holiday in Adelaide, with a plan to possibly then travel further north.⁴ Their exact time of departure and subsequent route are unknown. Kai did not have an Australian driver's licence. The pair were travelling in Shanjing's white 2019 Mercedes GLE300D sedan.⁵
11. At approximately 5:25 pm, Kai was driving, with Shanjing in the front passenger seat, as they travelled west along the Chinkapook-Nyah West Road, just past Chinkapook in north-western Victoria.
12. At the same time, Mr Trevor Neilson was driving a Kenworth Prime Mover truck, towing a single trailer fully loaded with carrots, south towards Melbourne along the Robinvale-Sea Lake Road, travelling at the marked speed limit of 100 km/h.⁶
13. For an unknown reason, Kai failed to give way at the Robinvale-Sea Lake Rd intersection and collided with Mr Neilson's truck in the middle of the intersection, causing major damage to both vehicles and the semi-trailer to tip onto its passenger side.⁷
14. As Mr Neilson approached the intersection, he observed the white Mercedes 'maybe a couple hundred metres back from the intersection' and assumed that the driver had seen him. He

³ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

⁴ Statement of Terri Mo, Coronial Brief.

⁵ Statement of Terri Mo, Coronial Brief.

⁶ Statement of Trevor Neilson, Coronial Brief. Mr Neilson's vehicle was speed limited to 100 km/h.

⁷ Statement of Trevor Neilson, Coronial Brief.

- observed that the Mercedes was also travelling at approximately 100 km/h. Mr Nielson's attention was then necessarily focused on navigating his own truck around the bend in Robinvale Road, which curves away from the intersection at this point.⁸
15. The intersection of the two roads is controlled by a give way sign on the Chinkapook-Nyah West Road side, giving priority to the busier Robinvale-Sea Lake Road, designated as Route C251 but commonly referred to as the Mallee Highway.⁹ Although nothing turns on the precise dimensions, at this point, the highway is a dual lane bitumen surface with wide bitumen shoulders.¹⁰
 16. Unfortunately, the white Mercedes did not slow down or give way to the priority route, and was struck in the middle of the driver's side of the car with great force by the oncoming southbound truck in the middle of route C251.¹¹ There were no other witnesses, but Mr Neilson, who cooperated with police investigations, said 'I didn't have time to do anything'.¹²
 17. In the aftermath investigation, there were found to be no skid marks from either vehicle prior to the collision point that would indicate braking in the lead-up to the collision.¹³
 18. The force of the impact caused the truck to roll up and over the Mercedes, before tipping onto its passenger side and sliding down the road and gravel shoulder, losing its steer axle in the process, before coming to rest across both lanes. The damage to the Mercedes was even more extensive, leaving my investigators with a difficult task to initially ascertain the orientation of the vehicle.¹⁴
 19. Passers-by pulled over and the drivers immediately offered assistance,¹⁵ but it is likely that Kai and Shanjing died immediately in the catastrophic impact.¹⁶
 20. Mr Neilson suffered minor injuries and subsequently tested negative for the presence of any alcohol or drugs.¹⁷ This was a regular delivery run for him, so he had travelled the route many

⁸ Statement of Trevor Neilson, Coronial Brief.

⁹ Statement of SC Toby Gilmour, Coronial Brief.

¹⁰ Exhibit 1 – Scene photographs, Coronial Brief.

¹¹ Statement of Trevor Neilson, Coronial Brief.

¹² Statement of Trevor Neilson, Coronial Brief.

¹³ Summary of SC Toby Gilmour, Coronial Brief.

¹⁴ Statement of SC Toby Gilmour, Coronial Brief.

¹⁵ Statement of Trevor Neilson, Coronial Brief.

¹⁶ Statements of Mark Burns & Peter Carnegie, Coronial Brief.

¹⁷ Exhibit 4 – Toxicology certificate of approved analyst re Trevor Neilson; Statement of Michael Neuschafer, Coronial Brief.

times and was not fatigued. The collision occurred one hour into his driving shift and he had enjoyed his typical amount of sleep the night before.¹⁸

21. At the time of incident, the weather was fine, with clear skies, a light wind, and a temperature of approximately 32 degrees.¹⁹
22. Subsequent review of the relevant road surfaces and signage revealed that they were compliant with domestic standards, and no other apparent cause for the collision was identified other than a momentary lapse of concentration by Kai. Sun glare was unlikely at this time of day and time of year, as the sun was high in the sky, but possible.
23. Without going so far as to be satisfied that the presence of ‘rumble strips’ on either side of the intersection with Route C251 would have prevented this collision, in my view, such an addition is a worthy prevention initiative, given the proximity of the Chinkapook township to the busy Mallee Highway route.

Identity of the deceased

24. On 2 January 2024, Kai Lun Chok, born 23 May 1995, was visually identified by his friend of 18 years, Wai Seng Cheoh. Identity is not in dispute and requires no further investigation.

Medical cause of death

25. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an external examination on 26 December 2023 and provided a written report of her findings dated 15 January 2024.
26. Examination of a postmortem CT scan showed bleeding inside the brain, but no cervical spine or skull fractures. There was a fractured left mandible and left clavicle, an ‘open book’ pelvic fracture with bilateral superior and inferior pubic rami fractures, proximal and distal left femoral fractures, left distal humerus fracture dislocation, bilateral haemopneumothoraces, as well as left and right rib fractures.
27. The physical examination revealed no other independent cause of death.

¹⁸ Statement of Trevor Neilson, Coronial Brief.

¹⁹ Statement of SC Toby Gilmour, Coronial Brief.

28. Toxicological analysis of post-mortem samples did not identify the presence of alcohol or any other common drugs or poisons.
29. Dr Baber provided an opinion that the medical cause of death was 1(a) multiple injuries sustained in a motor vehicle incident, and I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

30. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.²⁰ The effect of the authorities is that adverse comments or findings should not be made unless the evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.
31. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Kai Lun Chok, born 23 May 1995;
 - b) the death occurred on 22 December 2023 at Robinvale-Sea Lake Road and Chinkapook-Nyah West Road, Chinkapook, Victoria 3546, from 1(a) multiple injuries sustained in a motor vehicle incident ; and
 - c) the death occurred in the circumstances described above.
32. Having considered all of the evidence, I am satisfied that:
 - a) Mr Neilson did not have an opportunity to avoid the collision; and
 - b) the collision was the tragic result of Kai's failure to give way to oncoming traffic as he entered the intersection.

²⁰ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

- i) That Advanced Audible Warning Systems (rumble strips) be installed on the Chinkapook-Nyah West Road in the lead-up to the Robinvale-Sea Lake Road intersection.

I convey my sincere condolences to Kai Lun's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Boon Hing & Lau Sew Chen Chok, Senior Next of Kin

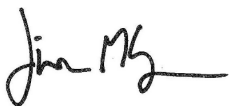
Kai Shen Chok, Brother

Carmela Danet, QBE Insurance (Australia) Ltd

Allen Guo, Applicant

Sergeant Tobias Gilmour, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 22 January 2025

NOTE: Under section 83 of the *Coroners Act 2008* (**the Act**), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
