



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004851

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Simon McGregor
Deceased:	Kerry Kathleen Capes
Date of birth:	26 April 1954
Date of death:	31 August 2023
Cause of death:	1a: Multiple injuries sustained in a motor vehicle incident (passenger)
Place of death:	Wenkes Road and Hume Freeway Chiltern Valley Victoria 3683
Keywords:	Motor vehicle accident, passenger

INTRODUCTION

1. On 31 August 2023, Kerry Kathleen Capes was 69 years old when she died in a motor vehicle accident. At the time of her death, Kerry lived at 14A Franklin Drive, Estella, New South Wales with her husband, Noel.
2. Kerry and Noel both grew up in country New South Wales. Kerry had been a child services support worker and Noel had been a truck driver, but both were now retired and enjoyed travelling. Their three sons were grown, and the couple enjoyed spending time with their seven grandchildren. In her spare time, Kerry also enjoyed reading and working with the retirement village committee.¹
3. Kerry was generally in good health.

THE CORONIAL INVESTIGATION

4. Kerry'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 Coroner's Investigator for the investigation of Lorraine's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, witnesses, the forensic pathologist, collision reconstruction experts and investigating officers – and submitted a coronial brief of evidence.

¹ Statement of Ryan Capes, Coronial Brief.

8. This finding draws on the totality of the coronial investigation into the death of Kerry Kathleen Capes 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.²
9. In considering the issues associated with this finding, I have been mindful of Kerry'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 the morning of Thursday 31 August 2023, Kerry's brother, Trevor Breen, was driving his 2022 Subaru Forester south towards Melbourne on Wenkes Road, Chiltern. Trevor's wife, Lorraine, was in the front passenger seat. Kerry and Noel were passengers, seated in the rear right and left passenger seats respectively. The foursome was on their way from Wagga Wagga, New South Wales, to the Mornington Peninsula to visit one of Kerry and Noel's sons and had just stopped for a coffee break in Chiltern.³
11. At the same time, Rajwinder Singh was driving a red 2021 Volvo FH600 prime mover towing two Maxitrans Freighter Table Top trailers (**the truck**) along the Hume Freeway towards Sydney. Mr Singh had spent the night at home in Wangaratta and had returned to his truck and inspected the truck, trailers and tyres before commencing driving at approximately 9:45 am that morning.⁴ Mr Singh was 31 years old and had driven tractors and trailers back in India. He obtained a heavy rigid driver's licence once he migrated to Australia in 2018, and had been driving trucks ever since.⁵ At approximately 10:13 am, Mr Singh made a phone call and talked on the phone using Bluetooth.⁶

² 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.

³ Summary of Leigh Nicholds, Coronial Brief.

⁴ Statement of Rajwinder Singh, Coronial Brief.

⁵ Statement of Rajwinder Singh, Coronial Brief.

⁶ Statement of Leigh Nicholds, Coronial Brief.

12. It was daylight when the collision occurred, the road was dry, the weather fine and traffic light.⁷
13. At approximately 10:25 am, the Subaru approached the intersection of Wenkes Road with the Hume Freeway, but failed to give way to Mr Singh's oncoming truck travelling east along this part of the freeway.⁸ Despite braking hard and swerving,⁹ the truck hit the driver's side of the Subaru, causing the Subaru to rotate clockwise and clip the wire barrier in the centre median strip, then roll down the road, coming to rest on its passenger side.¹⁰
14. All four of the Subaru's occupants died at the scene of the accident.¹¹
15. Mr Singh suffered only minor injuries in the collision,¹² and no alcohol or illicit drugs were detected in his system.¹³ His work records showed that he was accredited in basic fatigue management.¹⁴
16. Dashcam footage recorded from Mr Singh's truck shows Mr Singh concentrating appropriately while the truck is travelling along the Hume Freeway, then the Subaru failing to give way as it pulled out of Wenkes Road. Multiple witnesses also observed the Subaru pull out in front of the truck, leaving no opportunity for Mr Singh to avoid the collision.¹⁵

Identity of the deceased

17. On 6 September 2023, Kerry Kathleen Capes, born 26 April 1954, was identified via DNA comparison.
18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine conducted an external examination on 4 September 2023 and provided a written report of her findings dated 14 September 2023.

⁷ Statements of Rajwinder Singh, Rod McKenzie, Clayton Delaney, Coronial Brief.

⁸ Statement of John O'Bryan and Exhibit 1, Dash Camera Footage, Coronial Brief.

⁹ Exhibit 6 – LSC Gibson body-worn camera footage transcript, Coronial Brief

¹⁰ Statement of Dr Jenelle Hardiman, Coronial Brief.

¹¹ Statement of Michael Savage, Coronial Brief.

¹² Statement of Rajwinder Singh, Coronial Brief.

¹³ Statement of Braithe Gibson, Coronial Brief.

¹⁴ Statement of Matthew Nixon, Coronial Brief.

¹⁵ Statements of Moore, White, Filipenko, McAuliffe, Clements, Evmorfias, McKenzie and Delaney, Coronial Brief.

20. The examination revealed significant trauma to the head, neck, chest, and pelvis. There was a horizontal band-like abrasion about the right lower abdomen and pelvis, consistent with being restrained by a seatbelt.
21. Toxicological analysis of post-mortem blood samples did not identify the presence of alcohol or any common drugs or poisons.
22. Dr Zhou provided an opinion that the medical cause of death was 1(a) multiple injuries sustained in a motor vehicle incident (passenger).
23. I accept Dr Zhou's opinion.

COLLISION INVESTIGATION

24. Attending police examined the scene and conducted a walk-through, taking measurements, photographs and video recordings. Data was also able to be downloaded from the Subaru's Airbag Control Module.¹⁶
25. Wenkes Road is a two-way, single lane road that runs in a general north-south direction. The road is constructed of bitumen and was in good condition with no obvious damage or faults that would have caused or contributed to the collision. It joins the Sydney-bound lanes of the Hume Freeway from the north side and continues south from the Melbourne-bound lanes with the name Old Cemetery Road. There is a break in the centre median strip of the Hume Freeway to allow traffic from Wenkes Road to cross the freeway and continue onto Old Cemetery Road. There are no road markings on Wenkes Road to delineate the opposing traffic directions until approximately 62 metres north of the give way line at its intersection with the Hume Freeway. Approximately 62 metres from the give way line, the opposing directions of traffic become separated by a splitter (triangular) traffic island.¹⁷
26. Along Wenkes Road, just before its intersection with the Hume Freeway, there is a 'Freeway Entrance' sign followed by a 'Give Way' sign on each side of the road as it joins the Hume Freeway. Below the 'Give Way' sign on the left side is a 'Look Right' sign, which is the direction Mr Singh's truck was coming from.¹⁸

¹⁶ Statement of Dr Jenelle Hardiman, Coronial Brief.

¹⁷ Statements of Dr Jenelle Hardiman and Leigh Nicholds, Coronial Brief.

¹⁸ Statement of Dr Jenelle Hardiman, Coronial Brief.

27. In the vicinity of the collision, the Hume Freeway has two lanes in each direction separated by a median strip. The collision occurred entirely in the Sydney-bound lanes.¹⁹ The two Sydney-bound lanes of the Hume Freeway are separated by broken white lines and there are additional left and right turning lanes on each side to allow traffic to turn left into Wenkes Road or right, across the Melbourne-bound lanes into Old Cemetery Road. The Hume Freeway is the priority road at this intersection, and the speed limit is 110 km/h.²⁰
28. The intersection is an older ‘crossroad’ type of intersection. Whilst modern intersections are usually designed with more infrastructure, my investigation has not identified any relevant material defect in this particular intersection.²¹
29. Using the available data, scene measurements and dashcam footage, Victoria Police collision reconstructionist Dr Jenelle Hardiman was able to determine that at the commencement of emergency braking, Mr Singh’s truck was likely travelling at 98 km/h. At the moment of impact, the Subaru was travelling at about 32 km/h and neither braking nor accelerating. Whilst the Subaru had been capably navigating the road’s bends as it approached the intersection, it had never slowed below 30 km/h per hour as it approached, and then crossed, the give way line into the intersection. The Subaru was effectively ‘coasting’.²²

FINDINGS AND CONCLUSION

30. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Kerry Kathleen Capes, born 26 April 1954;
 - b) the death occurred on 31 August 2023 at Wenkes Road and Hume Freeway, Chiltern Valley, Victoria 3683, from multiple injuries sustained in a motor vehicle incident (passenger); and
 - c) the death occurred in the circumstances described above.
31. Having considered all of the evidence, I am satisfied that none of Kerry’s conduct contributed to her own death.

¹⁹ Statement of Leigh Nicholds, Coronial Brief.

²⁰ Statement of Leigh Nicholds, Coronial Brief.

²¹ Statement of Leigh Nicholds, Coronial Brief.

²² Statement of Dr Jenelle Hardiman, Coronial Brief.

32. I am further satisfied that Rajwinder Singh, the driver of the truck, could not avoid the collision despite his best efforts.

I convey my sincere condolences to Kerry'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:

Ryan Capes, Senior Next of Kin

Leading Senior Constable Leigh Nicholds, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date: 20 November 2024

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.
