



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002637

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

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| Findings of: | Coroner Simon McGregor |
| Deceased: | Pramod Acharya |
| Date of birth: | 25 November 1992 |
| Date of death: | 17 May 2023 |
| Cause of death: | 1(a) Multiple injuries sustained in a motor vehicle incident (driver) |
| Place of death: | Princes Highway, Pomborneit, Victoria, 3260 |
| Keywords: | Motor vehicle collision, wildlife hazard |

INTRODUCTION

1. On 17 May 2023, Pramod Acharya was 30 years old when he died in a motor vehicle collision. At the time of his death, Pramod lived at 3 Alexander Street, Colac, Victoria with his wife, Sujata Khanal.
2. Pramod was born in Rupandehi, Nepal, the youngest of three siblings. Pramod and Sujata met and formed a friendship while in high school in Nepal. They became romantically involved in 2014 and maintained a happy and committed relationship until Pramod's passing. In 2018, Pramod moved to Australia to study biotechnology and bioinformatics. Pramod and Sujata supported one another while studying apart for approximately four years, with Sujata studying and living in Nepal. Sujata ultimately joined Pramod in Australia and the couple married in New South Wales in September 2022.¹
3. While studying, Pramod applied for his NSW learner permit and took professional driving lessons before getting his probationary licence. Pramod had a Nepali driver's licence before moving to Australia for two to three years.² Sujata stated that Pramod was an experienced and careful driver, and conscious of the maintenance and regular servicing of his vehicle. She noted that the car had been serviced approximately a month prior to the collision and no defects had been identified.³
4. Pramod was in good health and had no known medical conditions or prescribed medications. He had been working two jobs, as a chef at the Austral Hotel in Colac and for Total Livestock Genetics in Camperdown.⁴

THE CORONIAL INVESTIGATION

5. Pramod'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.
6. 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

¹ Coronial Brief, statement of Sujata Khanal, p.9.

² Coronial Brief, statement of Sujata Khanal, p.9.

³ Coronial Brief, statement of Sujata Khanal, p.10.

⁴ Coronial Brief, statement of Sujata Khanal, p.10.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. 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.
8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Pramod's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
9. This finding draws on the totality of the coronial investigation into the death of Pramod Acharya 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.⁵
10. In considering the issues associated with this finding, I have been mindful of Pramod'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, pursuant to section 67(1)(c) of the Act

11. At approximately 6:25pm on Wednesday 17 May 2023, Pramod was driving alone on his way to work in his silver Kia Rio sedan, travelling in a westerly direction on the Princes Highway, Pomorneit.
12. The relevant section of the Princes Highway is a sealed road with single traffic lanes running generally southeast-northwest, with double solid white lines dividing the lanes of traffic and a posted speed limit of 100 km/h. The highway has a slight camber with the high side being

⁵ 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.

the west bound lane.⁶ The collision occurred on a sweeping bend, where the east bound lane veered to the right. At the time of the collision it was dark, with no street lighting, but conditions were clear and dry and visibility was otherwise good.⁷

13. At the same time, Bruce Cunningham was driving a white 2020 Hino FM500 tanker truck in the east bound lane of the Princes Highway towards Melbourne. Mr Cunningham described coming to a bend in the road on a slight downhill slope and suddenly seeing a silver car sliding sideways towards him. Mr Cunningham braced and braked, and saw the passenger side of the vehicle collide with the front of his truck at a right angle (T-bone). The truck then pushed the vehicle approximately 30 metres down the road before both vehicles came to a stop.⁸
14. Witness Scott Johnstone, who had been driving in the same direction as Pramod, approximately 200 metres behind him, arrived at the bend and realised the truck and silver car had collided. He stopped to render assistance and called emergency services. Mr Cunningham appeared to him to be in shock. Mr Johnstone observed a deceased koala on the roadway, on the right-hand side of the west-bound lane.⁹
15. By this time, a number of passers-by had also stopped to render assistance. Mr Johnstone approached Pramod's car with other witnesses and found him to be unconscious but breathing. He observed that Pramod's seatbelt was still on.
16. Ambulance Victoria members arrived on the scene at approximately 6:35pm and removed Pramod from the vehicle with the help of bystanders. On initial assessment they found that Pramod was not breathing and did not have a pulse. Despite intensive resuscitation efforts for close to an hour, Pramod was unable to be revived and he was formally pronounced deceased at 7:27pm.¹⁰
17. At approximately 9:20pm, Sujata had become concerned that she was unable to contact Pramod and attended the Colac police station driven by her co-worker Manpreet Singh. Sujata provided police with a photograph of Pramod, his vehicle registration, and a description of his vehicle and the clothes and accessories he was wearing. Based on these details, police were able to confirm the identity of Pramod as the driver of the silver Kia Rio.¹¹

⁶ Coronial Brief, statement of Adrienne Cauchi, pp.43-44.

⁷ Coronial Brief, statement of Bruce Cunningham, p.14; statement of Scott Johnstone, p.19.

⁸ Coronial Brief, statement of Bruce Cunningham, p.14.

⁹ Coronial Brief, statement of Bruce Cunningham, p.18.

¹⁰ Coronial Brief, Ambulance Victoria electronic Patient Care Record, p.104.

¹¹ Coronial Brief, statement of Allysha Turner, pp.29-30.

Scene investigations

18. Police attending the scene conveyed Mr Cunningham to Colac Area Health and a blood sample was taken at 8:57pm pursuant to section 55BA(2) of the *Road Safety Act 1986*.¹² Subsequent toxicological analysis of the sample did not identify the presence of alcohol or any common drugs or poisons.
19. Police investigators conducted a walk-through of the scene and took comprehensive photographs and measurements. Their observations included the following:
 - a) A pool of blood in the middle of the west-bound lane and a deceased koala in the middle of the road a short distance away;¹³
 - b) The white Hino FM500 tanker truck in the east bound lane facing east, with major damage to the front end;¹⁴
 - c) The silver Kia Rio on the east bound shoulder facing the westerly direction with major damage to the rear end and passenger side of the vehicle. The rear passenger wheel was a spare wheel fitted to the vehicle.¹⁵ The rear of the vehicle had been crushed and compressed up behind the driver's seat.¹⁶
 - d) Yaw, skid and gouge marks on the roadway evidencing the course of Pramod's vehicle from the apparent point of impact with the koala, to the vehicle veering and then spinning onto the wrong side of the road, impacting with the Hino tanker, and then being pushed approximately 30 metres before coming to rest.¹⁷
20. On the basis of the measurements taken, police were satisfied that neither vehicle had been travelling in excess of the 100 km/h speed limit.¹⁸
21. Mr Cunningham's work diary was examined by police and found to have been filled out correctly in all areas, with no issues identified in respect of the hours worked and breaks taken by Mr Cunningham.¹⁹

¹² Coronial Brief, statement of Aaron De Graaf, p.23; Certificate of taking blood sample, p.118.

¹³ Coronial Brief, statement of Patrick Brady, p.26; statement of Adrienne Cauchi, p.46.

¹⁴ Coronial Brief, statement of Patrick Brady, p.26; statement of Adrienne Cauchi, p.44.

¹⁵ Coronial Brief, statement of Adrienne Cauchi, p.45.

¹⁶ Coronial Brief, statement of Patrick Brady, p.26.

¹⁷ Coronial Brief, statement of Adrienne Cauchi, p.46.

¹⁸ Coronial Brief, statement of Greg Hart, p.41.

¹⁹ Coronial Brief, statement of Adrienne Cauchi, p.47; Copy of Work Diary sheets VND No 912125, p.120.

22. Inspection of Pramod's mobile phone showed that Pramod had not been on his phone at or near to the time of the collision.²⁰
23. On 27 June 2023, Senior Constable David Giulieri of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit conducted a mechanical inspection of the Kia Rio, in relation particularly to the spare wheel that was fitted at the time of collision. Senior Constable Giulieri found that although the vehicle was severely impacted at the rear, he was nevertheless able to test and confirm there were no faults with the vehicle's brakes, steering or accelerator system. Of the remaining components, the inspection did not reveal any faults, failures or conditions that could have caused or contributed to the collision.²¹

Identity of the deceased, pursuant to section 67(1)(a) of the Act

24. On 19 May 2023, Pramod Acharya, born 25 November 1992, was visually identified by his brother-in-law, Bikash Paudel.
25. Identity is not in dispute and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

26. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an external examination on 18 May 2023 and provided a written report of her findings dated 8 June 2023
27. The post-mortem computed tomography (CT) scan showed bilateral haemopneumothorax²² and chest wall subcutaneous emphysema,²³ and extensive fractures to the left femur, left upper arm, pelvis and ribs.
28. The external examination revealed external bruises and abrasions, and changes to the left upper arm and chest in keeping with the underlying injuries.
29. Toxicological analysis of post-mortem blood samples did not identify the presence of alcohol or any common drugs or poisons.

²⁰ Coronial Brief, statement of Adrienne Cauchi, p.47.

²¹ Coronial Brief, statement of David Giulieri, pp.32-35; Mechanical Investigation Unit notes of S/C David Giulieri, p.132-142.

²² Blood and air in the pleural space, often due to trauma, making it difficult or impossible for the lung to inflate.

²³ Air or gas trapped beneath the skin.

30. Having regard to her findings, Dr Archer provided an opinion that the medical cause of death was 1(a) multiple injuries sustained in a motor vehicle incident (driver).
31. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

32. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Pramod Acharya, born 25 November 1992;
 - b) the death occurred on 17 May 2023 at Princes Highway, Pomborneit, Victoria, 3260, from multiple injuries sustained in a motor vehicle incident (driver); and
 - c) the death occurred in the circumstances described above.
33. Having considered all of the circumstances and available evidence, I am satisfied that Pramod's death was the result of:
 - a) an initial collision with wildlife on the roadway;
 - b) leading Pramod to swerve in an attempt to avoid that collision and over-correct as he has steered right, causing the vehicle to spin and skid backwards onto the east bound lane into the path of the oncoming truck.

RECOMMENDATION

34. Pursuant to section 72(2) of the Act, I make the following recommendations:
 - i) That Regional Roads Victoria conduct a safety review of the Princes Highway in the Pomborneit area, with particular consideration to be given to the display of advisory wildlife warning signs.

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

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

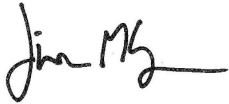
I direct that a copy of this finding be provided to the following:

Sujata Khanal, Senior Next of Kin

Paul Northey, Chief Regional Roads Officer, Regional Roads Victoria

Leading Senior Constable Adrienne Cauchi, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 14 August 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.
