IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004848

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	Trevor Michael Breen
Date of birth:	2 August 1947
Date of death:	31 August 2023
Cause of death:	1(a) Multiple injuries sustained in a motor vehicle incident (car vs. truck, driver) 2 Ischaemic and hypertensive heart disease
Place of death:	Wenkes Road and Hume Freeway Chiltern Valley Victoria 3683
Keywords:	Motor vehicle accident, driver

INTRODUCTION

1. On 31 August 2023, Trevor Michael Breen was 76 years old when he died in a motor vehicle accident. At the time of his death, Trevor lived at Unit 17 Settlers Village, 1 Franklin Drive, Estella, New South Wales with his wife, Lorraine.

2. Trevor and Lorraine had both been raised in country New South Wales. They met around the age of 18 and married in 1970, raising their children around Lake Cargelligo and its vibrant netball and football club. Trevor worked with machinery, especially harvesters, and Lorraine worked in the offices associated with those businesses. Whilst the couple had eventually worked with John Deere franchises, they both retired in 2016 and loved travelling together.[1]

3. Trevor had a history of heart attacks since his early 40s for which he took medication and had a pacemaker inserted.[2] In June of 2023, his New South Wales truck licence was cancelled due to a medical assessment, but by August 2023 he had been medically assessed as meeting the required standards to continue to hold a full car driver's licence.[3] He had no other relevant medical history.[4]

THE CORONIAL INVESTIGATION

4. Trevor'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.

[1] Statement of Christopher Breen, Coronial Brief.
[2] Ibid.
[3] Statement of Leigh Nicholds, Coronial Brief.
[4] Statement of Dr Mourine Mansour, Coronial Brief.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Trevor'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.

8. This finding draws on the totality of the coronial investigation into the death of Trevor Michael Breen 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]

9. In considering the issues associated with this finding, I have been mindful of Trevor'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, Trevor was driving his 2022 Subaru Forester south towards Melbourne on Wenkes Road, Chiltern. Lorraine was in the front passenger seat. Trevor's sister Kerry Capes and her husband, Noel, were seated respectively in the rear right and left passenger seats. The foursome was on their way from Wagga Wagga, New South Wales, to the Mornington Peninsula to visit Noel and Kerry's son, and had just stopped for a coffee break in Chiltern.[6]

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.[7] 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

[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.
[6] Summary of Leigh Nicholds, Coronial Brief.
[7] Statement of Rajwinder Singh, Coronial Brief.

had been driving trucks ever since.[8] At approximately 10:13 am, Mr Singh made a phone call and talked on the phone using Bluetooth.[9]

12. It was daylight when the collision occurred, the road was dry, the weather fine and traffic light.[10]

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.[11] Despite braking hard and swerving,[12] 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.[13]

14. All four of the Subaru's occupants died at the scene of the accident.[14]

15. Mr Singh suffered only minor injuries in the collision,[15] and no alcohol or illicit drugs were detected in his system.[16] His work records showed that he was accredited in basic fatigue management.[17]

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.[18]

Identity of the deceased

17. On 6 September 2023, Trevor Michael Breen, born 2 August 1947, was identified via DNA comparison. Identity is not in dispute and requires no further investigation.

[8] Statement of Rajwinder Singh, Coronial Brief.
[9] Statement of Leigh Nicholds, Coronial Brief.
[10] Statements of Rajwinder Singh, Rod McKenzie, Clayton Delaney, Coronial Brief.
[11] Statement of John O'Bryan and Exhibit 1, Dash Camera Footage, Coronial Brief.
[12] Exhibit 6 – LSC Gibson body-worn camera footage transcript, Coronial Brief
[13] Statement of Dr Jenelle Hardiman, Coronial Brief.
[14] Statement of Michael Savage, Coronial Brief.
[15] Statement of Rajwinder Singh, Coronial Brief.
[16] Statement of Braithe Gibson, Coronial Brief.
[17] Statement of Matthew Nixon, Coronial Brief.
[18] Statements of Moore, White, Filipenko, McAuliffe, Clements, Evmorfias, McKenzie and Delaney, Coronial Brief.

Medical cause of death

18. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an autopsy on 6 September 2023 and provided a written report of his findings dated 12 October 2023.

19. The autopsy revealed extensive injury to the torso, including rib fractures, rupture of the diaphragm, laceration of the liver, a tear in the thoracic aorta, and pelvic fractures. These extensive and severe injuries are sufficient to cause rapid organ dysfunction and death, for instance through blood loss, loss of respiratory function, and effects on cardiac function.

20. It also confirmed the presence of substantial cardiac disease, including previous infarction of the posterior wall of the left ventricle, coronary artery disease, and a permanent pacemaker. Dr de Boer opined that the substantial cardiac disease would have placed Trevor at risk for a cardiac arrythmia.[19]

21. Trevor's pacemaker was interrogated by cardiologist Dr Neil Strathmore. According to his report, the pacemaker clock was 31 minutes before actual time. The pacemaker had recorded an episode of arrhythmia (ventricular tachycardia) on 31 August at 10:18 am, which would correspond with a real time of 10:48 am. According to the ambulance report, Ambulance Victoria received a call relating to the incident at 10:26 am. This would indicate that the ventricular tachycardia was a result of the crash, rather than a precipitating event.

22. No other medical conditions that might have contributed to the collision were detected.

23. Toxicological analysis of post-mortem blood samples identified the presence of antihypertensive and other medications at doses consistent with the medical history given, and did not identify the presence of alcohol or any other common drugs or poisons.

24. Dr de Boer provided an opinion that the medical cause of death was 1(a) multiple injuries sustained in a motor vehicle incident (car vs truck, driver), with ischaemic and hypertensive heart disease as contributing factors.

25. I accept Dr de Boer's opinion.

[19] Where the heart beats too fast or too slow, which in turn degrades many other bodily functions.

COLLISION INVESTIGATION

26. 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.[20]

27. 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.[21]

28. 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.[22]

29. 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.[23] 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.[24]

30. 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.[25]

[20] Statement of Dr Jenelle Hardiman, Coronial Brief.
[21] Statements of Dr Jenelle Hardiman and Leigh Nicholds, Coronial Brief.
[22] Statement of Dr Jenelle Hardiman, Coronial Brief.
[23] Statement of Leigh Nicholds, Coronial Brief.
[24] Statement of Leigh Nicholds, Coronial Brief.
[25] Statement of Leigh Nicholds, Coronial Brief.

31. 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'.[26]

FINDINGS AND CONCLUSION

32. 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.[27] 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.

33. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Trevor Michael Breen, born 2 August 1947;

    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 (car vs. truck, driver) with ischaemic and hypertensive heart disease as contributing factors; and

    c) the death occurred in the circumstances described above.

34. Having considered all of the evidence, I am satisfied that Trevor failed to stop at a clearly marked intersection and give way to oncoming traffic. This omission caused the collision which resulted in the death of the four occupants of the Subaru.

[26] Statement of Dr Jenelle Hardiman, Coronial Brief.

[27] *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…'.

35. 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 Trevor's family for their loss.

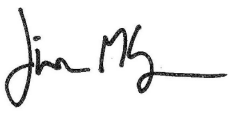
Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Christopher Breen, 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.