



**INTERNATIONAL SAFETY FOUNDATION INC.**  
**EXPERT REPORT FOR**  
**Supreme Court of Victoria Proceedings SECI 2023/02705**  
**Dr Raymond Neil Shuey**

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## Executive Summary

Dr Raymond Neil Shuey AM., APM., FAIM, FIPAA,, RRSP, BA

### States:

I have 41 years’ experience in Victoria Police at all ranks from Constable to Acting Deputy Commissioner, followed by 20 years in international road safety specialising in crash investigation. My PhD doctorate was in international road safety with a focus on star rating of investigation techniques, processes and practices. i have researched best practice, trained police and road safety

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officers in crash investigation to diploma status and published manuals, guidelines and research papers.

## Circumstances:

Shortly after 1pm on Monday 7<sup>th</sup> January 2013, a Government-owned Ford Territory SUV Registered YKV136 turning right from Melbourne Road, a major 80kph thoroughfare into a minor suburban 50 kph road, Ridley Street, Blairgowrie, collided with Ryan Meuleman, a helmeted cyclist. Ryan was riding his sister's bike with a mechanics bag full of tools, along a gravel/sandy service road running parallel to Melbourne Road, and intending to cross Ridley Street. The cyclist was critically injured with life-threatening injuries and transported to The Royal Melbourne Children's Hospital by Air Ambulance. Local police attended and finalised the investigation.

## Review:

An analysis of the incident and subsequent attendance and investigation by Victoria Police has been undertaken with consideration of the Victoria Police definition "*An investigation is a search for the truth, in the interests of justice, and according to the specifications of the law.*" The review considered the police response, actions, inactions, explanations, recordings, notes, statements, observations, documents, photographs and a scene inspection. Of special relevance is the lack of police adherence to standard practices, the lack of rigour in the investigation and deliberate misdirection and factual inconsistencies.

## Findings:

In reviewing the known evidence, and with consideration to the undisputed path of the cyclist, the approximate point of impact, the injuries to the cyclist, the squealing of tyres in the vehicle manoeuvre, the absence of braking of either the vehicle or cyclist, the trajectory of the cyclist and landing after the collision, the vehicle braking distance, and the damage to the vehicle, I make the following observations and findings:

1. The impact occurred in Ridley Street 27 metres from the centre-white line point of Melbourne Road, Blairgowrie,
2. The point of impact was approximately 1.5metres onto the bitumen from the cyclist entry point where the road width is 3.8 metres placing the SUV still partially on the incorrect side of the road at that 27-metre point
3. It was definitely not a low-speed vehicle impact,
4. It was definitely not a high-speed bike impact against a slow speed vehicle – otherwise the flip motion of the cyclist would have been in a different and opposite direction to his actual trajectory,
5. If the vehicle was travelling from a stationary start in Melbourne Road (as stated by Catherine and Daniel Andrews), 27 metres prior to impact, it would not have reached the resultant speed to cause the damage and injuries. Low speed impacts propel pedestrians and cyclists forward of impact. This impact was so severe, it flipped the cyclist i.e. the hit, the flip onto the bonnet, propulsion over the roof line and then sideways onto the roadway. This throw distance, and angle is critical and together with the trajectory indicates the vehicle was travelling at speed prior to impact
6. The forward momentum of the SUV carried the cyclist a further 5.7 metres (throw distance)
7. It is stated that neither party saw the other before impact. There is no evidence of evasive action of either party

8. The track where the tool laden bike was being ridden was a gravel/sandy track not enabling any bike speed as well as there being a distinct lip for the rider to negotiate prior to crossing Ridley Street and with foliage obstructing the view to the rider's left (as well as the driver's view of the rider). The rider's explanation, the bike, the load, plus the track do not enable the determination of any type of entry speed on the part of the cyclist.
9. From the tyre marks on the roadway and observing the pattern of behaviour of drivers undertaking a right-hand turn into Ridley Street, it appears as common practice to undertake a sweep turn when negotiating this right-hand turn. The possibility of tyre marks was ignored by the attending police.
10. The statement of Brad Morgan, (independent and potentially material witness), that he heard the squeal of tyres, immediately prior to impact, is an indication of higher than usual speed to negotiate any type of vehicle movement – acceleration, deceleration, braking or turning. (I observed several vehicles negotiating the turn at approximately 25 kph without stopping and did not hear any abnormal tyre noises),
11. The statements from both Daniel and Catherine Andrews that their vehicle stopped at Melbourne Road are not consistent with impact consequences, nor the report by Brad Morgan of the squeal of tyres prior to impact. This version submitted by Daniel and Catherine Andrews (in unusual prepared sworn statements 3 weeks following the event (dated 31<sup>st</sup> January and 5<sup>th</sup> February 2013) is subject to challenge. Further, the content of the statements do not align with normal police procedures in obtaining full explanations and circumstances surrounding a crash of this nature. i.e. the content of the statements do not match the gravity of the incident. NB: The need to eliminate numerous factors including, speed, fatigue, distractions of children, mobile phone, other distractions, and familiarity with the vehicle have not been addressed.
12. The absence of any normal/routine police procedures being followed, and the absence of tangible preserved evidence or legitimate investigation from the attending police – specifically no point of impact, no point of references, no point of rest for either vehicle or body, no scene containment or vehicle preservation, no measurements, no photographs, no scientific reconstruction, no eye witness testimony (no separation of witnesses), no effective door knocks, and no preliminary breath test.
13. The effective vehicle stopping distance of 19.2metres following impact is indicative of a speed of 45kph prior to impact.
14. From the above information, it is my opinion that the impact speed of the vehicle was in excess of 40kph and more likely to be in the range of 40kph to 50kph.
15. It is most probable that the vehicle undertook a sweep turn at speed, cutting the corner and still on the incorrect side of the roadway in Ridley Street, 27 metres from Melbourne Road when the collision occurred,

## Expert Opinion:

The investigation of this crash is deeply flawed and raises serious concerns about its credibility. It does not demonstrate competent professional practice for Victoria Police. The investigators' failure to follow even a rudimentary examination of the evidence is demonstrated in the hasty and illogical conclusion. The report lacks critical information including measurements, photographs and professional interview techniques. Instead, the investigator has drawn a baseless and unsupported conclusion that fails to account for the available evidence. This negligent approach not only undermines the integrity of the investigation but also jeopardises the pursuit of justice and accurate accountability in this case. Further, it demonstrates a high level of incompetence or alternatively a deliberate attempt to simplify the crash to rudimentary reporting requirements. This omission in recording and preserving of accurate measurements has directly contributed to an unsubstantiated



conclusion and directly to the inability to easily and accurately undertake a forensic reconstruction and analysis of the crash.

This opinion is provided in consideration of my experience within Victoria police, my international research and assessment of police practices, policies and procedures over 60 years in the field, the latter years specialising in crash investigations.

The following course of conduct and pattern of behaviour are strong reasons to assert this investigation was strongly influenced to keep the ANDREWS identity concealed and without prosecution or media attention.

1. The fact that S/C Sage jumped the call after it was already allocated to another unit two minutes prior; Sage stating she was closer but was actually at Rye police station doing urgent correspondence, then taking 6 ½ minutes to leave
2. The failure to call expert and/or experienced officers to the scene (Major Collision Unit and the Highway Patrol) – as required by policy, custom and practice.
3. The failure to notify police hierarchy of a public, political figure involved in a serious incident
4. Police acceptance of the ANDREWS' version in the first instance when the vehicle damage, ambulance report, and cyclist catapult clearly indicates vehicle speed
5. Not thoroughly investigating who was driving a government vehicle
6. Only spending a total of 35 minutes at the scene and without thorough examination
7. Failure to undertake a cursory/basic investigation
8. Recording KESIK in the indexed retrieval on TIS report as the driver
9. Writing the file off at 1821 hours the same afternoon as NFPA (No further Police Action) prior to any possible completion of evidence -statements etc.
10. Failure to exchange names and addresses of driver and owner of vehicle or ensure the exchange occurred
11. Advising the victim's father to find out details of the driver from FOI and TAC
12. The recording of KESIK as the driver in government insurance system
13. Door knocks, photos etc undertaken only after prompting
14. Not taking a PBT, falsely reporting it was negative and then continuing to cover up the omission in subsequently released documents.

Many questions still remain unresolved.

## Part A [Dr Raymond Neil Shuey AM., APM., FAIM, FIPAA, RRSP, BA](#)

### **Summary Credentials – Policing and Crash Investigation**

States: I have read, understood, and agree to be bound by the Supreme Court Expert Witness Code of Conduct. My full name is Raymond Neil SHUEY. My address has been provided for court records.

I am Chairman of the International Safety Foundation, a not-for profits international charity and Associate member of the Global Road Safety Alliance of Non-government Organisations. I am a Police Veteran as well as a Vietnam war Veteran. My background includes 41 years' experience in operational and administrative policing including 14 years in the senior executive positions of Assistant Commissioner and acting Deputy Commissioner for Victoria

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Police, Australia. For the past twenty years I have specialised my career in international road safety and particularly Crash Investigation. I have designed, developed and delivered training programs (train the trainer), and strategies to over 3,000 road safety participants in more than 20 countries on behalf of the World Bank, Asian Development Bank, World Health Organisation, Asia Injury, Handicap International Belgium, VicRoads International, ARRB Australia, Bloomberg Foundation, and the Global Road Safety Partnership. I have authored Manuals and International Publications on Crash Investigation.

## 1. Academic Qualifications:

- a. PhD Research Doctorate (Doctorate in International Road Safety and Road Policing). RMIT University 2006-2013.
- b. Bachelor of Arts (Police Studies), Monash University 1992
- c. Post Graduate Diploma of Criminology, Melbourne University 1983
- d. Diploma of Police Studies, Monash University, 1981
- e. Diploma of Government Investigations, Churchill Institute 2011
- f. Certificate 1V in training and Assessment, Australian Security Academy, 2009, upgraded in 2019.
- g. Alumni to RMIT, Melbourne and Monash Universities.

## 2. Victoria Police Training Qualifications:

- a. Police Executive Course
- b. Senior Officer's Course
- c. Detective Training Investigator
- d. Advanced Detective Training Investigator
- e. Collision Investigation
- f. Vehicle Roadworthiness and Examination
- g. Road Safety Enforcement Strategy

## 3. Other Qualifications

- a. Licensed Private Security Investigator Number 46353530S current to 14 July 2027 (enabling investigations to be undertaken in the State of Victoria)
- b. Victorian Driving Licence held for over 60 years blemish free
- c. Certificate from Victoria Police for 41 years collision free history including police pursuit and urgent duty driving
- d. Qualified Shorthand/Typist – Royal Melbourne Institute of Technology 1963.
- e. Qualified Electronic Technician, Marconi School of Wireless (NSW 1967)

## 4. Membership of Professional Associations and Selected Awards

- a. **2001-2003** – As a member of the Ministerial Council for Road Safety, in partnership with Transport Accident Commission and VicRoads, developed key implementation strategies and was the media police spokesperson for the very successful “Wipe Off 5” and “60kph means 60kph” campaigns resulting in road trauma reduction of 17%

- and 11% in Victoria over the two successive years. (Award of outstanding contribution to Road Safety in Victoria by the Ministerial Council).
- b. AM. Member of the Order of Australia. Australia Day Honours 2022 (for significant service to Road Safety Organisations and Initiatives)
  - c. Awarded the Victorian Senior Australian of the Year 2020 (Role of Road Safety Champion)
  - d. Life member, International Association of Chiefs of Police (IACP)
  - e. Member of IACP, Managers of Police Colleges Training Section (USA)
  - f. Associate Fellow, Australasian College Road Safety, (ACRS), Recognised Road Safety Professional (RRSP)
  - g. Fellow of the Australian Institute Management (FAIM)
  - h. Fellow of Institute of Public Administration, Australia (FIPAA)
  - i. Chairman and Director, Pedestrian Council of Australia
  - j. Chairman and President, International Safety Foundation
  - k. Member, Road Policing Academic Network
  - l. Director, International Road Policing Network
  - m. Traffic Police Specialist for the Global Road Safety Partnership (GRSP)
  - n. Medal of Royal Government of Cambodia for high dignity 'Sahametrei -Theppaden' Commander 26-2.2015) – Road Safety in Cambodia
  - o. Cambodian Medal Royal Order of Sahametrei – Sena (Officer) (17-1-2018) Road Safety in Cambodia
  - p. Australian Police Medal (1996), Victoria Police Service Medal and Double Bar, National Medal and Bar,
  - q. Military Training and Active Service in a War Zone and associated recognition including the Vietnam Star.

## 5. International Training Provider in Crash Investigations

- a. **2001** – In conjunction with Victoria Police Education Department, designed and developed a Diploma of Public Safety (Policing) for the Malaysian Traffic Police including practical components for collision investigation. Compulsory course for Traffic Management Police.
- b. **2006-2013.** Researched and collated International Best Practices in Crash Investigations in 10 High Income countries (including, Victoria, Australia) and compared with 10 Low- and Middle-Income Countries. Interviewed 10 international experts in various countries and surveyed over 400 senior police officers internationally. Published the International Road Policing Assessment Program, a 5 star-rating program including star rating assessment for crash investigations for traffic police internationally. Development of Best Practice Manual.
- c. **2007-2009 – Malaysia. Professional Development of Royal Malaysian Traffic Police.** On behalf of the Global Road Safety Partnership- Trained over 200 Senior Traffic Police officers in Road Safety including Crash Investigation.
- d. **2009-2010. Yemen. World Bank Project.** Team Leader and Road Safety Capacity Review including Crash Investigation capability and presentation for World Bank funding to assist the national police and road safety agencies.

- e. **2010-2012. Vietnam:** National Road Accident Database System (NRADS). Contracted by VicRoads International during 2010-2012 to assist as an Accident Investigation Specialist in the NRADS Project. Designed, developed and delivered, a Crash Investigation Train the Trainer and Data entry program. 17 Courses at 40 students per course over the period in Vietnam Provinces. Review Highway Accident Information Management System. Development of Audit on training methods, and Data entry. (World Bank funded)
- f. **2010 -2012. Ethiopia:** Designed, developed and delivered Crash Investigation Course for the Ethiopian Federal Police at the Police University, Sendafa, Addis Ababa.
- g. **2010 – Indonesia.** Review and Audit of Crash Investigation Techniques and Practices for the Indonesian National Traffic Police. Review of Fatal Crash in Denpasar involving deaths of six villagers from an overloaded quarry truck. (12/10/2010).
- h. **2014 – Manila Philippines.** Development of Master Trainers. Train the Trainer Program for 10 ASEAN Nations (including Crash Investigations) on behalf of the Asian Development Bank. Each participant was provided with a Training Manual, PowerPoints, Facilitator Skills and reference material. Trained 33 trainers from the 10 Nations.
- i. **2019 -2021 Iran –** World Health Organisation Project – Implementing a Safe Systems Approach as a Demonstration Model for The Eastern Mediterranean Region (Including Crash Investigation Policies, Procedures, Practices and Training)
- j. **2019-2020. Saudi Arabia:** A World Bank Project. Designed, developed and delivered a Diploma of Crash Investigations for the NAIF Arab University for Security Studies, Kingdom of Saudi Arabia – for its Centre of Regional Excellence. Basic, Intermediate and Advanced Courses. Train the trainer for University Staff to continue training. Including the implementation of 3D Laser Scanning Technology, PC Crash Reconstruction simulation, and other crash investigation technology. A diploma of Road Policing course was also provided

## 6. Victoria Police:

41 years' service including at operational ranks from Constable to Senior Sergeant. During that time attended and investigated numerous road safety trauma incidents including fatal, life threatening and non-fatal collisions. Assessed and prosecuted numerous traffic safety incidents. Presented cases to Magistrates Court, County Court, Appeals' Court, Supreme Court and Coroner's Court. Provided testimony and prosecution at various levels. As sergeant, supervised many crash investigations prior to submission or prosecution. As Senior Sergeant was prosecutor for several committals in serious cases.

**Officer Ranks:** on the Directing Staff of Airlie Officers' College, directly responsible for training over 100 Commissioned Officers in Command and Control as well as other Audit, Managerial and Administrative responsibilities.

**Internal Investigations, Personnel, Organisational Review, restructure of the operational arm of Victoria Police (Project Arbitrator) and as Ministerial Liaison Officer for 12 months.**

**Executive Positions:**

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**1994-2003 – Acting Deputy Commissioner Operations, Acting Deputy**

**Commissioner Administration.-** for a cumulative period of two years – usually for 3-4 weeks at a time.

**1989-1992. Assistant Commissioner: in Command of** Services Department

**1992-1994 -Assistant Commissioner:** Communication and Information Technology (Established it as a new Department)

**1994-1996 Assistant Commissioner:** Project Beacon, (established new Training Regime for Operational Safety – including review of all training courses)

**1996-1998. Assistant Commissioner:** Training Department. Introduced Sequential and Education Framework, and competency -based training for all courses under the Australian Qualifications Framework. Chairman of Industry Training Board for all Emergency Services in Victoria, Member of the Australian Police Education Standards Council, and Australian Institute of Police Management. Responsibilities included all Crash Investigation and driving Courses and all policing courses from Induction to Executive Management.

**1998- 2003. Assistant Commissioner:** Traffic and Operations Support Department. In command and responsible for all traffic enforcement and road safety for Victoria. Including developing and implementing strategic and operational plans, legislative review. Portfolio included collision investigation, Major Collision Investigation Unit, heavy vehicle, breath-testing operations, safety camera program, data collection and analysis, training, management and supervision, police/government interface. Member of Ministerial Road Safety Council, National interface for Road Safety, Member of the World Road Safety Network, Global Road Safety Partnership and exchange programs for police traffic training, including China, Fiji, and Egypt . (Portfolio also included Operational units of Air Wing, Dog Squad, Mounted Branch, Special Operations Unit, Intelligence Unit, Force Response Unit, Prosecution Division, and Transit Police)

## 7. Collision Investigation International Selected Publications:

- a. Shuey, R., & Myers, D. (2021). The AAA approach to crash investigation reform-the perspective from road policing practitioners. *Journal of road safety*, 32(4), 51-59.
- b. Dinh-Zarr, T. B., Shuey, R., & Mooren, L. (2024). The Five “I” Framework of crash investigation: Linking investigation practices to safety reform. *Accident Analysis & Prevention*, 194, 107296.
- c. Mooren, L., & Shuey, R. (2024). Systems thinking in road safety management. *Journal of road safety*, 35(2), 63-73.
- d. Shuey, R. The Safety Camera Partnership in Victoria-Key Success Factors to Achieve Road Trauma Reduction for Speed Related Collisions. *Road Safety Towards 2010*, 37.
- e. Shuey, R., Mooren, L., & King, M. (2020). Road safety lessons to learn from Low and Middle-Income Countries. *Journal of road safety*, 31(3), 69-78.
- f. Shuey, R. International Road Policing Assessment Program (IRPAP)–A Star-Rating System for Road Safety Enforcement Capacity and Capability.
- g. Shuey, R. (2013). International road policing assessment program (IRPAP), A star-rating, good practice, benchmarking assessment model (pp1-71). Companion



document to the research thesis. RMIT University, Melbourne. Australia. *Companion document to the research thesis. RMIT University, Melbourne. Australia.*

- h. Shuey, R. (2013). Benchmarking international road policing in low-middle income countries. *Doctor of Philosophy), RMIT University, Melbourne.*
- i. Mooren, L., Shuey, R., Hamelmann, C., Mehryari, F., Abdous, H., Haddadi, M., ... & Hosseinizadeh, S. (2021). Speed management in Iran: a review process. *Journal of road safety*, 32(3), 31-42.
- j. Mooren, L., Shuey, R., Hamelmann, C., Mehryari, F., Abdous, H., Haddadi, M., ... & Hosseinizadeh, S. (2021). Road safety case studies: Speed management in Iran: A review process. *Journal of Road Safety*, 32(3), 31-42.
- k. Mooren, L., Shuey, R., Chambers, G., Ranjbar, M., Hamelmann, C., Zakeri, H., & Hosseinizadeh, S. (2021). Governance and effective management: speed management demonstration project, in the Islamic Republic of Iran. *Journal of road safety*, 32(4), 40-50.
- l. Ranjbar, M., Kashani, A. T., Besharati, M. M., Bondarabadi, M. A., Zakeri, H., Hosseinizadeh, S., ... & Shuey, R. (2022). Road safety case studies adopting a safe system approach to determine safer speed limits: A case study from Iran. *Journal of road safety*, 33(1), 30-35.

## 8. Collision Investigation Manuals:

- a. Numerous in-country manuals on crash investigations were designed for specific countries e.g. Cambodia, Vietnam, China, Indonesia as well as generic manuals for the Global Road Safety Partnership for general distribution and translation to focus countries.
- b. Training, notes and PowerPoint presentations were provided to train the trainer participants in over 20 countries over the past 20 years.

## 9. Lecturer at Monash University Accident Research Centre (MUARC)

- a. 2021: Use of Haddon Matrix in Crash Investigation – to Graduate Certificate in Road Safety (Numerous Victoria Police participants)
- b. 2023: Principles of Crash Investigation- Indonesian Delegation of Traffic Police
- c. 2024: Crash Investigation – Iranian Road Safety Delegation – Date Pending

## 10. Editorial Board member of Journal for Road Safety

- a. Peer reviewer for Journal Publications for Crash Investigations
- b. Peer reviewer for Traffic Injury Prevention Crash Investigations Publications

## Part B Critical Review of Incident of 7th January 2013

### 11. Overview:

In conducting my investigation, I have sourced information from the following documents including:

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- a. Incident Reports provided under Freedom of Information (FOI),
- b. Police reports, Form 502, Ambulance Reports, Medical Reports,
- c. ePDR Form FOI release 23/08/2017
- d. ESTA 000 release 8/03.2024
- e. Statements from Daniel Andrews, Catherine Andrews, Jane Crittenden, Brad Morgan, Ryan Meuleman, Scott Hanley, Peter Meuleman,
- f. Police policies, regulations, training and applicable procedures
- g. Photographs, graphs, scale models, and charts compiled by Mr Colin D Robertson, B App Sc GDID (Grad Diploma Industrial Design)
- h. Undertaking a scene visit on 13<sup>th</sup> September 2023, taking photographs, notes and observations

Scene management and investigation normally follows a structured approach, however, the dynamics of an evolving situation and varying avenues of enquiry may impact the direction. Similarly, written documents may be modified, corrected or changed with or without explanation. Generally, documents should be self-evident.

### 12. Incident:

Shortly after 1pm on Monday 7<sup>th</sup> January 2013, a Government owned Ford Territory SUV Registered YKV136 turning right from Melbourne Road, a major 80kph thoroughfare into a minor suburban 50 kph road, Ridley Street, Blairgowrie, collided with Ryan Meuleman, a helmeted cyclist. Ryan was riding his sister's bike with a mechanics bag full of tools, along a gravel/sandy service road running parallel to Melbourne Road, and intending to cross Ridley Street. The cyclist was critically injured with life-threatening injuries and transported to The Royal Melbourne Children's Hospital by Air Ambulance.

The review and analysis of the incident and subsequent attendance and investigation by Victoria Police has been undertaken with consideration of the Victoria Police definition "*An investigation is a search for the truth, in the interests of justice, and according to the specifications of the law.*"

Victoria Police has had for decades a professional and robust system for dealing with fatal, life-threatening and serious road trauma. When the investigation is completed professionally, and according to standard operating procedures, there is minimal potential for any courts, victims, insurance claims, experts or "John Citizen" to refute the findings. In assessing the available evidence:

- **Exact times are critical – to determine a pattern of behaviour/actions/responses**
- **Dates are critical – interviews/occurrences/actions/inactions/excuses**

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- **Measurements are vital in all crash investigations**
- **Content of communication is critical – who said what and why, what was written and why?**
- **What was recorded in documentation?**

### 13. The Narrative as presented by Victoria Police on 7<sup>th</sup> January 2013.

**Only 35 Minutes at Scene:** Senior Constable Shayna Sage 35090 and Constable Daniel Ward 37287, on Divisional Van, Rye 308, were the only police to attend the crash scene at 1.20pm on 7<sup>th</sup> January 2013 clearing at 1.55pm for a total of 35 minutes. (NB: 10 additional minutes were recorded as accompanying the paramedics to Rye oval for the air transport and a further 10 minutes at 29 Ridley Street, re further enquiries with driver – no statements or notes were recorded). However, 3 photos of the damaged car were taken, but not included in Sage’s investigation notes in documents provided to Ryan’s lawyers. Without the parameters of any basic investigation processes being followed, a conclusion of NFPA (No Further Police Action) was recorded at 6.21pm, the same day, with the following narrative. This narrative has been maintained to this day.

- a. *“No further police action. Vehicle has turned right into Ridley St from Melb Road, cyclist was travelling along unpaved service road and crossed Ridley St into the vehicle as it turned right. Cyclist collided with the front drivers side of the vehicle, causing the cyclist to be ejected onto the windscreen, causing it to smash. Cyclist was treated at the scene by MAS and taken by air to Royal Childrens. Driver of vehicle suffered minor abrasions to left thigh from smashed glass. Nil witnesses. Police unable to speak to cyclist, however damage to vehicle is consistent with drivers story. Call to father of cyclist, suffered 3 broken ribs, ruptured spleen and lungs. NFPA to be taken with wither (sic) party”* **NB: critical observation “unpaved service road” and “into the vehicle as it turned right” – both aspects given scant follow-up attention or commentary.**

**Comment: This conclusion is unfounded and contrary to the available evidence.**

**NOTE: this summary is omitted from the TIS report provided to Slater and Gordon under FOI in 2013. This appears to have been deliberate. As an expert in TAC representations, Stuart Le Grand should have noted its absence. The summary is present in the version provided to O’Donohue in 2017 and the version produced under subpoena in 2024.**

- b. It is further noteworthy that this documented conclusion was drawn without any basic required investigation:
  - i. Without expert police attendance or advice – as mandated by policy
  - ii. Without any required preliminary breath-test, or assessment for drugs or fatigue
  - iii. Without any assessment of distraction(s)
  - iv. Without any documented reference to supervisors or experts
  - v. Without recorded interviewing of witnesses
  - vi. Without any scene photographs,
  - vii. Without any scene measurements



- viii. Without exact point of impact, point of vehicle rest, point of cyclist landing, or any required points of reference,
- ix. Without vehicle examination, either preliminary or forensic
- x. Without any door to door checking or canvassing for witnesses
- xi. With only a crude representation of the crash scene.

#### 14. Scene Inspection on 13<sup>th</sup> September 2023.

To appreciate the location and circumstances, I undertook a scene inspection in September 2023, made observations and took several photographs. The intersection layout and service lane parallel to Melbourne Road, was unremarkable compared with photographs, land and aerial photography from 4<sup>th</sup> January 2013.

Note: the track being used by Ryan was wide enough for vehicles and used by residents for vehicular access in 2013 and less vegetation. Due to building works, it is now substantially narrower and suitable only for bicycles and pedestrians. The centre line at the junction of Melbourne Road and Ridley Street has been substantially extended since 2013.

A striking observation was the proliferation of tyre markings on the road surface created by vehicles turning right from Melbourne Road into Ridley Street, i.e. resulting from vehicles undertaking a sweep turn and cutting the corner. This was further validated by observing half a dozen vehicles undertake this manoeuvre during my hour in attendance. Most were turning at an approximate speed of 25kph. No tyre noises were heard. It was further noted that those vehicles executing a left-hand turn from Ridley Street into Melbourne Road, either stopped at the stop sign or slowed to almost stop before turning, therefore negating any suggestion that the markings were caused by left-turning vehicles into Melbourne Road. In any event, that would be a blind turn at high risk. Several pedestrians were noted using the service lane as a thoroughfare. It is also of note that there are ten similar intersections off Melbourne Road along that stretch of road network.

Any right-hand turn from Melbourne Road becomes high risk, the more the corner is cut, and the faster the speed because of the limited sight distance. Independent to the laneway cross traffic, there is always the potential of conflict with any vehicle approaching the stop sign at Melbourne Road, intending to turn right or left. Due caution must apply.

The tyre markings are significant, notwithstanding the proliferation of markings and having occurred over time, because, if as reported by Brad Morgan, there was a squeal of tyres and a loud bang, prior to the crash, there is a high potential for the SUV to have left tyre markings on the roadway leading to the point of impact and subsequent point of rest. This was not investigated. Even feint markings could then be traced to indicate the vehicle path prior to collision. Further, the squealing of tyres is more conducive to a vehicle making a sweep turn at speed rather than a vehicle moving off from a stationary position and only travelling 25 metres without the application of brakes (Cross reference the narrative provided by the Andrews and Police version).

It was notable that the intersecting service lane comprised loose gravel and sandy surface rendering it difficult and dangerous for any cyclist to achieve any speed. Further, for a cyclist to cross Ridley Street, to continue on the opposite path, they must negotiate a small culvert where the path crosses the bitumen roadway. Neither the path surface nor the bitumen edge is conducive to a cyclist negotiating at speed.

Note: Ryan’s statement specifically states he was travelling slowly and the rationale. It was further notable, that the two most obvious houses with potential for security camera observations (CCTV) or direct witness observations of the crash location would be those directly opposite the intersection in Melbourne Road (i.e. 344 and 342). Neither was canvassed in the door knock undertaken by police for witnesses in the days following the incident. Nor were several other houses in Ridley Street up to and including No 10 Ridley Street, notably the source of the initial call to 000 and recorded on the eDPR “with the caller’s phone number” – an easy source of witness validation.

Further, it is normal for investigating officers to review a scene such as this, where vehicles arrive from different directions to do a drive-through and/or walk-through from the different directions, taking video and/or photographic evidence from the perspective of both road users. This was not done or considered in any reporting.

**Model Scene replication:** on 11<sup>th</sup> October 2023 and again on 27<sup>th</sup> February 2024 I viewed the model scene developed to scale, by Mr Robertson. I observed varying interactions of the vehicle and cyclist. In conjunction with the scene inspection, this enabled an assessment of differing variables

## 15. Failing to Comply with Standard Policies and Procedures

**Comment: There is no evidence in the TIS documents, the Form 502 (Running Sheet) or contemporaneous notes that even the basic requirements of investigation have been met or attempted. Specifically, there has been:**

- **No contact or attempt to contact any Major Collision Investigation Unit**
- **No contact or attempt to contact any Highway Patrol or any of the range of support units available at the time (in fact the unit SR0 888, originally allocated the call was cancelled by S/C Sage) why?**
- **No measurements recorded in any diagrams**
- **No directions (North or otherwise)**
- **No measurements to any reference points**
- **No point of impact or point of rest of vehicle (a meaningless cross appears in one sketch)**

The instructions, and policy on crash attendance has existed for decades and outlined herein.

## 16. Victoria Police Manual (Policy) (Relevant sections extracted)

### Vehicle Collisions

Any fatal or life-threatening motor vehicle crash investigation is to be undertaken by experienced police officers.

4.1 The Police Forward Commander must ensure that:

MCIU (Major Collision Investigation Unit) is notified immediately of every fatal or life-threatening collision. The senior MCIU notified will determine whether the MCIU attend the

collision or investigate outside attendance criteria listed in section six of this policy. (See below)

#### 4.3 Attending Unit

Police must attend a collision as either first response unit or second response unit in accordance with the table below. The second response unit is tasked only when a first response unit is unavailable.

Attending Unit for Collisions		
Collision Type	First Response Unit	Second Response Unit
<ul style="list-style-type: none"> <li>Fatal</li> <li>Injury (ambulance dispatched)</li> </ul>	Highway Patrol within PSA or elsewhere on the direction of the divisional patrol supervisor	General duties patrol unit as per Computer Aided Dispatch (CAD) or in consultation with divisional patrol supervisor.
Non-injury (no ambulance dispatched)	General duties patrol unit as per CAD or in consultation with divisional patrol supervisor	Highway Patrol from within PSA or elsewhere on direction of the divisional patrol supervisor.

**Comment: The MCIU was not notified of the incident and the Highway Patrol within the PSA was not notified or tasked with the responsibility of attending the crash.**

## 17. Fatal or Life-threatening collisions

- The MCIU must be notified immediately of all fatal and life-threatening injury collisions via Police Communications. Attending police should arrange this from the scene as soon as practicable, via Police Communications.
- MCIU may attend and provide specialist assistance and expertise where the involvement of police is likely to bring discredit to Victoria Police. The decision to attend will be made by an MCIU Officer/sub-Officer after a request from the oversight PSC Officer/sub-Officer.

**Comment: No contact was made with the MCIU for any advice or decision.**

#### MCIU Website Advice to members – When to notify MCIU of a collision?

- MCIU must be notified of ALL fatal or life-threatening collisions**
- This should occur from the scene as soon as practical via the police Communications Centre**
- The MCIU on-call supervisor will then phone the police Forward Commander to obtain more information**
- If you're not sure, make the notification anyway – earlier is better – we may be able to provide advice to prevent the loss of evidence or assist in offender management.**

## 18. Requirement for Preliminary Breath Test Victoria Police Road Policing Enforcement

12.2 A preliminary breath test (PBT) must be conducted on all:

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- drivers and persons in charge of motor vehicles involved in a collision within the preceding three hours (except where injury precludes this)

- When a PBT is conducted record the following details on ePDR, Form 501, PB 13 or Record of Non-operational PBT's (Form 1130):
  - Serial number of the device used
  - Last test number before the start of the shift and last test number at the end of the shift
  - The number of the test where an offence is disclosed

**Comment: No breath tests were conducted. Traffic Incident System Records state a test was conducted and was negative. This was later changed to read "not applicable". Both entries considered in my review to be deceptive and misleading.**

## 19. Legislation Compliance

ROAD SAFETY ACT 1986 - SECT 61

### **Duty of driver etc. of motor vehicle if accident occurs**

(1) If owing to the presence of a [motor vehicle](#) an [accident](#) occurs whereby any person is injured or any property (including any animal) is damaged or destroyed, the [driver](#) of the [motor vehicle](#)—

(a) must immediately stop the [motor vehicle](#); and

(b) must immediately render such assistance as he or she can; and

**[S. 61\(1\)\(c\)](#) amended by No. 8/2018 [s. 9\(1\)](#).**

(c) must at the scene of the [accident](#) as soon as possible give his or her name and address and also the name and address of the [owner](#) of the [motor vehicle](#) and the identifying number of the [motor vehicle](#) and, in the case of an [automated vehicle](#), state whether it was operating in [automated mode](#) at the time of the [accident](#)—

(i) to any person who has been injured or to the [owner](#) of any property which has been damaged or destroyed; or

(ii) to a person representing the injured person or the [owner](#) of the property; and

**Comment: Section (c) was certainly not complied with, in fact deliberately avoided by both the driver and representative police i.e. No names/addresses were provided to any victim representative, nor the fact that it was a govt vehicle (as the owner). NB: The victim's sister attended the scene; contact from S/C Sage was made to victim's mother on several occasions, and S/C Sage refused to supply details to the victim's father, even following direct requests, stating he was aggressive and irrational and could find out through FOI and TAC. This is an**

indictment on “victim support” and in no way mitigates the non-supply of detail by police to the victim’s sister Samantha, mother Sonia, or even Peter on interactions prior to the 8<sup>th</sup> January. Further, FOI is not a normal process due to the extensive delays in responses. It appears as advice designed to conceal the identity of those involved, delay the obtaining of information and an obvious frustration to the requester.

(b) is in dispute. (From Brad Morgan “*The Andrews were not directly attending to him, so I ran back to my house to get some blankets*”. From Jane Crittenden, “*I do not recall any other person attending to the child... I ran back to my vehicle to get a towel and put it under his head*” and also from the first caller from No 10 Ridley Street “*I am just going to get a blanket for him*”. Even from the victim in his recall that Daniel and Catherine were yelling at each other. NB: If the Andrews were returning from the beach as later asserted, then there would have been towels in their vehicle in close proximity to the victim. This is not evident and in fact three other persons separately had to provide comfort. The Andrews’ yelling is corroborated by Brad Morgan.

## 20. Collision Scene Sketch

### 13.5 Collision Scene Sketch

- **Minimum requirements for a collision scene sketch are:**
  - Road structure, names and measurements (including distance from intersection or landmark for reference)
  - All applicable vehicles/objects involved with labels
  - Point of impact
  - Pre and post vehicle/object travel

**Comment:** Non-compliant in all aspects with only a crude sketch being presented.

### 13.6 Photographs and other documentation

Electronically attach all relevant and available reports and documents to the TIS report. Retain hard copies. Only core photographs should be attached with the remainder retained for reference. A note on the report should state that other photographs exist.

**Comment:** Non-compliant. NB: Although it was stated that scene photographs were taken the following day, there is no further reference to any photos. The grainy photograph of the vehicle damage to the front panel and windscreen did not surface until 2022, 9 years after the event.

This raises serious questions. If S/C Sage had the equipment to photograph the damage to the car at 29 Ridley Street, why weren’t photographs taken of the vehicle “in situ” as well as scene photographs, point of impact, point of rest etc.? Why did they have to return to take scene photographs and why were none of the photos filed as required?

## 21. Victoria Police TIS instructions – measurement.

The following instructions apply - Initial Action at Collision

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## Field Sketch

*“A field sketch is a freehand sketch of the scene made as soon as possible after the investigator arrives to record and measure things that will be moved, lost, destroyed or changed. The investigator then adds other items and evidence, such as vehicle positions, tyre marks etc., during the continuing investigation. The field sketch is part of the investigators notes, recording, observation and measurements taken at the collision scene. It is to be retained in a manner similar to notes made during the investigation and is to be considered as an exhibit for prosecution purposes”.*

Specific failures to comply with initial action requirements of TIS include:

- (c) Record measurements as they are made
- (d) The person making the sketch is the person who is to read the measuring device
- (g) Direction of North
- (i) Clear and defined reference points
- (j) Distance and direction to nearest well-known landmark when collision is not at an intersection
- (k) Baseline from which measurements were made
- (s) Debris

### Scale:

*“An appropriate scale is to be used”*

Other information is provided on *“triangulation and coordinate methods”* – none of which have been followed;

*“If future reconstruction is required, the reference point becomes the key from which the scene is mapped. ...Remember, that the reference point is the keystone from which the entire collision is measured and drawn”*

Specific instructions are provided to identify skid, scuff, tyre, scrub, yaw marks, flat, furrow, acceleration, deceleration, etc.,

### Point of impact:

**This is a critical piece of evidence usually determined by debris on the road surface (broken glass, metal fragments, paint flakes, mud residue from the vehicle impact). The point of rest of vehicles following impact is a further critical point of measurement for evidential value (i.e. To determine what happened between point of impact and point of rest of all relevant vehicles),**

*“It is however, mandatory to add a sketch to any accident with an injury. In addition, if your station instruction is to add a sketch for non-injury incidents as well, then you must add a sketch before submitting” (P31 of 36).*

**Comment: there has been no compliance with any of these requirements. Just a crude sketch with no reference points or measurements.**

## 22. Ambulance and Medical Records – Log 10773

1308 hours -received the call from ESTA

1309 Hours -The Mica Ambulance was Dispatched as “time critical” arriving at 1323 hours

The case history states he was **“struck by the Ford Territory on his left side throwing him onto the bonnet and shattering the windscreen” “15YO on bike. Struck on L side by car travelling at 40-**

**60KPH...Pt onto bonnet then onto windscreen which cracked on impact...thrown onto roadway...helmet worn”**

1315 hours – Air 490, Air Ambulance requested and dispatched at 1330 hours

1401 hours – Air Ambulance arrived at Rye Oval with patient lift-off at 1422 hours

NB: Paramedics had Ryan’s mother phone number as contact, next of Kin. Ryan’s sister Samantha, attended the scene and accompanied Ryan to the oval and hospital.

Ryan’s Meuleman’s injuries included fractured ribs, internal bleeding, punctured lungs, degloving skin injuries, removal of 90% of his spleen, and psychological injuries.

Ryan Meuleman was subsequently issued with a Serious Injury Certificate by the Transport Accident Commission on 1<sup>st</sup> May 2015.

## 23. Explanation of Documents Referenced

1. **The Victoria Police Traffic Incident System (TIS) report** is a means of providing a permanent record of all reported crashes and a running commentary of the status of the investigation whereby the informant or anyone else involved can add notes. *“It is designed to keep a narrative of the incident so that anyone who requires an update of the status of the report can look here to obtain it. Also, if there is any additional information you can add it to this section”.*

Specific sections apply to life threatening injuries where the injury or seriousness may need to be updated.

Check boxes apply before final submissions.

Further, there is a dedicated manual on *“Smart Roads”* (62 pages) on the design and development of sketches, measurement, etc., to complement the TIS reporting.

## 24. General Police training and qualifications

From 1<sup>st</sup> October 1996 to October 1998, I was appointed as Assistant Commissioner in Command of Training for all courses and training requirements for Victoria police. During this period, the Sequential Training Model was developed and professional accreditation pursued for training against national competency standards:

- In July 1997, Victoria Police was accredited as a Registered Training Organisation (RTO). This RTO status is awarded by the Australian Qualifications Framework to organisations that meet the standard national requirements and with the capacity and capability to deliver those services,
- In November, 1997, Sequential training and the Education Framework was introduced to Victoria Police
- In June 1998, the Diploma of Policing for recruit training was added to the scope of registration for Victoria Police. This was the Diploma of Public Safety (Policing) (PUA 50212 updated in 2015). Since then, there has been several versions to the now Diploma of Policing (Pol 50115)- Content, format, recoding, title updates and operational outcomes, to satisfy AQF and National requirements. These are standard training packages for which all recruits must be assessed as competent prior to the completion of their two-year confirmation. The focus is on theory and practice which must be demonstrated in practical application under supervision. Students are required to be deemed competent in all the elements and



performance criteria. The Diploma includes specific units of competency, two of which relate to investigation practices.

- PolGen022/031 – Conduct an initial investigation. This includes managing investigations, managing incident scenes, managing information and evidence, managing exhibits, interviewing witnesses, conducting searches and managing persons of interest. Problem solving skills to manage behaviours and develop solutions are required elements,
- PolGen025/034 - Deliver Road Policing Services. This unit describes the fundamental skills to police roads in a safe and professional manner, including the ability to apply road safety principles, control traffic, drive conduct and initial crash investigations. The elements of crash investigations include:
  - Manage crash incidents to support traffic flow and safety of self, colleagues and the public
  - Secure crash incident scene to identify and protect potential evidence,
  - Assess crash incidents to determine resources required,
  - Gather details of potential witnesses, victims for further investigation purposes.

**Comment: it is noteworthy that both S/C Sage and Const Ward had graduated from police Training with the relevant Diploma. S/C Sage had approximately 7 year's policing experience and Constable Ward 6 year's experience at the time of the incident.**

## 25. The Process of Investigation – The ICECICR Model

The basics of crash investigations have universal application and follow a sequential flow to ensure all avenues are followed. The acronym ICECICR is used for easy of memory retention. This applies for Traffic Incident Management and Crash Scene Management. ICECICR – Isolate, Contain, Evacuate, Communicate, Investigate, Conclude, and Rehabilitate.

**Comment: There is no evidence of compliance with any formal or even routine process in the 35 minutes allocated to scene attendance (Just basic information).**

## 26. Points of System Failure – deliberate or careless?

The requirement to notify MCIU is the direct responsibility of the Forward Commander, however, can be activated by any person in authority or stage in the process. This has not been done by anyone in the hierarchical chain. It could/should have been activated by:

- (a) The police Communications' Centre
- (b) The Supervising Senior Sergeant
- (c) The Supervising Sergeant
- (d) The Senior police member at the scene – Senior Constable Sage, the only police at the scene and designated under the circumstances as the forward commander.

The trigger is “life threatening” and a clear indicator to all is the commitment of the Air Ambulance.

As a further safeguard, the requirement to have an experienced investigator in charge is well documented in police policy, custom and practice for decades. Neither MCIU or TMU were activated and no explanation is provided as to why?



## 29. Critical Assessment – Police Compliance with Policies, Procedures, Practices and Training

The police investigation of this crash is deeply flawed and raises serious concerns about its credibility. The investigators' failure to follow even a rudimentary examination of the evidence is demonstrated in the hasty and illogical conclusion. The report lacks critical rigour and information including measurements, photographs and professional interview techniques. Instead, the investigator has drawn a baseless and unsupported conclusion that fails to account for the available evidence. This negligent approach not only undermines the integrity of the investigation but also jeopardises the pursuit of justice and accurate accountability in this case. Further, it demonstrates a high level of incompetence or alternatively a deliberate attempt to simplify the crash to rudimentary reporting requirements. This omission in recording and preserving of accurate measurements has directly contributed to an unsubstantiated conclusion and directly to the inability to easily and accurately undertake a forensic reconstruction and analysis of the crash.

## 30. Analysis of Documents

### The receipt of the call – review of ESTA call log and ePDR

1310 hours - this call was initially allocated to a CREST Unit SRO 888 (three-man Community Patrol), They were two minutes into their response, lights and siren, when S/C Sage came up on the radio, saying they were a closer unit (in fact, she was at Rye Police Station according to the ePDR, and Form 502 completing "Urgent Correspondence."

1310 hours – supervisor 251 notified.

1312 hours – S/C Sage cancels the Crest unit and is allocated the call. NB: in police responsibilities, it is highly unusual for a patrol unit to volunteer to take on the unsavoury responsibility of a collision.

1318 hours – S/C Sage and Const Ward on Rye 308, according to the ePDR were still at the Rye Police Station, having not yet commenced the response.

**Comment: This raises critical questions as to (a) Why S/C Sage wanted to take over the call and cancel a unit already en route two minutes into its response (i.e. Jumped an unsavoury call (b) why she said she was closer, when that wasn't correct as the Unit was in the Rye Station and (c) why they then took over six ½ minutes before leaving the station (eDPR actual records) and (c) What external communication via telephone or radio with S/C Sage occurred in the time from the crash to being en route at 1318 hours?**

1320 hours – Rye 308 arrives on scene.

1352 hours – SHS 265 (regional supervisor from Hastings) is recorded as "monitoring"

### 31. Standard Form 502, Book No 15289 (Pages 18-21):

These are contemporaneous entries recorded by observer Const Ward. States: Attended at 1320 hours on 7<sup>th</sup> January, 2013. (Code 5 = at scene 1320 to 1355 Code 1 = Cleared. This is a total of 35 minutes at the crash site without any basic investigation). A further 10 minutes was recorded at 29 Ridley Street, enquiry with vehicle driver, (and taking photos of unroadworthy vehicle which had been driven from the scene by Daniel Andrews). Recorded driver as Catherine Andrews 22/8/74, Licence expiring 24/8/2022. 1400 hours to Rye Oval for the airlift of patient by Air ambulance to Children's hospital.

**Comment: (a) Total = 35 Minutes at the crash scene – this has only been to record names, addresses, vehicle and licence particulars and NO recorded investigation.**

**This is abnormally short for any serious crash investigation. Under No circumstances could it be considered by any reviewer, supervisor, oversight body or insurance representative to be thorough or even an investigation. This is extremely negligent for all parties involved.**

**(b) This presents as a total of 50 minutes attention to a life-threatening crash during a 10-hour shift to then conclude with an erroneous finding at 6.21pm that same evening.**

**(c) In question: Who authorised the vehicle to be driven from the scene, in the condition photographed with a smashed windscreen?** Not disclosed. If police, it is a dereliction of duty, if Daniel Andrews on his own volition, it is the removal of evidence and in any event dangerous/careless driving at minimum.

**Note:** Sage notes that Daniel Andrews drove the car from the scene with the children in the rear. This statement is in direct conflict with Brad Morgan who said Daniel Andrews walked his children away. Jane Crittenden said she saw Daniel Andrews driving his vehicle away in the presence of police.

(d) details on the Form 502 of tasks from 1500 (3pm) to 1800 of those deemed to be released under FOI are of insignificant policing value compared to dealing with the aforementioned crash and investigation. Why weren't the TIS entries made during the normal course of the 10 shift instead of the other superfluous duties? It is noted that twice prior on the same shift, they have been "off-road" for urgent correspondence.

(e) Notably from 6.21pm there are entries made on TIS report and other reports which could have been commenced during the shift. Note: Sage has signed the 502 as off duty at 6pm.

(f) There is no authorisation on the Form 502 for any overtime from the 10-hour shift, yet entries appear to have been made after operational hours.

(g) There is no perceived operational value in accompanying the paramedics to the Rye oval for the air lift. Other units could have been tasked if warranted.

### 32. Traffic Incident Report T20130000403 (Completed by S/C Sage 35090)

This is a normal report for officially recording crash information, parties involved and reasons for the collision. It is required to be commenced prior to shift completion and may be updated. For each category or element, it requires consideration and deliberate key

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board entries, either free-text or registering a mark in a box. Accompanying instructions are itemised and clear.

NB: While, I have several iterations of this document released under FOI on various dates, I have not been provided with any meta data relevant to those entries i.e. when the entries were made or any alterations.

Anomalies identified:

- (a) **The propagation of a lie!** A striking deception immediately obvious in the TIS report is that the participant driver is recorded as **Catherine Louise KESIK**, DOB 22/8/1974, Licence Number 48377573 exp 24/8/2022. NB: This is the name under which an “index” reference is recorded. This is contrary to the name of ANDREWS as recorded by police as contemporaneous notes on the form 502, the investigation notes, TAC reports, Statements and all other recordings provided. KESIK then becomes the name under which the crash is indexed and retrievable. This irregularity would be a “standout” for supervisors, insurance, legal reviewers. It remains in all iterations of the TIS report without any logical explanation. NB: this deception is further corroborated in Peter Meuleman’s statement at Para 6 & 7 whereby Peter was advised about 10 January 2013 by a woman from an insurance company that the driver’s name was KESIK. Peter then tracked the name to ANDREWS. **This deception is further highlighted in the contrary in her sworn statement opening with “My full name is Catherine ANDREWS...” (i.e. not KESIK.**

**The deception remains unexplained suffice to say it involves three participants to achieve both recordings i.e. Sage to knowingly record the information on the TiIS report, Daniel Andrews to report the matter to Government Insurance Office and Catherine Andrews as a knowing participant. The premise that it is Catherine’s maiden name, does not render it legitimate for reporting purposes.**

**It is my opinion that this deception is part of a course of conduct and a component of an overt cover-up to avoid implicating a political figure in a life-threatening crash.**

**Failure by supervisors and reviewers to identify this or seek explanation is inexcusable.**

- (b) **No preliminary breath test (PBT) – another perpetuated lie!** Both legislation and policy require a PBT for all drivers involved in a collision. This was not done for either Catherine or Daniel Andrews. NB: it is still in question as to who the driver was as it was never verified or corroborated. Various iterations of the TIS report have recorded a different status relative to the taking of a PBT. NB: these are deliberate keyboard entries – which cannot be categorized as mistakes or errors.
- Version print 21/02.2013 – PBT Details – PBT Conducted, Negative
    - EBT (Evidential) Not conducted – PBT Negative reading (NB Both deliberate keyboard entries and a lie!) (Notwithstanding, ‘counselling’ occurred on 16<sup>th</sup> January, the TIS report remained unchanged in the FOI release over one month following.
  - Version Print 23/08/2017 – PBT – Not Conducted. Not Applicable (Another lie!)  
*Version print 3/5/2024 – PBT Details – PBT Not Conducted, Not Applicable (Still recorded without explanation) (information altered in the interim – however still not justified – no meta data provided)*
  - It is further noteworthy that following the revelation in the media of 16th January, 2013, that no PBT was conducted, Victoria Police announced that they would undertake a review of the failing, however, to date has not produced any review;
  - Further, S/C Sage recorded an unqualified opinion/excuse in the TIS Notes Request on the 11<sup>th</sup> of January, *“While talking to the driver at the scene, I noted she did not appear to be alcohol effected. While speaking to her in close proximity, she was*

*steady on her feet, her speech was fine and did not smell of intoxicating liquor....she appeared in shock and upset by the situation but in my opinion was not affected by alcohol"* **NB: This appears as an excuse and does not in any way mitigate the non-taking of a PBT. PBT legislation was introduced in Victoria to ensure the legitimate and accurate screening of alcohol affected drivers prior to any "Evidential Breath Test" (EBT). In fact, it counteracts the original excuse that S/C Sage thought that Const Ward had undertaken the test**

- **The Counselling:** The "counselling", (if it was such), only eventuated on paper following it being raised by Peter Meuleman and then the media disclosure on 16<sup>th</sup> January, that there was no PBT undertaken of the driver. (1<sup>st</sup> edition 1am and 2<sup>nd</sup> edition at 3.15pm). This does not appear as an official counselling as it is recorded by S/C Sage not in official records nor by the Counselling Officer in the member's file or performance management. This is an highly unusual process appearing to justify an omission. Furthermore, if counselling was to be applied to one officer, why should it not be applied to the other?

**(c) Ineffective Door knocks:** Instead of door knocks on the day, these were tasked to others and then only three were checked rather than those considered relevant on my scene inspection. It should have been an automatic considering the potential for CCTV in that environment plus the number of persons in the vicinity at the time. As it evolved, Brad Morgan's testimony has become key just in the reporting of the squeal of tyres and a loud bang. He was not questioned at the scene and no statement was taken as part of the door knock and again rejected by S/C Sage on a follow up as him not seeing anything. Overall, the door knock concept was an afterthought and just tokenism.

(d) Other anomalies

- a. Driver's intention – turning right (Indicates a need for extreme caution)
- b. Allowing vehicle to be removed from scene, stating it is driveable in the TIS report when in fact it is obviously unroadworthy with a smashed windscreen with limited vision – this is an illegal and a culpable action exacerbated if involved in another collision. (Another cover-up to excuse the inappropriate removal of the vehicle from the scene)
- c. Recording indigenous status of the cyclist as both aboriginal and TSI (Actually neither is true) or legitimately sourced
- d. Passenger Noah Andrews (11 years). Seat Belt NOT worn – (Illegal activity, Driver liable – whether it was Catherine or Daniel). No action taken or contemplated – **Not even a warning**. All lives are precious and considering Victoria Police, TAC and Victorian Government emphasis on road deaths and injuries attributed to non-wearing of seat belts), this is a glaring omission in road trauma prevention.
- e. Member opinion of cause – "Pedestrian related. Jumped out from behind object" = Careless recording.
- f. Environment related = Stated none – yet S/C Sage organised to have shrubbery cut back.
- g. Section 61 RSA not complied with - especially, fail to exchange name and address of driver and owner of vehicle or facilitate arrangements.
- h. Member's recommendation: From the first iteration to that on the latest on 3/5/2024 and the TAC reports, the summary has remained constant (including typos)

### 12.3 Notes /Requests (Parallel typewritten notes accompanying the TIS crash Report)

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- 1821 07/01/2013. First entry is verbatim from the TIS report or vice versa. (As per Police Narrative - para 13.

### 33. Statements from Daniel and Catherine Andrews

The Sworn Statements prepared for Daniel and Catherine Andrews to sign, have little evidential value and are collusive in content (purportedly prepared by S/C Sage and forwarded to Springvale Police Station for signature and perjury jurat). Neither statement has any substantive information suffice that one corroborates the other in an assertion that the vehicle came to a complete stop at Melbourne Road before completing a right-hand turn. Neither statement has been subjected to any form of challenge, questioning or even “what happened next?” neither are contemporaneous with the event, being 24 and 28 days following. Further, no meta data is provided. Both statements offer content in contrast to the dynamics of the situation including position on road, speed, damage to vehicle and injury to the cyclist. It is also noted that Daniel Andrews in various press statements has reconstructed versions clearly intended to place fault on the cyclist contradicting his initial statement to the 000 operator “*and we have hit him*”. Further, the statement “*and a kids come flying through on the bike path*” is a reconstruction not consistent with his sworn statement namely, “***The first I saw of him was when he smashed into the windscreen on the driver’s side***” immediately followed by “*The cyclist was travelling at speed and hit our car at a perfect right angle very heavily. I want to make it clear – the cyclist hit our vehicle*”. Both statements are contradictory and cannot be true!

**NB: Normal Statements or alternatively “Records of Interview” in critical incidents of this nature canvas events leading to the incident, driving experience, speed, intentions, reactions, explanations, distractions, fatigue, temperament, stress, alcohol, drugs, environmental awareness, and other detail. Witnesses are separately interviewed to avoid collusion. Statements are to be taken at the time or shortly after an event while recollection is clear.**

### 34. Analysis of the Crash

#### **Andrews Version – improbable and implausible?**

**Notably, no crash scene measurements were taken or recorded by police.**

Both Catherine and Daniel Andrews in sworn statements, say they came to a complete stop in Melbourne Road intending to turn right into Ridley Street, and allowing an oncoming learner driver to pass. Then travelling only a distance of 25 metres, their car was hit by the cyclist. While neither Catherine nor Daniel saw the cyclist prior to impact, their reconstruction has concluded as “cyclist fault at speed” – a reconstruction without an evidential foundation and contrary to the facts.

- The impact** of the SUV vs cyclist has resulted with a typical catapult of the cyclist, first impact being the front driver’s side fender/headlight, bonnet, windscreen, over the vehicle and finally onto the roadway. The carry forward distance of the cyclist, while the vehicle is still in forward motion is 5.7 metres. NB: this trajectory action alone is an indicator of ‘speed’ of the vehicle involved. Slow speed impacts with cyclists and pedestrians result in forward projection of the victim, wrap projection onto the bonnet, or pushback depending on several variables (Vehicle

- shape and size, victim centre of gravity and initial conditions of impact). This crash was a combination of fender vault and possible roof vault.
- ii. **It was definitely not a slow speed crash, as the prime factor was vehicle speed.**
  - iii. **The initial impact** is the front driver's side light panel, it did not hit at a "perfect right angle" or "collided heavily with the side of our vehicle" as stated by Daniel Andrews.
  - iv. **Speed and supposed distance travelled.** From a stationary position in Melbourne Road, to the potential impact point, the distance is 25.3 metres. **To reach a speed responsible for the vehicle, injury and achieve the cyclist trajectory path, the driver would need to have floored the accelerator – this is not considered a possibility in that short distance.**
  - v. **Point of Impact:** There is no reason why this should not have been precisely measured. From the damage to the SUV and the bicycle, it is obvious there would have been metal, plastic, paint flakes and other debris sufficient to pin-point and reference to fixed objects/landmarks. Even on the crude police sketches combined with intersecting points, it is apparent that the point of impact is approximately 1.5 metres from the eastern bitumen edge of Ridley Street, placing the SUV still on the incorrect side of the roadway (negating the version describing completing a turn from a complete stop)
  - vi. **Point of landing for cyclist:** From the point of impact to the point of vehicle rest is 19.2metres. (determined by Brad Morgan's specific placement of the resting vehicle). This is an extended distance to stop considering Catherine stated she braked immediately following impact. This is not withstanding hazard perception, reaction time and braking distance. Hazard perception in this instance is considered at first impact which then becomes the commencement of the 19.2metres.
  - vii. **Stopping distance:** Applying a credible model (<https://www.random-science-tools.com/physics/stopping-distance.htm> ) for calculations, the following information is available. Some variances may apply with type of vehicle and the perception/reaction. At 35 kph, this equates to a total of 14 metres inclusive of 7 metres thinking distance and 7 metres braking distance. At 40 kph, this equates to a total of 15 metres inclusive of 7 metres reaction distance. **At 45 kph, this equates to a total of 20 metres inclusive of 12 metres reaction distance – approximately the same as the actual distance in Appendix A.**
  - viii. **Throw Distance:** Of critical importance in speed calculations is "throw distance" from the point of impact of the cyclist to point of landing. This includes the carry forward of the body by the forward movement of the vehicle i.e. **the vehicle has driven through the body causing the flip and catapult while in braking motion.** The body has come to rest approximately 5.7 metres from the point of impact. While various calculations can be made from "throw distance", precise measurements

are preferred for accuracy. Slight variations in the variables may provide inaccurate results.

- ix. Slow speed impacts will result in the victim, hitting the bonnet on a wrap projection and falling back onto the roadway. The faster the speed, the further up the bonnet and onto the lower section of the windscreen, will be the second and third level impacts (indicative of speeds @ 20-40 kph). Further, higher level impacts on the upper section of the windscreen are indicative of speeds greater than 40kph. Any impact onto the roof line indicates a progressively higher speed. NB: a roof hit is not verified except from one press comment by Daniel Andrews in his media reconstruction of the event. No roof damage is recorded as the vehicle was never examined. Note: in a 3AW interview in January 2013, Daniel Andrews states that Ryan landed on the roadway just behind the car.
- x. Ryan Meuleman states he slowed but didn't stop, "**I remember putting my left foot down onto the gravel path to steady myself**"..... Notably, the trajectory of his body after being hit supports a version that it was the vehicle speed that caused this trajectory up and forward opposed to a fast speed hit by the bike which would result in the bike and body being propelled up and over the vehicle laterally – this latter option being discounted because it didn't happen
- xi. Ryan Meuleman further claims in his statement that "*Whilst I was on the ground, I saw a man and a woman who seemed to be yelling at each other. They were not yelling at me of even looking down at me, but they were yelling at each other.....they did not bend down to assist me*" This observation from a critically injured person indicates a conflict between the parties involved rather than actions to 'render assistance' – notably provided by others in attendance. It also highlights the reason why temperament, stress, distractions and fatigue are important factors to assess as potential preliminary factors that lead up to an incident. I.e. was the yelling a continuation, a result of, or, of no relevance to the crash cause?
- xii. **Sight Distance:** A crucial element to be considered in any crash is "sight distance" for all parties involved. To determine this, the investigator should do a walk through and drive through applicable to both parties – this was ignored by the investigator. Sight distance is considerably advantaged for both the driver and the cyclist, if a driver has stopped at Melbourne Road and was on the correct side of the roadway after having made the turn. With the vehicle travelling at normal speed, there is ample time to take evasive action should a cyclist "appear from nowhere!" likewise for the cyclist to take evasive action to avoid a collision. A driver cutting the corner severely disadvantages the vision for both parties. This sight distance will directly impact upon the ability to take evasive action should an emergency occur (as it did happen).

- xiii. **Crude re-enactment of a sweep turn:** S/C Sage states on 11<sup>th</sup> January she undertook the turn in a “marked police vehicle (unspecified) at 30 kph without applying the brakes. She then provides an opinion that it would be difficult to corner faster than 30kph and remain on the paved road. In vehicle re-enactments, for validity, it is important to replicate the vehicles and driver capabilities involved thus negating the value or otherwise of this single turn. NB: S/C Sage has given no consideration for the report of tyres squealing as reported by Brad Morgan and she discounted his statement because he didn’t “see” anything.

**In summary, the version as provided by Catherine and Daniel Andrews is considered improbable and implausible.**

### 34. Interpretation of the Law

**Legal liability and responsibility:** At minimum, a basic standout **prima facie driving offence which ought to have been considered by the investigation, supervisors, and particularly, Slater and Gordon in addressing compensation is:**

Road Safety Rules 2009. Rule 73 (6) (b)

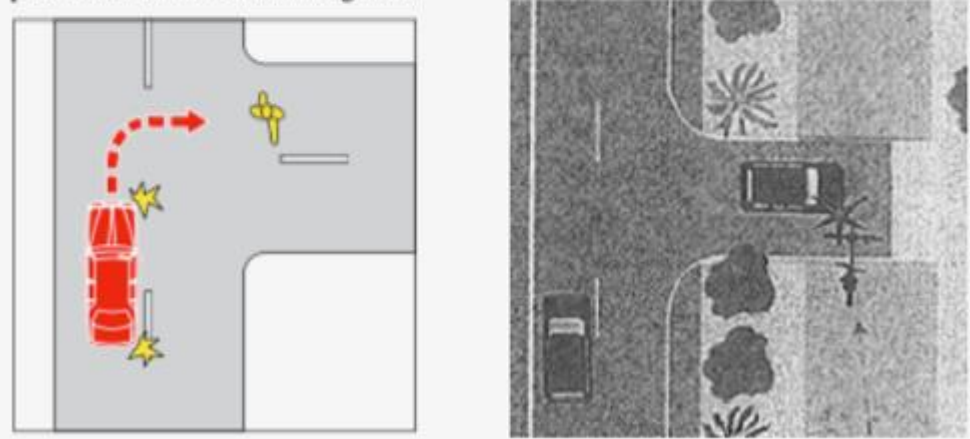
(6) If the driver is turning right from the continuing road into the terminating road, the driver must give way to —

(b) any pedestrian who is crossing the terminating road at or near the intersection.

Example 7

Driver turning right from the continuing road giving way to a pedestrian on the terminating road

Police Diagram Feb 13



The diagram on the left shows a red car turning right from a continuing road into a terminating road. A yellow pedestrian is crossing the terminating road. A red dashed arrow indicates the car's path. The aerial view on the right shows a real-world intersection with a car turning right and a pedestrian crossing the terminating road.

NB:



Rule 19 Pedestrian does not include a bicycle

Rule 15: Vehicle includes a bicycle

Rule 239: Bike path defined

Rule 13: Road related area defined.

++At or near the intersection – maybe a matter of practical interpretation, worthy of a more comprehensive review and check on precedence. Requires further legal advice.

While there can be some ambiguity and definitional cross referencing, the spirit of the legislation is for drivers to pay due care and attention to avoid collisions and protect vulnerable road users, especially while executing a turn. The proposition that shrubbery obscures the vision of the driver or cyclist is an “excuse” not justified in law and subject to separate discussion in this report under “sight distance,” and importantly, totally reliant on whether the driver cut the corner at speed or commenced from a stationary start.

This leads to the automatic consideration of Careless Driving under ROAD SAFETY ACT 1986 - SECT 65(1) A person who drives a motor vehicle on a highway carelessly is guilty of an offence.

The totality of available evidence must be considered including:

- (a) The statement from Bradley Morgan, (not sought by police), asserting “**I heard the squeal of tyres, then an almighty bang, followed by screams of pain.**” NB: Squealing is regularly considered as “careless” by police and the courts as the driver is not in full control of the vehicle.
- (b) The vehicle manoeuvre was aggressive in nature
- (c) The driver’s stated knowledge of the area
- (d) The position where Ryan was lying following the crash – body at rest 5.7 metres from impact
- (e) The communication from the initial caller to 000
- (f) The paramedics injury report and medical reports (40-60Kph)
- (g) The damage to the car,
- (h) The braking distance from point of impact to point of vehicle rest (19.2 metres)
- (i) The description of the series of impacts, trajectory and landing of cyclist. i.e. A catapult

Dangerous and Reckless driving causing injury may have also been a consideration had a full and thorough investigation been undertaken with appropriate measurements, statements and analysis.

**Comment:** For S/C Sage to repeatedly assert that the cyclist is at fault is erroneous, when in analysis, the driver is clearly liable. The driver was in familiar surrounds with a holiday house in the immediate vicinity and turning right from a continuing road to a terminating road with clear obligations to take due care and attention. The investigation is clearly misled, by Andrews’ statements of coming to a complete stop at Melbourne Road prior to completing a right-hand turn. This is compounded by Sage’s verbal and written assertions. At minimum, legal advice ought to have been sought before any determination of fault.

## Part C Conclusion

### 35. FINDINGS

In reviewing the known evidence, and with consideration to the undisputed path of the cyclist, the approximate point of impact, the injuries to the cyclist, the squealing of tyres in the vehicle manoeuvre, the absence of braking of either the vehicle or cyclist, the trajectory of the cyclist and landing after the collision, the vehicle braking distance, and the damage to the vehicle, I make the following observations and findings:

16. The impact occurred in Ridley Street 27 metres from the centre-white line point of Melbourne Road, Blairgowrie,
17. The point of impact was approximately 1.5 metres onto the bitumen from the cyclist entry point where the road width is 3.8 metres placing the SUV still partially on the incorrect side of the road at that 27-metre point
18. It was definitely not a low-speed vehicle impact,
19. It was definitely not a high-speed bike impact against a slow speed vehicle – otherwise the flip motion of the cyclist would have been in a different and opposite direction to his actual trajectory,
20. If the vehicle was travelling from a stationary start in Melbourne Road, 27 metres prior to impact, it would not have reached the resultant speed to cause the damage and injuries. Low speed impacts propel pedestrians and cyclists forward of impact. This impact was so severe, it flipped the cyclist i.e. the hit, the flip onto the bonnet, propulsion over the roof line and then sideways onto the roadway. This throw distance, and angle is critical and together with the trajectory indicates the vehicle was travelling at speed prior to impact
21. The forward momentum of the SUV carried the cyclist a further 5.7 metres (throw distance)
22. It is stated that neither party saw the other before impact. There is no evidence of evasive action of either party
23. The track where the tool laden bike was being ridden was a gravel/sandy track not enabling any bike speed as well as there being a distinct lip for the rider to negotiate prior to crossing Ridley Street and with foliage obstructing the view to the rider's left (as well as the driver's view of the rider). The rider's explanation, the bike, the load, plus the track do not enable any type of entry speed on the part of the cyclist.
24. From the tyre marks on the roadway and observing the pattern of behaviour of drivers undertaking a right-hand turn into Ridley Street, it appears as common practice to undertake a sweep turn when negotiating this right-hand turn. The possibility of tyre marks was ignored by the attending police
25. The statement of Brad Morgan, (independent and potentially material witness), that he heard the squeal of tyres, immediately prior to impact, is an indication of higher than usual speed to negotiate any type of vehicle movement – acceleration, deceleration, braking or turning. (I observed several vehicles negotiating the turn at approximately 25 kph without stopping and did not hear any abnormal tyre noises),
26. The statements from both Daniel and Catherine Andrews that their vehicle stopped at Melbourne Road are not consistent with impact consequences, nor the report by Brad Morgan of the squeal of tyres prior to impact. This version submitted by Daniel and Catherine Andrews (in unusual prepared sworn statements 3 weeks following the event (dated 31<sup>st</sup> January and 5<sup>th</sup> February 2013) is subject to challenge. Further, the content

- of the statements do not align with normal police procedures in obtaining full explanations and circumstances surrounding a crash of this nature. i.e. the content of the statements do not match the gravity of the incident. NB: The need to eliminate numerous factors including, speed, fatigue, distractions of children, mobile phone, other distractions, and familiarity with the vehicle have not been addressed.,
27. The absence of any normal/routine police procedures being followed, and the absence of tangible preserved evidence or legitimate investigation from the attending police – specifically no point of impact, no point of references, no point of rest for either vehicle or body, no scene containment or vehicle preservation, no measurements, no photographs, no scientific reconstruction, no eye witness testimony (no separation of witnesses), no effective door knocks, and no preliminary breath test
  28. The effective vehicle stopping distance of 19.2metres following impact is indicative of a speed 45kph prior to impact.
  29. From the above information, it is my opinion that the impact speed of the vehicle was in excess of 40kph and more likely to be in the range of 40kph to 50kph.
  30. It is most probable that the vehicle undertook a sweep turn at speed, cutting the corner and still on the incorrect side of the roadway in Ridley Street, 27 metres from Melbourne Road when the collision occurred,

### 36. Failure to follow Police Procedures

Further conclusion in relation to the police investigation, not following normal police procedures written policy and custom and practice:

1. Life threatening and serious injury investigations are to be conducted by experienced police officers, (Not followed)
2. The Major Collision Investigation Unit (MCIU) is to be notified of every fatal or life-threatening collision – to determine their attendance, (Not followed)
3. For collision types involving serious injury, the first response and investigating unit is to Highway Patrol within the PSA or elsewhere (Not followed).
4. The MCIU may attend and provide specialist assistance where the involvement of police is likely to bring discredit to Victoria Police (Not followed)
5. Failure to follow normal practice and procedures in isolating, containing, scene preservation, and separating and interview witnesses (Not followed)
6. Failure to isolate with crime scene tape preserving evidence (Not followed)
7. Where a VIP or dignitary is involved in a serious crash, it is normal to notify the Assistant Commissioner, Traffic in case of media attention (Not followed),
8. Failure to record any measurements, especially the critical point of impact, points of reference, skid and tyre marks (before and after impact), as well as points of rest of the vehicle and the victim (Not followed) ,
9. Failure to provide a referenceable scene diagram as required by policy, procedures and instructions (Not followed),
10. Allowing a vehicle with an obscured/smashed windscreen to be driven from the scene of a near-fatal crash (Dangerous action),
11. Failure to undertake a PBT, falsely recording it as negative, and then later attempts to justify this omission (A documented lie),
12. Failure to follow the principles of investigation i.e. an investigation is a search for the truth in the interests of justice and according to law (The truth is still outstanding)
13. Prejudice: Failure to keep an open mind and breaching a basic investigation tenet i.e. Bias, prejudice and preconception are the forerunners to defeat. This is evident with early recorded attempts to write the crash off as “No further Police Action” (NFPA) without a



thorough investigation and within five hours of the actual crash. i.e. at 1821 hours on 7<sup>th</sup> January 2013 (at a time when there were no statements, no measurements, no photographs and no evidence of support for the findings. Further there are numerous other references throughout recorded police information for NFPA and continued attempts to level blame with the rider (Demonstrated bias).

14. Failure to have the vehicle forensically examined (A careless or intentional omission)
15. There is not even a recorded police statement from the attending police to explain their version of recordings and why (The excuse would be that it is all in the TIS report, the Form 502 and the investigation notes NB: Often in conflict and all over the place). (Sloppy police work)
16. Overall, the investigation demonstrates a course of behaviour and pattern of recordings that were unprofessional, at best sloppy and with rudimentary attempts to cover-up inadequacies. These deficiencies may be interpreted as deliberate or careless.
  - a. No formal investigation processes followed,
  - b. Recording the driver as Catherine KESIK, in the TIS Crash Report and elsewhere consistently referred as Catherine Andrews in all other reports, statements etc without explanation or correction – considered a deliberate and conscious misdirection for the audit trail.
  - c. No scene photographs, however, stated to be taken the following day (although no evidence that they were taken and none have been produced)
  - d. No witnesses recorded from the scene (Brad Morgan, Jane Crittendon). Names and particulars would normally be taken for follow up,
  - e. Manipulation of the PBT data recordings in the TIS report,
  - f. Consideration of door knock for witnesses, only after prompting and then not validated,
  - g. Advising victim's father to obtain details of other party from FOI or TAC
  - h. A rudimentary and unprofessional attempt at crash reconstruction with no legitimate evaluation (undertaking a sweep turn in a marked police vehicle)

The critical issue from any Supervisor (There are many in the recordings including IBAC)

1. Accepting the Surname of KESIK in the Crash TIS report – in conflict with all other reports and allowing this to remain unchallenged and not amended at any time
2. Why has this mis-direction still not been addressed?
3. If S/C Sage was to be "counselled" for the PBT omission, why was Constable Ward not likewise counselled?
4. Why was this PBT omission only addressed after media reports?
5. Why was the TIS report not immediately amended when this became known? (NK when amended but not before the FOI release of February 2013)

The prepared statements, sworn by both Catherine and Daniel Andrews only have basic content to write off the crash investigation and should not have been accepted by any supervisor, review or audit.

### 37. EXPERT OPINION:

The investigation of this crash is deeply flawed and raises serious concerns about its credibility. It does not demonstrate competent professional practice for Victoria Police. The investigators' failure to follow even a rudimentary examination of the evidence is demonstrated in the hasty and illogical conclusion. The report lacks critical information including measurements, photographs and professional interview techniques. Instead, the investigator has drawn a baseless and unsupported conclusion that fails to account for the available evidence. This negligent approach not only

undermines the integrity of the investigation but also jeopardises the pursuit of justice and accurate accountability in this case. Further, it demonstrates a high level of incompetence or alternatively a deliberate attempt to simplify the crash to rudimentary reporting requirements. This omission in recording and preserving of accurate measurements has directly contributed to an unsubstantiated conclusion and directly to the inability to easily and accurately undertake a forensic reconstruction and analysis of the crash.

This opinion is provided in consideration of my experience within Victoria police, my international research and assessment of police practices, policies and procedures over 60 years in the field, the latter years specialising in crash investigations.

### 38. The cover-up of a political figure in a potential media incident

Several highly unusual aspects identified:

1. S/C Sage volunteering to attend the crash on the pretext that her unit was closer when in fact she was at Rye Police Station with urgent correspondence and then taking 6½ minutes before leaving for the job.
2. No experienced police attending the scene
3. Non-contact with MCIU, Highway Patrol, or other police services.
4. No questioning on why a non-govt employee was driving a government allocated vehicle
5. No measurements or scene photos taken or any police protocols followed
6. Why the name of KESIK is recorded on the TIS report as the retrievably indexed driver.
7. Why no breath test and falsely recording information as to its disposition (twice)
8. The non-challenge of the Andrews' version, when it was clearly presented contrary to the available evidence
9. The non-supply of driver and owner particulars to the injured party or representative.
10. The hasty conclusion to write the crash off as NFPA at 6.21pm that evening having spent only 35 minutes attending the scene?

### 39. Unresolved questions:

- (1) Who was the driver of the vehicle?
- (2) The critical time of the crash, the reporting times, the action times and any interventions
- (3) What intervention occurred to ensure that no further police action or investigation occurred?
- (4) Were the Andrews at the sailing club for lunch as advised by Daniel to Jane Crittenden or at the Beach as later asserted?
- (5) What phone calls or other communication was sent or received to impact on the legitimate outcome of this investigation?
- (6) Why did S/C Sage jump the call to take over, when another unit had already been allocated the call and was en route?

- (7) Why was the incident written off at 6.21pm that same evening with only 35 minutes in possible examination of the scene?
- (8) Why was the surname KESIK recorded on the TIS report and Government Insurance Records?
- (9) Why were none of the official protocols and policies followed?
- (10) If the SUV had commenced from a standing start, and only travelled a few metres and the brakes were immediately applied on impact, how come it took 19.2 metres to stop?
- (11) Why cross examine victim, Ryan at length and not challenge Catherine and Daniel Andrews version of events?
- (12) Why take a photo of the vehicle later at 29 Ridley Street and not in situ at the scene?
- (13) Who authorised Daniel Andrews to remove the unroadworthy vehicle to be driven from the scene?

Attachment "A" Aerial Photograph 4<sup>th</sup> January 2013 with super- imposed point of impact, vehicle and body point of rest and measurements as identified by witnesses.  
Attachment "B" – Letter of instruction from Princeton Legal.

I Raymond Neil Shuey, declare that I have undertaken due diligence and made relevant enquiries to date to ensure a comprehensive appraisal of the known facts to draw the conclusions identified in this report. It is noted that evidence of significant value that has not been forthcoming to date includes significant communications (telephone, radio) to and from the investigation scene and attending police. It is strongly asserted these communications will explain much of the unresolved questioning as to the intervention which thwarted a normally thorough and professional investigation of a life-threatening incident.



**Raymond Neil Shuey**  
**11<sup>th</sup> August 2024**

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