



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2020 001341**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Simon McGregor
Deceased:	Takamasa Takeda
Date of birth:	27 May 1988
Date of death:	9 March 2020
Cause of death:	1(a) Head injuries- horse rider struck by a motor vehicle
Place of death:	Thirteenth Beach Road & Blackrock Road, Barwon Heads, Victoria, 3227
Keywords:	Motor vehicle collision, pedestrian, horse riding, road crossing, cannabis, THC

## INTRODUCTION

1. On 9 March 2020, Takamasa Takeda was 31 years old when he died from injuries sustained when a motor vehicle collided with the horse he was riding.
2. Takamasa was a Japanese national and had been in Australia for approximately nine months on a working holiday visa.<sup>1</sup> During his time in Australia, he had worked for approximately six months at Cumani Racing Stables in Ballarat, then commenced work as a full-time track rider with O'Brien Thoroughbreds (Aust) Pty Ltd ('O'Brien Thoroughbreds') in January 2020.<sup>2</sup> He was an experienced and capable horse rider<sup>3</sup> and had also ridden in Japan for many years before coming to Australia.<sup>4</sup>
3. Takamasa was known to his friends and colleagues as 'Taka'. They described him as calm, honest and loyal, a good friend with a good personality.<sup>5</sup>

## THE CORONIAL INVESTIGATION

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

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<sup>1</sup> Exhibit 37 to WorkSafe Hand-Up Brief of Evidence.

<sup>2</sup> Statement of Tomomi Mori, Coronial Brief.

<sup>3</sup> Statements of Andrew Edwards, Kenneth O'Connor, Coronial Brief.

<sup>4</sup> Statement of Tomomi Mori, Coronial Brief.

<sup>5</sup> Statement of Tomomi Mori, Coronial Brief.

taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Takamasa Takeda including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.<sup>6</sup>
9. In considering the issues associated with this finding, I have been mindful of Taka’s human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

### **Circumstances in which the death occurred**

10. On the morning of 9 March 2020, Takamasa was with a group of four riders, taking horses to Thirteenth Beach in Barwon Heads for routine beach work under the supervision of Assistant Trainer Andrew Edwards. The riders arrived at the beach marker 40W carpark just after 6:30 am in a truck with four horses loaded. From the carpark, the group needed to cross Thirteenth Beach Road to get to the beach itself.<sup>7</sup> The beach is designated as an area to work horses and is known locally as the ‘horse beach’.<sup>8</sup>
11. Thirteenth Beach Road, Barwon Heads, runs in an east-west direction, roughly parallel with the beach. It is a sealed carriageway with one lane for traffic in each direction. A solid centre white line with a short gap at the carpark divided the east and west bound traffic. A sign-posted speed limit of 80 km/h applied at the time of the collision.<sup>9</sup> The road surface was flat, dry and in good condition.<sup>10</sup> Dense shrubs grew alongside the road on both sides.<sup>11</sup> Yellow

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<sup>6</sup> Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

<sup>7</sup> Statement of Andrew Edwards, Coronal Brief.

<sup>8</sup> Statements of Kenneth O’Connor and Jeffrey Brooks, Coronal Brief.

<sup>9</sup> Statement of Michael Hardiman, Coronal Brief.

<sup>10</sup> Statement of David Winton, Coronal Brief.

<sup>11</sup> Statement of Matthew Moon, Coronal Brief.

traffic signs depicting a horse being ridden and a woman and child pedestrian were present from both the east and west approaches to the carpark.<sup>12</sup>

12. At approximately 6:40 am, it was still somewhat dark. The evidence of witnesses varies on this point, with the riding group recalling that it was half-light<sup>13</sup> or ‘maybe 50-50 light’,<sup>14</sup> while other witnesses observed it to be ‘dark’,<sup>15</sup> ‘very dark’,<sup>16</sup> or ‘almost pitch black’.<sup>17</sup> I accept that this divergent evidence was given in good faith and that subjective perceptions of darkness may vary depending on the perceiver’s relative adjustment to light conditions and the presence of other lighting, such as car headlights, which can cast surrounding areas into comparative darkness. There was no street lighting on this section of road.<sup>18</sup> Mr Edwards stated that over the preceding month he had been gradually delaying the start of their beach visits to ensure that there was enough light to work safely with the horses on the beach. The riders were not wearing high-visibility or light-reflecting clothing, and were not using any lights, lamps or head torches. The horses had reflective strips approximately 5 cm wide and 30 cm long sewn diagonally across their saddle pads.<sup>19</sup>
13. The horses were unloaded from the truck and were calm and behaving well. All four horses were dark-coloured. Taka was assigned to ride a two-year-old, brown-coloured colt that had been to the beach on many occasions.
14. Mr Edwards stated that there was no set policy or procedure for crossing the road to the beach, but for safety he would always walk to the middle of the road and check the road in both directions, as he did on this morning. Mr Edwards could see approximately 800 metres towards the east, looking back towards Barwon Heads. He observed headlights of a vehicle about 500 metres away in that direction and called out to the riders that it was safe to cross.<sup>20</sup>
15. The riders and horses started to cross the road together. Of the four horses with riders, Takamasa was on the fourth horse, being the last to cross.
16. Mr Edwards was still standing in the middle of the road, observing the approaching vehicle, which did not appear to be slowing down. When the vehicle was approximately 100 metres

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<sup>12</sup> Statement of Jeremy O’Brien, Coronial Brief.

<sup>13</sup> Statement of Kenneth O’Connor, Coronial Brief.

<sup>14</sup> Statement of Andrew Edwards, Coronial Brief.

<sup>15</sup> Statement of Adrienne Currie, Coronial Brief.

<sup>16</sup> Statement of Matthew Moon, Coronial Brief.

<sup>17</sup> Statement of Richard Melder, Coronial Brief.

<sup>18</sup> Statements of Richard Melder and Matthew Moon, Coronial Brief.

<sup>19</sup> Statement of Andrew Edwards, Coronial Brief.

<sup>20</sup> Statement of Andrew Edwards, Coronial Brief.

away, Mr Edwards started waving his arms and yelling at the car to slow down or stop. At this time, Mr Edwards was focused on getting the vehicle to stop and was not aware of the horses' positions behind him. To avoid being struck by the vehicle, Mr Edwards moved to the southern side of the road, at which time he heard the screech of the tyres from the vehicle. Mr Edwards turned and saw the vehicle hit the horse that Takamasa riding. The horse was hit on its left side and fell onto the car bonnet. Takamasa hit the windscreen of the vehicle and was thrown to the ground, landing on his left side. The horse got up immediately and moved towards the beach.<sup>21</sup>

17. Mr Edwards immediately went to Takamasa and found him unconscious, with his riding helmet badly cracked. He called 000 and asked the other riders to control any oncoming traffic. A passing group of cyclists stopped to assist. One of the cyclists, Adrienne Currie, was qualified as a registered nurse and attended to Taka, observing that he appeared to have serious head injuries. On instruction from the 000 call-taker, Ms Currie performed CPR, assisted by Mr Edwards.<sup>22</sup>
18. Approximately 25 minutes later, Ambulance Victoria paramedics arrived and took over resuscitation efforts. Sadly, Takamasa was unable to be revived and he was formally pronounced deceased at the scene.

### **Identity of the deceased**

19. On 9 March 2020, Takamasa Takeda, born 27 May 1988, was visually identified by his colleague, Andrew Edwards.
20. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

21. Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an external examination on 10 March 2020 and provided a written report of his findings dated 11 March 2020.

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<sup>21</sup> Statement of Andrew Edwards, Coronial Brief.

<sup>22</sup> Statement of Adrienne Currie, Coronial Brief.

22. A post-mortem computed tomography (CT) scan showed extensive skull and facial fractures with pneumocerebrum and subarachnoid haemorrhage.<sup>23</sup>
23. The post-mortem external examination was unremarkable.
24. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or common drugs or poisons.
25. Dr Bedford provided an opinion that the medical cause of death was 1(a) head injuries - horse rider struck by a motor vehicle.
26. I accept Dr Bedford's opinion.

## **COLLISION INVESTIGATION**

### **Scene investigations**

27. Attending police examined the collision scene and took measurements, photographs and statements from witnesses.
28. The driver of the vehicle, Haylee Holt, remained at the scene and spoke with attending police. Ms Holt produced a current driver's licence<sup>24</sup> and underwent a preliminary breath test for alcohol and preliminary oral fluid test for drugs, both of which returned negative results. Ms Holt stated to police that she had been on her way to work, it was dark, and she had suddenly seen two or three horses being ridden across the road. She slowed and moved to drive around them, but there was another horse and she braked but hit it. She agreed that she didn't see the horses until she was 'basically on top of them'.<sup>25</sup>
29. Ms Holt's vehicle, a blue 2004 Hyundai Getz hatch, was not mechanically inspected after the collision. Damage to the vehicle on the passenger side of the windscreen and 'A' pillar corroborated witnesses' account that Takamasa struck the windscreen of the vehicle before landing on the ground.<sup>26</sup>

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<sup>23</sup> Bleeding into the subarachnoid space of the brain (the area between the arachnoid membrane and the pia mater surrounding the brain). This may occur spontaneously, usually from a ruptured cerebral aneurysm, or may result from head injury.

<sup>24</sup> It was subsequently confirmed that Ms Holt had no prior traffic offences recorded: Certificate under section 84(1) of the *Road Safety Act 1986* (26 November 2020).

<sup>25</sup> Statement of David Winton, Coronial Brief.

<sup>26</sup> Statement of Michael Hardiman, Coronial Brief.

30. Collision reconstructionist Leading Senior Constable Michael Hardiman prepared a collision reconstruction statement. From evidence gathered at the collision scene, Leading Senior Constable Hardiman calculated that the speed of Ms Holt's vehicle at the commencement of emergency braking was up to 66 km/h, in compliance with the applicable 80 km/h speed limit. At the point of impact with the horse and Takamasa, the vehicle speed was approximately 36 km/h.
31. Victoria Police Traffic Incident System (TIS) data was analysed for the period 12 months prior to the day of collision to three years past the collision date. Of the 34 collisions recorded in the area (Barwon Heads) in this four-year period, only one further accident was recorded on Thirteenth Beach Road, being a minor injury collision involving a vehicle and a cyclist.<sup>27</sup> Road design therefore does not appear to have been a factor in the collision.

### **Criminal prosecution**

32. A blood sample was taken from Ms Holt at 9:05 am at University Hospital Geelong<sup>28</sup> pursuant to section 55BA(2) of the *Road Safety Act 1986*.<sup>29</sup> Toxicological analysis of that sample identified the presence of delta-9-tetrahydrocannabinol (THC)<sup>30</sup> at a concentration of 3 ng/mL.
33. Ms Holt elected to provide no further comment to police in relation to the collision, as was her right. No other evidence is available to me in this investigation in relation to Ms Holt's use of cannabis and the time at which she last ingested cannabis.
34. Forensic Physician Dr Jason Schreiber from the Victorian Institute of Forensic Medicine provided an expert opinion in relation to the level of THC detected in Ms Holt's blood.<sup>31</sup>
35. Dr Schreiber explained that THC levels rise rapidly in the minutes following ingestion and peak within two hours, then fall rapidly and usually reach a baseline level in regular users at about 2-4 hours following administration. Blood THC concentrations of 2-5 ng/mL and recent cannabis smoking are suggested to be associated with substantial driving impairment,

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<sup>27</sup> Exhibit 1 to Coronial Brief – Traffic Incident System Incident Report, 15 March 2020.

<sup>28</sup> Certificate of the taking of a blood sample, 9 March 2020.

<sup>29</sup> A police officer may require any person they believe to have been driving a motor vehicle involved in an accident to allow a registered medical practitioner or an approved health professional to take from the person a sample of that person's blood for analysis.

<sup>30</sup> The active component of cannabis.

<sup>31</sup> Statement of Dr Jason Schreiber, Coronial Brief.

particularly in occasional smokers, however, it is also possible for a baseline level of 3 ng/mL to be found in regular users several days after last using cannabis.<sup>32</sup>

36. Dr Schreiber provided an opinion that:

- a) Ms Holt was driving after having consumed cannabis;
- b) she had a blood THC concentration of 3 ng/mL within three hours of the collision;
- c) the THC concentration may have been higher at the time of driving but could not be back-calculated;
- d) it is possible that the measured THC concentration was a baseline level from cannabis use several days before;
- e) in the absence of witnessed signs or symptoms of THC intoxication, it was possible that Ms Holt's driving skills were affected by the low level of THC present, but this could not be conclusively determined.<sup>33</sup>

37. Ms Holt was charged and pleaded guilty to failing a drug blood test within three hours of the collision.<sup>34</sup> At the Geelong Magistrate's Court on 20 April 2022, she was fined, her driver's licence was cancelled and she was disqualified from driving for a period of six months.<sup>35</sup>

## **WORKSAFE INSPECTION AND INVESTIGATION**

### **Workplace inspection**

38. WorkSafe inspectors attended the scene at approximately 8:45 am on the day of the collision, having been notified of the incident by Victoria Police.<sup>36</sup>

39. Inspector Glenn Woods observed that aside from the two yellow street signs, there was no other indication to approaching road traffic that horses may be crossing the road at the carpark location.<sup>37</sup>

40. Inspector Woods was informed by Danny O'Brien, owner and manager of O'Brien Thoroughbreds, that the company's practices to ensure the safety of riders and horses when

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<sup>32</sup> Ibid.

<sup>33</sup> Statement of Dr Jason Schreiber, Coronial Brief.

<sup>34</sup> Contrary to section 49(1) of the *Road Safety Act 1986* (Vic).

<sup>35</sup> Certified extract of orders, Magistrates' Court of Victoria, 20 April 2022.

<sup>36</sup> Statement of Glenn Woods, Coronial Brief.

<sup>37</sup> Ibid.

crossing public roadways were not formalised in writing, and that employees were informed verbally of actions to be taken by the assistant trainer or by Danny O'Brien, if present.<sup>38</sup>

41. Inspector Woods confirmed that guidance in relation to safety in the horse racing industry was available from several resources:

a) The *WorkSafe Guidebook: Horse stables and track riding safety* (Edition 2, August 2018) recommends that:

Riders, stable employees, strappers, trainers and visitors, use approved high visibility vests for both day and night work; and

Every horse that is led or ridden on a public road or thoroughfare before sunrise should wear a rug or other gear with reflective strips. The rider or attendant should wear a reflective high visibility vest.<sup>39</sup>

b) Racing Victoria's *Rules of Racing* (as at 1 January 2020) provides, *inter alia*, the following:

AR 108 Horse's clothing before sunrise

If a horse is being led or ridden outside a stable premises on a public road or thoroughfare before sunrise, the trainer of the horse and any person responsible for leading or riding the horse must ensure that the horse wears a rug or other gear with reflective strips and that its rider or attendant wears a reflective vest of a design approved by the Stewards.

AR 122 Helmets

[...]

(5) When mounted on a horse during darkness, every licensed person or registered person or permit holder must affix to his or her helmet a safety warning light of a type approved by Racing Australia, a PRA or the Stewards (except that this rule does not apply to any location where the Stewards have ruled that sufficient artificial lighting exists).<sup>40</sup>

42. Inspector Woods determined that by not maintaining a safe system of work, there was risk to employees' health and safety, and issued an improvement notice<sup>41</sup> requiring the company to maintain a safe system of work to ensure the safety of riders and horses when loading and unloading horses from vehicle floats and crossing public roadways and reserves. Inspector

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<sup>38</sup> Ibid.

<sup>39</sup> Statement of Glenn Woods, Coronial Brief; Exhibit 6 to WorkSafe Brief of Evidence.

<sup>40</sup> Statement of Glenn Woods, Coronial Brief; Exhibit 7 to WorkSafe Brief of Evidence.

<sup>41</sup> Exhibit 5 to WorkSafe Brief of Evidence, Improvement Notice dated 9 March 2020.

Woods explained to Mr O'Brien that compliance with the improvement notice could be achieved by the company developing and implementing a formal safe system of work.<sup>42</sup>

43. As an interim measure, O'Brien Thoroughbreds was advised not to undertake any horse training activities involving movement on public roads and reserves until such time as a safe system of work had been implemented.<sup>43</sup>
44. O'Brien Thoroughbreds subsequently developed and implemented a formal safe system for road crossing with horses including the following:
  - a) Horses and riders are to work from sunrise;
  - b) All riders and supervisor must wear high visibility vest;
  - c) All horses to be saddled with high visibility packing;
  - d) Supervisor to inspect and assess horses and riders for compliance with above before mounting horses;
  - e) Should a vehicle appear which may make crossing unsafe, get horses mid crossing to the other side and cease any other horses crossing. Recommence once safe.<sup>44</sup>
45. Training in the safe work system was provided to all relevant employees and O'Brien Thoroughbreds was deemed to be in compliance with the improvement notice.<sup>45</sup> I note that, with the notable exception of the requirements for high visibility gear, the now formalised safe system of work largely reflects practices that were routine at the time of Takamasa's passing.<sup>46</sup>

### **WorkSafe investigation and prosecution**

46. On 10 March 2020, a WorkSafe investigation into the incident that caused Takamasa's death was commenced by Inspector Jeremy O'Brien from the WorkSafe Enforcement Group and a brief of evidence was prepared.

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<sup>42</sup> Statement of Glenn Woods, Coronial Brief.

<sup>43</sup> Ibid.

<sup>44</sup> Exhibit 16 to WorkSafe Brief of Evidence, Safety System for Road Crossing with Horses, dated 15 April 2020.

<sup>45</sup> Statement of Glenn Woods, Coronial Brief.

<sup>46</sup> Statement of Andrew Edwards, Coronial Brief; Trial transcript of DPP v O'Brien Thoroughbreds Pty Ltd (14 November 2023), T136.31-142.1.

47. On the basis of the evidence gathered, O'Brien Thoroughbreds was charged with one count of failing to provide and maintain for employees a working environment that is safe and without risks to health, contrary to section 21(1) of the *Occupational Health and Safety Act 2004* (Vic).
48. On 30 November 2023, in the Magistrates' Court at Geelong, a jury acquitted O'Brien Thoroughbreds of that charge.<sup>47</sup>

## **FINDINGS AND CONCLUSION**

49. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.<sup>48</sup> Adverse findings or comments are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.
50. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was Takamasa Takeda, born 27 May 1988;
  - b) the death occurred on 9 March 2020 at Thirteenth Beach Road & Blackrock Road, Barwon Heads, Victoria, 3227, from head injuries - horse rider struck by a motor vehicle; and
  - c) the death occurred in the circumstances described above.
51. Having considered all of the circumstances, I make the following additional findings as to the circumstances of Takamasa's death:
  - a) The collision occurred as a result of low light conditions that impeded Ms Holt's ability to see the horses and riders crossing the road in time to brake safely.

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<sup>47</sup> Letter from Victorian WorkCover Authority to Coroners Court of Victoria dated 19 December 2023.

<sup>48</sup> *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'

- b) Poor visibility of the horses and riders was compounded by the absence of high-visibility clothing, reflective gear or lights worn by the riders.
  - c) I am satisfied, on the balance of probabilities, that the level of THC detected in Ms Holt's system impaired her driving ability on the morning of the collision to some extent. I am, however, unable to reach further particularised findings as to the degree to which this impairment contributed to the collision, particularly in circumstances where there were a number of other contributory factors.
  - d) Road surface conditions and weather conditions at the time of the collision did not contribute to the collision.
52. I am further satisfied that in the time since Takamasa's passing, O'Brien Thoroughbreds has implemented a safe system of work to ensure the safety of horses and riders crossing public roadways, including requirements for riders to wear high visibility clothing and horses to be saddled with high visibility packing.
53. I note that in the time since Takamasa's passing, the applicable speed limit at the collision site has also been reduced from 80 km/h to 60 km/h, which I consider appropriate.
54. In these circumstances, I consider the remediations that have taken place since Takamasa's passing will, as far as is reasonably practicable, mitigate the risk of future similar incidents.

## COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

55. It is well established that THC intoxication can cause impairment in cognitive and psychomotor functions, producing risk taking behaviours that may impair driving skills. In drivers, THC intoxication is also associated with increased lane weaving, impaired critical-tracking tests, increased reaction times, and impaired divided-attention tasks. In frequent users of THC, complex tasks show impairment despite purported tolerance.<sup>49</sup>
56. What is less well known in the community is that the presence of THC in a person's system, regardless of the regularity or recency of use, and regardless of the individual's subjective

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<sup>49</sup> Statement of Dr Jason Schriber, Forensic Physician, Coronial Brief, citing Hartman RL, Huestis MA. Cannabis effects on driving skills. *Clinical chemistry*. 2013 Mar 1 ;59(3):478-92.

feeling of being impaired or intoxicated, can cause psychomotor effects that increase a driver's risk of being involved in a collision.

57. A recent study into the role of impairing drugs in motor vehicle collisions examined data from the toxicological analysis of approximately 5,000 blood specimens collected over a five-year period pursuant to compulsory drug testing<sup>50</sup> of drivers hospitalised as a result of a road traffic collision.<sup>51</sup> Though the impact of cannabis use on crash risk has been the subject of debate, the study found that when THC was present in all driver categories (in the absence of any other potentially impairing substance), the odds of that driver being culpable<sup>52</sup> for the collision was 1.9 times higher than for the control group of drug-free drivers. The increase in the likelihood of culpability for the collision was even more pronounced in drivers with higher blood THC concentrations:

- a) at THC concentrations in the range of 1 - 4.9 ng/mL, the odds of culpability was 1.6 times higher than the drug-free control group;
- b) at 5 ng/mL and above, the odds of culpability was 3.2 higher than the drug-free control group; and
- c) at 10 ng/mL and above, the odds of culpability was 10 times higher than the drug-free control group.<sup>53</sup>

58. These findings are particularly relevant to regular users of cannabis. As discussed above, the blood level of THC falls rapidly after ingestion and usually reaches a baseline level in regular users at about 2-4 hours after ingestion. In regular users, it is possible for a baseline level to be present several days after last using cannabis, when the user may no longer subjectively feel any effects of the drug. The rapid fall in THC level reflects its redistribution into the fatty tissues of the body, including the brain, where it exerts its psychomotor effects. This recent study affirms our understanding that the impairing effects of THC may continue throughout

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<sup>50</sup> Under the *Road Safety Act 1986* (Vic).

<sup>51</sup> Olaf H. Drummer, Dimitri Gerostamoulos, Matthew Di Rago, Noel W. Woodford, Carla Morris, Tania Frederiksen, Kim Jachno, Rory Wolfe, Odds of culpability associated with use of impairing drugs in injured drivers in Victoria, Australia, *Accident Analysis & Prevention*, Volume 135, 2020.

<sup>52</sup> Culpability analysis (sometimes referred to as responsibility analysis) was undertaken by examining the known circumstances of the collision using an 8-point assessment guide. This included scoring each collision for the condition of road, condition of vehicle, driving conditions, accident type, witness observations, road law obedience, difficulty of task, and level of fatigue. Each factor had a predetermined numerical score.

<sup>53</sup> Olaf H. Drummer, Dimitri Gerostamoulos, Matthew Di Rago, Noel W. Woodford, Carla Morris, Tania Frederiksen, Kim Jachno, Rory Wolfe, Odds of culpability associated with use of impairing drugs in injured drivers in Victoria, Australia, *Accident Analysis & Prevention*, Volume 135, 2020.

this extended period after the blood level has fallen to baseline levels as the substance is still exerting its effect in the brain.<sup>54</sup>

## RECOMMENDATIONS

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

59. I recommend that VicRoads and the Transport Accident Commission consider updating their public education materials in relation to cannabis use and driving to reflect the longer-term effects on driving risk beyond the immediate psychoactive phase.

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

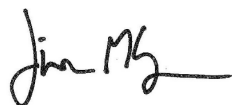
I direct that a copy of this finding be provided to the following:

Takeshi and Noriko Takeda, Senior Next of Kin

Adrienne Currie (C/- Peggy Lee, Robinson Gill Lawyers)

Sergeant Andrew Connors, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 9 May 2025

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

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<sup>54</sup> Statement of Dr Jason Schriber, Forensic Physician, Coronial Brief.