IN THE CORONERS COURT
OF VICTORIA
AT SOUTHBANK

Court Reference: COR 2013 3749

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: Roberto DI BARTOLO

Delivered On:	8 July 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street SOUTHBANK 3006
Hearing Dates:	29 April 2015
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr Ron GIPP of Counsel, instructed by the Victorian Government Solicitor for the Chief Commissioner of Police
Counsel Assisting the Coroner	Jessica WILBY from the Court's In-House Solicitors Service

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of ROBERTO DI BARTOLO
AND having held an inquest in relation to this death on 29 April 2015
at the Coroners Court of Victoria Southbank
find that the identity of the deceased was ROBERTO DI BARTOLO
born on 12 March 1972
and that the death occurred on 23 August 2013
at a location on the Hume Highway, Seymour, about 100 metres south of the Northwood Overpass
from:

1 (a) MULTIPLE INJURIES

in the following circumstances:

Background & Introduction

1. Mr Roberto Di Bartolo (referred to in this finding as Mr Di Bartolo) was 41 years at the time of his death and resided with his partner, Ms Maria Borderi, in Euroa.

2. Mr Di Bartolo married Mrs Maria Di Bartolo in 1994 and there were four children from that relationship who survived their father, Alessandro, Gabriele, Melissa and Daniel. Mr Di Bartolo and his wife separated in 2012.

3. Mr Di Bartolo was a renderer by trade but suffered a back injury at work in 2009 that prevented him from working for long periods of time and triggered a depression. Mr Di Bartolo received psychological treatment in relation to anger management issues in 2006 and 2007, acknowledging in the course of treatment that his temper was really bad, his 'blood boils' and that he often acted before he thought.

4. In 2009 Mr Di Bartolo was referred for treatment for the work injury and the secondary anxiety. During this period Mr Di Bartolo expressed suicidal ideation and attempted to take his own life on two occasions.

5. On 23 Augsut 2013, at about 1.20 pm, Mr Di Bartolo sustained fatal injuries and died when the vehicle he was driving, a maroon 1996 Holden Commodore, collided with a number of trees on the centre median strip of the Hume Freeway about 100 metres south of the Northwood Overpass, Seymour. Shortly prior to the collision a police officer had attempted to intercept Mr Di Bartolo's vehicle, following reports from other road users that it was

being driven erratically, dangerously and at speed. The attempt to intercept had been of brief duration and was called off some minutes and several kilometres before the collision.

Post Mortem examination

6. Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an autopsy on Mr Di Bartolo's body. He summarised his anatomical findings at autopsy as fracture dislocation atlanto-occiptial spine, ruptured descending thoracic aorta, bilateral haemothoraces, pulmonary contusions, ruptured liver, haemoperitoneum, traumatic subarachnoid haemorrhage and fractured pelvis. Dr Burke noted the results of post-mortem toxicological analysis that showed ethanol (alcohol) at a concentration of 0.13g/100mL (commonly referred to as 0.13%) and the anti-histamine Promethazine[1] at 0.02%mg/l.

7. Dr Burke advised that the medical cause of Mr Di Bartolo's death was multiple injuries. He commented that the distribution and severity of the injuries supported a finding that Mr Di Bartolo's death occurred immediately after the collision.

8. Dr Morris O'Dell, Clinical Forensic Physician, also from VIFM, examined the toxicology results advising that the intoxicating effects of alcohol would have been enhanced by the effects of promethazine. In Dr O'Dell's opinion, at the time of the collision, Mr Di Bartolo's driving ability would have been very adversely affected by the combined effects of the alcohol and promethazine on his motor skills and coordination.

Purposes of the Coronial Investigation

9. The purpose of a coronial investigation into a *reportable death*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[3] In the context of a coronial investigation, the *cause of death* refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The *circumstances* refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances that might form part of a narrative culminating in death.

---

[1] Promethazine is a sedating anti-histamine available over the counter under trade names such as Phenergen and Avomine and is used to treat allergies.

[2] Section 4 of the *Coroners Act 2008* requires certain deaths to be reported to the coroner including all deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury.

[3] Section 67(1) of the *Coroners Act 2008.*

10. The broader purpose of any coronial investigation is to contribute to a reduction in the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role. Coroners are empowered to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and to make recommendations to any Minister, public statutory body or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[4] These are effectively the vehicles by which the prevention role is advanced.[5]

11. A coroner's findings on these factual matters are based on the evidence produced by the coronial investigation, including any inquest, subjected to the requisite standard of proof – namely the civil standard of proof on the balance of probabilities.[6]

12. The circumstances of Mr Di Bartolo's death have been the subject of an investigation by Victoria Police on behalf of the Coroner. The Coroner's Investigator, Detective Sergeant Colin Schmidt, prepared a very detailed and comprehensive coronial brief of evidence comprising a range of evidentiary material including witness statements and visual material.

13. It was evident from the evidence and material in that brief that most of the facts about Mr Di Bartolo's death were clear including his identity, the medical cause of his death and aspects of the circumstances, including the place and time of his death.

14. After considering the brief, I determined that there was a need for an inquest as part of the coronial investigation of Mr Di Bartolo's death. The primary focus of the inquest was the events immediately preceding Mr Di Bartolo's death, in particular the apparent discrepancy between Ms Borderi's account of the morning of 23 August 2013, and Mr Biddle's account of the state of Mr Di Bartolo when he attended at his house at about 12:30 pm that day.

15. The following witnesses gave evidence at the inquest:

- Ms Maria Borderi
- Mr Garry Biddle
- Detective Sergeant Colin Schmidt.

---

[4] Sections 72(1), 72(2) and 67(3) of the Act

[5] See also sections 73(1) and 72 (5) which require publication of coronial findings, comments and recommendations and response respectively; sections 72(3) and (4) which oblige the recipient of a coronial recommendations to respond within three months, specifying a statement of actin which has or will be taken in relation to the recommendation.

[6] As per the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336

16. This finding is based on the entirety of the investigation material including the file, coronial brief of evidence, the statements and evidence of those witnesses who appeared at the inquest.

Circumstances of Mr Di Bartolo's death - the evidence of Ms Borderi and Mr Biddle

17. Ms Maria Borderi said that in the days leading up to the collision there were no arguments or issues between them, and that Mr Di Bartolo had seemed to be in good spirits.

18. On the morning of 23 August 2013 Mr Di Bartolo got out of bed between 9 and 10am, prepared breakfast and told her he was travelling to Melbourne to purchase some car parts. Ms Borderi says that Mr Di Bartolo left home at about 12.15 pm, while she was still in bed.

19. Mr Di Bartolo then drove to the address of a neighbour, Mr Garry Biddle, who lived in the same street. Mr Biddle immediately recognised Mr Di Bartolo's car, a maroon Holden sedan, and walked down the driveway to meet him. As he reached the driver's door Mr Di Bartolo got out of the car and stood revving the engine with one foot. Mr Di Bartolo had tears in his eyes and seemed very agitated.

20. Mr Di Bartolo began sobbing very loudly and was not making a lot of sense. Mr Biddle had a disjointed conversation with him, but understood that he was upset about money and that he had left one job to try and better his financial position but that it wasn't working out. Mr Di Bartolo was inconsolable saying he was in debt, that he had bills to pay and no money.

21. Mr Di Bartolo then said 'It's going to end or I'm going to end it'. Mr Biddle thought that he meant the money owed to him and told him to take care. Mr Di Bartolo drove out of the driveway, accelerated hard and then took off very fast. Mr Biddle heard him accelerating further as he turned out of the street.

22. While there is no direct evidence of the route he took, it is reasonable to infer that Mr Di Bartolo then drove onto the Hume Highway and began travelling in a southerly direction towards Melbourne.

The police response to calls to 000

23. A significant number of civilian reports were made to emergency services (000) about a vehicle travelling at high speeds south on the Hume Highway and being driven erratically. As a result of the triple zero calls, a broadcast was made to police units from the police communications centre at 12.48 pm.

24. At 12.49 pm Leading Senior Constable Christopher Cummins[7] acknowledged the broadcast and drove north along the Hume Highway in a marked police sedan to a well-known static radar/laser site located on the centre median strip of the Hume Highway.

25. Upon observing Mr Di Bartolo's vehicle from that location, LSC Cummins executed a U-turn and accelerated, observing that Mr Di Bartolo was travelling at 110 kph at the time.

26. LSC Cummins verified the registration of the vehicle and at 12.59 pm indicated over the police radio that he would intercept Mr Di Bartolo's vehicle. LSC Cummins then activated his blue lights, observing that Mr Di Bartolo's speed had increased to 154 kph and that he was still accelerating.

27. At 1.00.50 pm LSC Cummins advised the communications centre that Mr Di Bartolo's vehicle was travelling at 200 kph and that he was currently travelling at 150 kph.

28. At 1.01.11 pm, Sergeant Warren Taylor transmitted over the radio that LSC Cummins was to terminate if he was in a pursuit, or if he was not in a pursuit, not to engage in a pursuit.

29. At 1.01.21 pm LSC Cummins acknowledged the order, turned off his blue lights, reduced his speed and moved into the left lane behind a silver sedan.

30. As LSC Cummins pulled into the left lane, he observed the police radar displaying the speed of Mr Di Bartolo's vehicle as 200k kph.

Observations made by other civilians

31. The driver of the silver sedan, Mr Hans Sievers, saw a red coloured Holden coming up very fast behind him in the right lane in his centre rear vision mirror. Mr Sievers estimated that as he was travelling at approximately 110 kph the driver of the Holden had to be doing at least 190 kph: *'I could tell he was flying because of how quickly he was approaching me from behind and the way his car was moving on the suspension. The speed was so high the car was literally floating and rocking from side to side.'*

32. Mr Victor Siberas was driving a Kenworth prime mover towing two trailers in a B-double configuration south along the Hume Freeway. Mr Siberas had just passed under the Longwood overpass and was travelling in the right hand lane when he noticed a dark coloured red Commodore flying up the emergency lane doing what he approximated was 180 to 200 kph.

---

[7] Abbreviated to LSC Cummins

33. Mr Reece Lines was driving a prime mover south along the freeway and was travelling in the left hand lane being overtaken by Mr Siberas.

34. The Holden commodore driven by Mr Di Bartolo travelled along the left emergency lane to the left of these two trucks and the evidence suggests that in doing this the left wheels of the vehicle travelled into the shallow spoon drain. The vehicle was then oversteered to the right and travelled across the southbound lanes and into the centre median strip. Mr Di Bartolo's vehicle collided with several trees and vegetation along the grassed area before coming to a stop within the centre median strip.

35. Numerous civilian witnesses observed the collision and stopped to assist, observing that the fully marked police vehicle arrived at the collision a short time later. LSC Cummins arrived at the collision at 1.02 pm and immediately transmitted information about the collision over the police radio.

36. At the time of the collision it was a clear day with no rain, the road surfaces were dry and visibility was good. There is no suggestion that any aspect of road or road-related infrastructure caused or contributed to the collision.

Police investigation

37. Investigators from the Major Collision Investigation Unit attended at the scene and assumed responsibility for the investigation into the collision, oversighted by Victoria Police Professional Standards Command.

38. During the search of the wreckage of the Holden numerous weapons and components of firearms were located. These included machetes, knives, a rifle scope, assorted ammunition, a throwing star, a rifle stock, the wooden butt of the rifle stock and the barrels of a side by side shotgun containing one unfired shell shot. Mr Di Bartolo was wearing a leather firearm holster on his right hip that contained a non-functioning homemade handgun.

39. Mr Di Bartolo's mobile phone was retrieved from the scene. Examination of the mobile indicated that no text messages made or received from the service on the day of the collision and no calls were received. At 12.47 pm the mobile was used to call the mobile phone of Mr Di Bartolo's son, Gabriele, but this call was not answered.

40. The vehicle driven by LSC Cummins was a 2013 Holden Commodore marked Highway Patrol vehicle that was fitted with radios, moving mode radar and a Garmin Global Positioning System (GPS) device. The Garmin GPS device was retrieved from the police

vehicle, taken to Victoria Police E-Crime and downloaded. The information retrieved from the GPS unit download including time, direction and speed corroborates LSC Cummins' version of events.

41. The distance from first police contact, at the static laser site, to the collision site was measured as approximately 7.8 kms.

42. LSC Cummins underwent critical incident blood testing for drugs and alcohol, which produced negative results.

43. Detective Acting Sergeant Jenelle Mehegan, a <u>collision reconstructionist</u>, attended and examined the scene of the collision. She observed that Mr Di Bartolo's vehicle was at rest with the passenger side of the vehicle against a large tree. The vehicle had sustained excessive damage to most panels due to numerous impacts with trees, shrubs and plants.

44. The damage was consistent with the vehicle having rotated about its vertical axis symmetrically as it continued south along the median and the vehicle had sustained extensive damage to two areas on both the driver and the passenger sides of the vehicle, consistent with tree impacts.

45. Visible tyre marks were consistent with excessive steering input and there were visible yaw marks at the scene. It was determined that Mr Di Bartolo had tried to correct the yaw unsuccessfully by inputting a left steering manoeuvre. In Detective Acting Sergeant Mehegan's opinion, when Mr Di Bartolo's vehicle first commenced yawing, it was travelling at a minimum of 184 kph.

46. The impact/s cut the driver's seat belt in the vehicle, suggesting that it was being worn at the time of the collision.

47. <u>The vehicle</u> that Mr Di Bartolo was driving was a 1996 Holden Commodore Acclaim Sedan, maroon in colour. The registration of the vehicle had been suspended on 26 October 2012, and cancelled on 13 May 2013. The vehicle was displaying Victorian Registration plates UDC329 at the time of the collision, that belonged to another vehicle.

48. Senior Constable Ian Ellis, a Mechanical Investigator attached to the Major Collision Group inspected the vehicle on 26 August 2014 and found that the vehicle had two minor faults, a front shock absorber slight oil weep and front stabiliser bar rubbers that needed replacement. In Senior Constable Ellis' opinion neither of these faults would have any noticeable effect

on the driveability of the vehicle, and his inspection did not reveal any previous mechanical fault with the vehicle which would have caused or contributed to the collision.

49. The relevant Victoria Police Manuals at the time of Mr Di Bartolo's death set out the policies and procedures regarding the conduct of <u>a police pursuit</u>.

50. The incident resulting in Mr Di Bartolo's death falls within the Victorian Police pursuit policy, as Mr Di Bartolo apparently accelerated after LSC Cummins activated his police lights in an attempted intercept. That said, LSC Cummins disengaged relatively quickly and was not *in pursuit* when the collision occurred.

51. Coroner Olle has previously conducted a broad investigation into Victoria police pursuit policy as part of an investigation into the death of Sarah Booth[8] and Victoria Police have subsequently responded to the recommendations made by Coroner Olle in that matter. Consequetnly, I took the view that it was not necessary to explore the broader issue of public safety and police pursuits as part of the investigation of Mr Di Bartolo's death.

52. Mr Gipp, on behalf of the Chief Commissioner of Police (CCP) made submissions about whether or not this incident should be classed as a pursuit at all. He submitted that although it would fall within the policy definition of a pursuit, it is clear from the GPS material and the D24 recordings that the time from when LSC Cummins took up the position behind the Commodore until he terminated his *attempt to intercept* Mr Di Bartolo's vehicle, was only about 1 minute and 17 seconds. On the other hand, the fact that Mr Di Bartolo did increase his speed from 110 km/h to 150 km/h would indicate there was an attempt to get away from the police.

53. As I said during the course of the inquest, whenever an individual perceives that they are being followed by police, or the police are attempting to intercept them on the road, the police need to be assessing risk in relation to their own safety, that of the other driver and that of the road using public, in the broadest sense.

54. In this case a very clear direction was given by the patrol supervisor of LSC Cummins not to commence a pursuit, and if he was already engaged in a pursuit, to terminate it. Whether or not the attempted intercept, albeit short in terms of duration, is classed as a police pursuit or otherwise, or whether there are technical breaches of the police pursuit policy, is irrelevant from a causal perspective.

---

[8] Finding into Death with Inquest (Stage Two) Police Pursuits – Comments and Recommendations

Was Mr Di Bartolo in custody at the time of his death?

55. Another issues raised by the circumstances in which Mr Di Bartolo died was whether he 'person placed in custody or care' as defined in section 3 of the Act. If he was then an inquest is mandated by section 52(2)(b) of the Act. The potentially relevant clauses of the definition are:

- (f) *a person in the custody of a police officer; or*
- (j) *a person who a police officer is a attempting to take into custody or who is dying from injuries sustained when a police officer...attempted to take the person into custody.*

56. While the Act does not define the meaning of 'attempting to take into custody', the weight of the evidence supports a finding that LSC Cummins was no longer attempting to intercept Mr Di Bartolo at the time he lost control of his vehicle. Of course, one could speculate that even if successfully intercepted, Mr Di Bartolo would not necessarily have been taken into custody.

57. Although there were a significant number of civilian reports of Mr Di Bartolo driving erratically and in a dangerous manner prior to the interception, it appears that Mr Di Bartolo's driving may have been in direct response to the attempted intercept, as he rapidly accelerated to a speed in excess of 150 kph after LSC Cummins activated his police lights. It is entirely possible that Mr Di Bartolo believed he was still being pursued, or would be intercepted in the not too distant future.

58. Of particular significance in this regard, is the collision reconstruction evidence indicating that the vehicle was travelling at an estimated 184 kph when it commenced to yaw. Also significant, is Dr Odell's expert evidence that Mr Di Bartolo's judgement and driving ability would both have been impaired by alcohol and promethazine.

59. Whether or not Mr Di Bartolo thought LSC Cummins was still attempting to intercept him in the moments immediately before the collision and was therefore still trying to evade the police, can only be subject to speculative consideration. In any event, section 3 of the Act is concerned with the *status* of the deceased immediately before death, and not what was on the deceased's mind. This is at best a matter relevant to circumstances.

60. I find on balance that Mr Di Bartolo was not, immediately before death, a person placed in custody or care. Regardless, an inquest was warranted as an exercise of the broader

discretion in section 52(1) of the Act, by virtue of the proximity of the attempted intercept to the collision, the possibility that Mr Di Bartolo believed he was still being 'pursued' by the police and the relevance of the same broad road safety issues as in police pursuits proper.

Mr Di Bartolo's state of mind

61. During the investigation I had hoped to clarify what was going on in Mr Di Bartolo's mind that may have caused or contributed to the way he was driving, prior to any consideration of the police attempting to intercept him.

62. Ms Borderi described Mr Di Bartolo as having a very short fuse generally, and that he would get upset to the point of crying. Two weeks before his death he had expressed frustration to her about not working after finishing a concreting job and was upset about money. Ms Borderi had not seen Mr Di Bartolo drinking that morning, but after his death, discovered some empty old figurines in the garage that had contained alcohol.

63. Mr Biddle did not see Mr Bartolo drink that day, but noticed the smell of alcohol on him while he was in his driveway. Although he did had never spent a lot of time with Mr Di Bartolo, he knew him well enough from having had a number of conversations with him.

64. Mr Biddle believed that Mr Di Bartolo was primarily distraught about money on that day. He spoke of having left one job to go to another job that fell through Mr Bidlle thought that he may have been going to chase money he was owed. Mr Biddle described a man whose moods could change quickly and spontaneously, but that he had never seen him in such a state: 'I've never seen a grown man cry like that, it was just uncontrollable. I mean, it was shocking.'

65. As to what caused Mr Di Bartolo's particular agitation and distress on that day, there is a gap in the evidence that cannot be entirely resolved, despite a comprehensive police investigation and an inquest. However, the available evidence supports a finding that by the time Mr Di Bartolo left home he was in a highly emotional state

Conclusions

66. Having considered the totality of the available evidence, <u>I find</u> that Roberto Di Bartolo born on 12 March 1972 died on 23 August 2013 from multiple injuries sustained in a motor vehicle collision in the circumstances of an accident as described above.

67. <u>I further find</u> that the combination of a highly emotional state, an elevated blood alcohol content and the synergistic effects of promethazine impaired Mr Di Bartolo's judgement and his ability to drive a motor vehicle, and placed him at risk to himself and to other road users.

68. While the possibility remains open that Mr Di Bartolo believed he was still being 'pursued' by the police at the time of the collision, the evidence does not support a finding that this was so, that is, that it is probable that he had this belief at the time when he lost control of his vehicle, immediately before the collision.

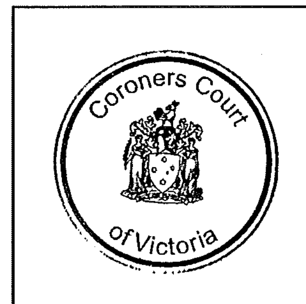
69. The evidence does <u>support a finding</u> that the attempted intercept had concluded at the time of the collision and was of short duration in any event, of the order of 1 minute and 17 seconds. The totality of the evidence, with particular reference to the evidence of the civilian witnesses, <u>supports a finding</u> that LSC Cummins and Sgt Taylor conducted themselves entirely appropriately and reasonably in the execution of their duties, in relation to the situation of exigency created by Mr Di Bartolo's driving on that day.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that a copy of this finding be published on the Internet.

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

- Ms Maria Borderi
- Mr Alessandro Di Bartolo
- Victorian Government Solicitor's Office on behalf of the Chief Commissioner of Police
- Detective Sergeant Colin Schmidt, Coroner's Investigator

Signature:



PARESA ANTONIADIS SPANOS
Coroner
Date: 8 July 2015