IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001375

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Timothy Rhys Cheshire
Date of birth:	25 January 1983
Date of death:	17 March 2019
Cause of death:	1(a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (PASSENGER)
Place of death:	Rochford Road, Lancefield, Victoria, 3435
Keywords:	Motor vehicle collision, criminal proceedings.

INTRODUCTION

1. On 17 March 2019, Timothy Rhys Cheshire (**Mr Cheshire**) was 36 years old when he died in a motor vehicle collision. At the time of his death, Mr Cheshire lived in Kyneton with his mother, Suzanne Cheshire.

2. Mr Cheshire had moved back home after a relationship breakdown and did not have children. He was a bricklayer by trade.

THE CORONIAL INVESTIGATION

3. Mr Cheshire'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.

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Cheshire's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Timothy Rhys Cheshire 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.[1]

8. In considering the issues associated with this finding, I have been mindful of Mr Cheshire'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

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

9. On 19 March 2019, having considered the *Police Report of Death (Police Form 83)*, the Victoria Police *Deceased (Fingerprint) Identification* Report, details supplied during early contact with Mr Cheshire's family, and the Victorian Institute of Forensic Medicine (**VIFM**) Identification Report, I determined the identity of the deceased to be Timothy Rhys Cheshire, born 25 January 1983.

10. In reaching this conclusion I was persuaded by the cogency and consistency of all available evidence relevant to identification.

11. Identity is not in dispute and requires no further investigation.

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

12. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an external examination on 18 March 2019 and provided a written report of his findings dated 8 May 2019.

13. The post-mortem examination revealed external injuries to the face, torso and limbs. No unexpected signs of trauma were seen.

14. A post-mortem computed tomography (**CT**) scan showed significant injuries to Mr Cheshire's chest, abdomen, pelvis and limbs. There were fractures to multiple ribs, the sternum, pelvis, left scapula, both femurs and the left tibia and fibula. Pneumothoraces and pneumoperitoneum were also evident.

[1] 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.

15. Toxicological analysis of post-mortem blood samples showed the presence of diazepam and its metabolite nordiazepam. Ethanol was detected in blood (0.16 g/100 mL) and vitreous humour (0.20 g/100 mL).

16. Dr Young provided an opinion that the medical cause of death was 1(a) multiple injuries sustained in a motor vehicle incident (passenger).

17. I accept Dr Young's opinion.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

18. At some time during the day on 16 March 2019, Mr Cheshire and Daryl Perkins (**Mr Perkins**) visited Sean Sambrooks (**Mr Sambrooks**) at his home. Mr Perkins was 31 years old at the time and had been working as a labourer for Mr Cheshire. Mr Sambrooks was 43 years old at the time and was friends with Mr Cheshire but had not previously known Mr Perkins.

19. Later in the evening, all three men attended the Lancefield Hotel and were captured on CCTV arriving shortly before 6:00 pm.[2] The three men can be seen drinking in the main bar. Hotel staff confirmed that they purchased three Jim Beam and Coke mixed drinks, then three rum and Coke mixed drinks, before moving out to the beer garden.[3] Both Mr Perkins and Mr Sambrooks subsequently purchased more beer for the table over their stay of approximately 40 minutes. Whilst in the beer garden, Mr Perkins can be seen engaging in a physical fight with male patrons at another table. Mr Cheshire can be seen making efforts to break up the scuffle, with limited success, and ultimately the other patrons move inside, leaving the three men in the beer garden. Mr Sambrooks remained seated throughout the incident.[4]

20. Upon being alerted to the altercation, the hotel manager contacted police and requested their attendance. CCTV footage depicts the three men then leaving the hotel at approximately 6:42 pm. A witness to the incident in the beer garden observed the men leave and get into a heavily modified green Holden utility, with one of the men getting into the driver's side and jumping onto the centre console.[5] The hotel manager again called police to advise them that the three men had left the hotel in a green VE ute.

[2] As corrected from inaccurate timestamp displayed on the recording, which was determined to be 1 hour and 9 minutes behind the actual time; Coronial Brief, statement of Detective Sergeant Mark Amos.
[3] Coronial Brief, statement of Kane Williams dated 18 March 2019.
[4] Coronial Brief, Exhibit 5, CCTV footage from Lancefield Hotel.
[5] Coronial Brief, statement of Georgia Jones dated 15 June 2019.

21. At approximately 6:45 pm, witness Ernest Betts was walking along High Street, Lancefield, when he observed a green Holden utility driving towards him, then accelerating heavily. Mr Betts estimated that the vehicle was travelling up to about 100 km/h whilst in the residential area.[6]

22. Witness Iona Hayes was driving back towards Lancefield along the Rochford Road between 6:45 and 6:50 pm when she observed a green vehicle coming fast towards her from her right-hand side. Rochford Road, Lancefield, is a two-way, two-lane undivided road surrounded by paddocks and rural houses. It is designated as a 100 km/h speed zone. It appeared to Ms Hayes that the vehicle was travelling 'way too fast for the road'. She became concerned for her safety because the vehicle was driving 'very erratically' and so pulled over to the side of the road. She estimated that as the vehicle passed her it was travelling 'at least 150 km/h' and observed that the back of the vehicle had drifted across the road towards her.[7]

23. Multiple witnesses confirmed that at this time in the evening the road was dry and the weather was fine.[8]

24. The collision occurred at approximately 6:50 pm. Witnesses Ralph and Suzan Penberthy were eating dinner at their nearby home when they heard a loud bang and ran outside to assist, also calling 000.[9] A passing motorcyclist, Nathan McCartin, also stopped to assist when he came upon a dust cloud and debris spread across the road at the crash site.[10] Mr Penberthy and Mr McCartin found two men with serious injuries outside the vehicle, having been thrown from the vehicle by the force of the collision. The identity of the male resting to the east of the vehicle was later established from documents found at the scene to be Mr Cheshire, while the contents of a wallet enabled the identification of Mr Perkins on the west side of the scene.[11] Mr Cheshire appeared to witnesses to be clearly deceased by the time of their arrival.[12] Mr Penberthy made efforts to release the driver, who was still trapped inside the vehicle, but was unable to because of its mangled condition. On instruction from emergency services call-takers, Mr McCartin assisted the driver to maintain a clear airway and Mr Penberthy

[6] Coronial Brief, statement of Ernest Betts dated 29 March 2019.
[7] Coronial Brief, statement of Iona Hayes dated 27 May 2019.
[8] Coronial Brief, statement of Iona Hayes dated 27 May 2019; statement of Detective Sergeant Robert Hay dated 17 May 2019; statement of Ernest Betts dated 29 March 2019.
[9] Coronial Brief, statement of Ralph Penberthy dated 16 March 2019.
[10] Coronial Brief, statement of Nathan McCartin dated 16 March 2019.
[11] Coronial Brief, statement of Leading Senior Constable Barry Skehan dated 14 June 2019.
[12] Coronial Brief, statement of Ralph Penberthy dated 16 March 2019, statement of Suzan Penberthy dated 15 March 2019; statement of Corey Webb dated 16 March 2019; statement of Leading Senior Constable Barry Skehan dated 14 June 2019.

commenced cardiopulmonary resuscitation (**CPR**) on Mr Perkins. Emergency services personnel arrived a short time later and took over the resuscitation attempts.

25. Sadly, both Mr Cheshire and Mr Perkins died at the scene.

CRIMINAL INVESTIGATION

26. Mr Sambrooks was cut free from the wreckage by State Emergency Services members and transported by air ambulance to the Alfred Hospital, where a blood sample was taken from him approximately 4 hours and 30 minutes after the collision. This sample was later analysed and recorded a result of 0.188% alcohol content. On the basis of this result, forensic physician Dr Angela Sungaila calculated that Mr Sambrooks' blood alcohol level at the time of the collision would have been in the range of 0.233%-0.278%. Dr Sungaila opined that this level of intoxication would have produced a 'gross adverse effect on driving skills' to the extent that Mr Sambrooks 'would have been unable to maintain control of his motor vehicle'.[13]

27. Victoria Police Major Collision Investigation Unit (**MCIU**) members were contacted by first responders and attended the collision scene later in the evening of 16 March 2019. The officers conducted a walkthrough examination, video and 3D scan of the scene, as well as a preliminary examination of the vehicle, which was found to be a 2009 two-door VE model Holden Commodore SS Utility containing seats for two occupants only. The passenger side seatbelt was not extended at all and appeared not to have been worn at the time of the collision.[14] Mr Sambrooks' seatbelt on the driver's side had been cut during rescue efforts and the buckle remained clipped into the stalk.

28. On the basis of tyre marks and damage to the gravel shoulder and roadside vegetation, MCIU members determined that the vehicle had been travelling south-west along Rochford Road, Lancefield. As the vehicle had approached a gentle right-hand bend in the road it had left the sealed road surface to the left-hand side, indicating excessive speed. The vehicle had then rotated in a clockwise direction and travelled approximately 85 metres before the passenger side front of the vehicle struck a tree, ripping it from the ground and causing massive impact damage to the front passenger side, before coming to rest lying on its driver's side on the eastern side of the roadway.[15]

[13] Coronial Brief, statement of Dr Angela Sungaila dated 4 June 2019.
[14] Coronial Brief, statement of Philip Frith dated 8 May 2019.
[15] Coronial Brief, statement of Detective Sergeant Robert Hay dated 17 May 2019; s statement of Philip Frith dated 8 May 2019;

29. Detective Sergeant Robert Hay, a collision reconstruction expert, provided an opinion based on data downloaded from the vehicle's airbag control module that 2.5 seconds prior to impacting the tree the Holden utility was travelling at approximately 196 km/hr.[16]

30. Mechanical Investigator Senior Constable Brett Gardner from the Victoria Police Mechanical Investigation Unit inspected the Holden utility on 7 May 2019 and found no mechanical fault or condition of the vehicle which would have caused or contributed to the incident.

31. On 2 May 2019, Mr Sambrooks was interviewed by police and made a 'no comment' record of interview. He was charged with two counts of culpable driving causing death, as well as associated summary charges relating to driving whilst under the influence.

32. The matter proceeded to a trial commencing on 19 October 2021 in the County Court sitting at Shepparton. Mr Sambrooks pleaded not guilty to the indictable charges, and on 27 October 2021, the jury returned a verdict of not guilty to both charges of culpable driving causing death.

33. The remaining summary charges were remitted to the Kyneton Magistrates' Court for hearing on 31 January 2022, at which time Mr Sambrooks was convicted of exceeding the prescribed concentration of alcohol (PCA) while driving and received a fine of $800 and licence disqualification for a period of 15 months.

FAMILY CONCERNS

34. Mr Cheshire's father, Mr Rowland Cheshire, wrote to me on 28 April 2023 to express his concern about the normalisation of community attitudes to drunk and high-speed driving. Mr Cheshire Snr also pointed to the video and eye-witness evidence of Mr Sambrooks' erratic driving in the minutes prior to the collision, and questioned whether a nuanced assessment of the totality of available evidence might lead to a different conclusion than was reached by the jury in the criminal proceedings.

35. Whilst I am sympathetic to Mr Cheshire Snr's position, and indeed share his concerns about the prevalence of drunk and hoon driving, the purpose of a coronial investigation is to establish the facts surrounding a person's death, and it is not within a coroner's role to lay or apportion blame or determine criminal or civil liability. That being said, an acquittal in the criminal

[16] Coronial Brief, statement of Detective Sergeant Robert Hay dated 17 May 2019.

jurisdiction, with its high standard of proof of *beyond reasonable doubt*, is no bar to a finding made on the *balance of probabilities*, as is required in this Court.

36. In considering these issues, I have had recourse to the transcript of the criminal trial.[17] At trial, Mr Sambrooks gave evidence that at the time of these events he was habitually a heavy drinker, that he could not recall exactly how many drinks he had had on the day of the collision, and that he felt 'not at all' incapacitated' by the alcohol he had consumed. He stated that he felt okay to drive, and that he was the most sober out of the three men at the time of leaving the Lancefield Hotel.[18]

37. Whilst I accept Mr Sambrooks' subjective recall of his state, I am unable to accept that he was objectively in a suitable condition to drive given the blood sample taken from him approximately 4 hours and 30 minutes after the collision recorded a result of 0.188% alcohol content. I am persuaded by the evidence of Dr Sungaila, including her calculation that Mr Sambrooks' blood alcohol level at the time of the collision would have been in the range of 0.233%-0.278%, a level which would have produced a 'gross adverse effect on driving skills'.[19]

38. Mr Sambrooks gave further evidence that shortly into the drive away from the hotel, Mr Cheshire, who was seated on the centre console with one leg either side, 'started playing funny buggers' and 'grabbing the wheel'. Mr Sambrooks described a lot of 'yelling and swearing and carrying on', and Mr Cheshire 'with his right leg putting it in front of mine every now and again' and tapping down on Mr Sambrooks' accelerator foot. Mr Sambrooks' evidence was that he initially thought Mr Cheshire was just 'mucking around', but that as the vehicle exited a bend in the road, Mr Cheshire 'practically had his foot flat' on the accelerator, causing Mr Sambrooks to lose directional and speed control over the vehicle, resulting in the collision.[20]

39. An expert report authored by Dr Shane Richardson, a forensic mechanical engineer called to give evidence by the defence at trial, concluded that:

    a) 'there is a possibility that Mr Cheshire could have pinned Mr Sambrooks' right foot onto the accelerator pedal, therefore accelerating the vehicle beyond Mr Sambrooks'

[17] Section 7 of the Act enjoins a coroner from unnecessary duplication of inquiries.
[18] Trial transcript, 25 October 2021, pp 217-224.
[19] Coronial Brief, statement of Dr Angela Sungaila dated 4 June 2019 at [27].
[20] Trial transcript, 25 October 2021, pp 226-231.

intention and removing speed control of the vehicle from Mr Sambrooks; and that, similarly,

b) 'it could be possible for Mr Cheshire to exert control over the steering wheel of Holden driven by Mr Sambrooks' and hence limiting and/or removing directional control of the vehicle from Mr Sambrooks.'[21]

40. I am unable to be satisfied to the requisite standard as to what happened inside the vehicle shortly prior to the collision, but I am satisfied, to the *Briginshaw* standard of proof, that he voluntarily drove the vehicle, in circumstances where he knew he had been recently drinking alcohol, could not be certain he had restricted his drinking to a safe amount, and knew that two of his fellow passengers were not safely restrained within the vehicle.

FINDINGS AND CONCLUSION

41. 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.[22]

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

a) the identity of the deceased was Timothy Rhys Cheshire, born 25 January 1983;

b) the death occurred on 17 March 2019 at Rochford Road, Lancefield, Victoria, 3435, from MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (PASSENGER); and

c) the death occurred in the circumstances described above.

43. I find that Mr Sambrooks contributed to the death of Mr Cheshire in choosing to drive away from the Lancefield Hotel whilst adversely affected by alcohol, with two unrestrained, also intoxicated, passengers.

44. I extend my sincere condolences to Mr Cheshire's family for their loss.

[21] Amended Report on Collision, prepared by Dr Shane Richardson, dated 1 October 2021.

[22] *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…'.

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

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

Rowland Cheshire, Senior Next of Kin

Suzanne Cheshire, Senior Next of Kin

Terry Perkins, Senior Next of Kin for Daryl Perkins

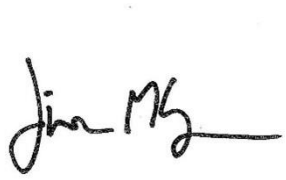
Elsa Perkins, Senior Next of Kin for Daryl Perkins

Sean Sambrooks

Claire Goodall, Transport Accident Commission

Detective Sergeant Mark Amos, Coroner's Investigator

Signature:



SIMON McGREGOR
CORONER

Date: 23 November 2023

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.