IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006933

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Sean David Scott

Delivered On:	26 May 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank VIC 3006
Hearing Dates:	26 May 2023
Findings of:	Coroner Paul Lawrie
Representation:	No appearances
Counsel Assisting the Coroner:	Lauren Bedggood, Senior Coroners' Solicitor
Keywords	Motor vehicle collision, attempted police intercept

I, Coroner Paul Lawrie, having investigated the death of SEAN DAVID SCOTT and having held an inquest in relation to this death on 26 May 2023 at Southbank,

find that the identity of the deceased was SEAN DAVID SCOTT born on 26 November 1985, aged 36 years, and the death occurred on 26 December 2021 at Chiltern-Rutherglen Road, Cornishtown, from:

1a: MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT

I find, under section 67(1) (c) of the ***Coroners Act 2008*** ('the Act') that the death occurred in the following circumstances:

On 26 December 2021, Sean Scott was driving a motor vehicle on Chiltern-Rutherglen Road, Cornishtown when he lost control of the vehicle and collided with a tree. Another male, Samuel Elsom[1], was a passenger in the vehicle also died in the collision. Post-mortem toxicology results indicate that Mr Scott had consumed alcohol and cannabis.

INTRODUCTION

1. On 26 December 2021, Sean David Scott was 36 years old when he died at in a motor vehicle collision at Chiltern-Rutherglen Road, Cornishtown.

THE CORONIAL INVESTIGATION

2. Mr Scott'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.

3. 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.

[1] COR 2021 6934

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Scott's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as eyewitnesses, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence. The coronial brief also contains CCTV recordings which capture certain moments in the lead up to the collision.

6. This finding draws on the totality of the coronial investigation into the death of Sean David Scott including evidence contained in the coronial brief. The brief will remain on the coronial file, together with the inquest transcript.

7. 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.[2]

BACKGROUND CIRCUMSTANCES

8. Mr Scott was born on 26 November 1985 and was 36 years old at the time of his death.

9. Mr Scott did not hold a Victorian driver's license at the time of his death and had never previously been issued with one.

10. On 22 July 2020, Mr Scott was intercepted by members of Victoria Police. He was found to be driving unlicensed and with a blood alcohol concentration of 0.062%. On 4 January 2021, at the Wangaratta Magistrates' Court, he was fined $1,000 in relation to this incident and he was disqualified from being able to obtain a driver's license for six months.

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[2] 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.

11. On 30 November 2021, Kaitlyn Shaw sold her silver 2010 model Holden Cruze sedan, with the registration number KS1993 (the Holden Cruze), to Brian King.

12. On 16 December 2021, Mr King sold the Holden Cruze to Mr Scott. The vehicle was still registered to Ms Shaw at the time it was involved in the fatal incident.

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

Circumstances in which the death occurred

13. On Sunday 26 December 2021, Mr Scott was driving the Holden Cruze in Mulwala, New South Wales. Samuel Elsom, age 30, was seated in the front passenger seat and a German Sheppard dog was also in the vehicle.

14. Shortly before 8.00pm, Leon Kelly and his wife, Stephanie Kelly, observed the Holden Cruze driving along Spring Drive, Mulwala, New South Wales. Mr and Mrs Kelly were travelling with their children in a vehicle going in the opposite direction.

15. Mr Kelly stated that he was driving and observed the Holden Cruze travelling at a fast rate of speed, which he estimated to be over 100 km/h. The Holden Cruze appeared to lose control and veered into the lane Mr Kelly was driving in. Mr Kelly was forced to take evasive action to avoid a collision. The Holden Cruze also took evasive action but did not stop after this incident.

16. Mr Kelly turned his vehicle around and followed the Holden Cruze as it travelled towards Yarrawonga. He attempted to obtain the vehicle's registration whilst Mrs Kelly called emergency services to report the erratic driving. Whilst they were following the Holden Cruze both Mr and Mrs Kelly observed that it was still being driven erratically. Mr Kelly stated it was 'all over the road' and Mrs Kelly described witnessing another incident in Melbourne Road where the vehicle appeared to lose control again and then nearly hit a pedestrian.

17. Mr and Mrs Kelly stopped following the vehicle after it entered Thorn Street, Yarrawonga.

18. At 8.05pm a vehicle matching the description of the Holden Cruze was recorded on closed circuit television (**CCTV**) travelling south on Thorn Street, Yarrawonga.

19. At 8.20pm, Leading Senior Constable Nicholas Rae and Senior Constable Kelsey O'Bryan were conducting divisional van patrol duties in Yarrawonga when they received a 'Keep A Look Out For' job for an erratic driver in the Holden Cruze. They patrolled Thorn Street, Yarrawonga and travelled to Bundalong, approximately 15 km east along the Murray Valley Highway, but could not locate the suspect vehicle. LS/C Rae then drove back towards Yarrawonga.

20. At 8.47pm LS/C Rae and S/C O'Bryan were travelling west towards Yarrawonga on the Murray Valley Highway when their mobile radar was activated with a vehicle travelling towards them at 121 km/h in a 100 km/h zone. At this point they were approximately 6 km east of Yarrawonga.

21. LS/C Rae pulled their vehicle over and activated their blue and red flashing lights to warn the motorist they intended to intercept them. LS/C Rae then observed the vehicle to match the vehicle described in the notification they had received at 8.20pm. After the Holden Cruze passed them, LS/C Rae completed a U turn and followed it, at which point the Holden Cruze started to further increase its speed.

22. LS/C Rae notified police communications that the vehicle was evading them, that it had been travelling at 121 km/h in the 100 km/h zone, and that it was headed towards Bundalong.

23. Immediately after activating the lights on their divisional van, LS/C Rae and S/C O'Bryan observed the Holden Cruze swerve into the opposing lane of the road for no apparent reason. LS/C Rae became concerned for the safety of the occupants of the vehicle and the general public and decided that pursuing the vehicle further would be too high a risk. He switched off the red and blue lights to indicate to the driver that they were no longer in pursuit.

24. LS/C Rae continued to follow the Holden Cruze, whilst remaining at or under the speed limit. During this time, he observed the vehicle swerve into and out of the oncoming lane again and noted it was getting further away. LS/C Rae and S/C O'Bryan followed the Holden Cruze for approximately 6 km before they lost sight of the vehicle. They continued to patrol the area but were unable to locate it.

25. S/C O'Bryan notified police communications that they had lost sight of the Holden Cruze and were no longer following it. She also provided the last known location of the vehicle.

26. At 8.56pm a vehicle matching the description of the Holden Cruze was recorded on CCTV in Main Street, Rutherglen, travelling south-east towards the Chiltern-Rutherglen Road.

27. At 9.01pm LS/C Rae and S/C O'Bryan were dispatched to an unrelated job at Woods Street in Yarrawonga. They arrived at this location at 9.22pm.

28. Brock Ornsby was driving towards Rutherglen at approximately 100 km/h on the Murray Valley Highway between Bundalong and Rutherglen when he observed a silver Holden Cruze. It approached his vehicle from behind at a high rate of speed before it 'aggressively pulled out to the right and overtook [him]. No indicator, no checking for other traffic...' Mr Ornsby estimated that the car was travelling up to 160 to 170 km/h. He observed the car to be 'all over the road, swerving over both lanes and going into the dirt on the left hand side.'

29. Shortly after 9.00pm, Jean Lyons was driving her vehicle along the Chiltern-Rutherglen Road towards Springhurst at approximately 95 km/h when she observed a vehicle come up close behind her. She initially sped up but then 'the driver started to move out to overtake me so I decided if he was happy to overtake then I would just let him go and then I went back to my normal driving speed.'

30. Approximately one to two kilometres later, shortly before 9.17pm, Ms Lyons drove around a sweeping right hand bend in the road and came upon an accident in which a vehicle had collided with a tree. She stopped and went up to the wrecked vehicle. She attempted to get a response from the occupants but heard nothing.

31. Ms Lyons contacted emergency services at 9.17pm. Members of Ambulance Victoria, Victoria Police, and the Victorian State Emergency Service attended a short time later. Mr Scott and Mr Elsom were declared deceased at the scene.

32. Detective Sergeant Jenelle Hardiman from the Major Collision Investigation Unit of Victoria Police attended at the collision scene and conducted an examination and investigation. During this investigation it was noted that both occupants of the vehicle had been wearing seatbelts,

no airbags were deployed, and the hand brake in the car was in the up position, meaning it was engaged.

33. Detective Hardiman concluded that, between 1.5 to 2.5 seconds prior to the collision, the Holden Cruze was in fifth gear and travelling at approximately 142 km/h when Mr Scott lost control of the vehicle. The vehicle commenced rotating anticlockwise and continued off the road to the left where it began to roll, sliding on the driver's side of the car before impacting a tree, roof first, at approximately 128 km/h.

34. Detective Hardiman was unable to determine why Mr Scott lost control of the vehicle. She noted that based on the position of the vehicle at rest, the handbrake could only have been engaged prior to impact. She stated it was possible the loss of control was as a result of hand brake application whilst travelling at speed, however it was also possible that the hand brake had been applied after the loss of control. She noted that tyre marks visible on the road surface could be consistent with a hand brake application but did not contain enough characteristics to determine this with certainty.

35. Chiltern-Rutherglen Road at Cornishtown is a two-way, two lane, undivided road with a single lane in each direction. The road runs generally north to south between Chiltern and Rutherglen. At the area of the road where the incident occurred, the opposing lanes are divided by double white lines. The outer edges of the travelling lanes are marked by single solid white fog lines that run along the edge of the road, and very narrow bitumen shoulders which vary in width up to 0.6 metres. Travelling south, the road had a gentle right curve prior to a short straight section with a gentle grade down slope. The south bound travelling lane was approximately 3.0 metres wide and the north bound lane was approximately 3.3 metres wide. The speed limit was 100 km/h.

36. The road has a bitumen surface which was in excellent condition. There were no obvious faults or features that could have caused or contributed to the incident. There were no overhead streetlights, and the area would be classified as rural. At the time of the incident, the road was dry and the weather was clear.

37. The vehicle involved in the incident was inspected by Victoria Police mechanic, Senior Constable Brett Gardner, on 18 January 2022. He identified no mechanical fault with the vehicle that would have caused or contributed to the collision.

Identity of the deceased

38. On 30 December 2021, Sean David Scott, born 26 November 1983, was identified via fingerprint identification.

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

Medical cause of death

40. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 29 December 2021 and completed a written report of her findings on 7 February 2022.

41. A post-mortem CT scan showed lateral compression of the head due to extensive comminuted fractures of the calvarium and facial skeleton. There were fractures of the left anterior ribs three to five, right anterior fourth rib, posterior right seventh and eighth ribs and small bilateral pneumothorax. There were fractures of the anterior vertebral body of the fifth lumbar vertebra, the dens of the second cervical vertebra, along with dislocation of the fifth and sixth cervical vertebrae.

42. The post-mortem examination showed numerous soft tissue injuries, in keeping with the underlying skeletal trauma.

43. The injuries were of a nature that would have caused rapid unconsciousness and death.

44. The post-mortem toxicology indicated the presence of alcohol (0.20g/100mL) and cannabis (delta-9-tetrahydrocannabinol and 11-nor-delta-9-carboxy-tetrahydrocannabinol).

45. Dr Sanjeev Gaya from VIFM reviewed the toxicology report and noted that the relative risk of a collision is found to rise exponentially as the driver's blood alcohol content (**BAC**) rises. Dr Gaya also noted that cannabis is known to have a profound adverse effect on driving skills. Dr

Gaya stated that the detected concentration of alcohol would have adversely impacted Mr Scott's driving and was at a level where the risk of collision was increased many-fold and where numerous studies have shown significant degradation in critical cognitive skills resulting in impaired driving. With the BAC level identified, Dr Gaya stated that Mr Scott would have been incapable of having proper control of a motor vehicle. Further, if the cannabis had been consumed in the few hours preceding the collision, Dr Gaya noted this would have further compounded the detrimental effect of alcohol on Mr Scott's ability to drive.

46. Dr Archer provided an opinion that the medical cause of death was 1 (a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT.

47. I accept Dr Archer's opinion, and the opinion of Dr Gaya.

FINDINGS AND CONCLUSION

48. Having held an inquest into the death of Mr Scott and having applied the appropriate standard to the available evidence, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008* (Vic):

    a) the identity of the deceased is Sean David Scott, born 26 November 1985;

    b) the death occurred on 26 December 2021 at Chiltern-Rutherglen Road, Cornishtown, from 1(a) multiple injuries sustained in a motor vehicle incident;

    c) the death occurred in the circumstances described above.

49. Having considered the available evidence, including a supplementary statement provided by Detective Senior Constable Samuel Spooner of the Major Collision Investigation Unit, I am satisfied that there was a sufficient gap in time and distance between the attempt to intercept Mr Scott's vehicle by police on the Murray Valley Highway near Yarrawonga and the collision to conclude that the collision did not occur in the context of a police pursuit or an 'extended follow'. I note that the collision occurred approximately 30 minutes after the attempted intercept, at a location approximately 51 km away. Accordingly, I find that the actions of the Victoria Police members were not proximate or otherwise causally connected to the collision.

50. Pursuant to section 73(1) of the Act, this finding will be published on the Internet in accordance with the rules.

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

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

Gilbert Mark and Lynn Scott, Senior Next of Kin

Sergeant Cameron Merrett, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date: 26 May 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 inquest. 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.