



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005390

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Allen Scott
Date of birth:	20 May 1940
Date of death:	11 September 2024
Cause of death:	1a: Head and chest injuries sustained in a motor vehicle incident (passenger)
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004
Keywords:	Medical review and suspension of driver licence; <i>Road Safety Act 1986 (Vic); Road Safety (Drivers) Regulations 2019 (Vic)</i>

INTRODUCTION

1. On 11 September 2024, Allen Scott was 84 years old when he passed away at the Alfred Hospital from injuries sustained in a motor vehicle collision that occurred three days earlier. He was the front passenger of a vehicle driven by a friend.
2. At the time of his death, Allen lived alone in a unit on Agonis Court, Rosebud. He received home care once per week to assist with shopping.
3. Allen is survived by his two daughters, Cara Perera and Elizabeth Scott.
4. The driver responsible for the collision was charged with dangerous driving causing death, failing to give way at an intersection and careless driving on 21 July 2025. Dangerous driving causing death is a serious indictable offence under the *Crimes Act 1958 (Vic)*.
5. The charges against the driver were subsequently withdrawn on the basis that it was not in the public interest to proceed with prosecution and due to the driver's debilitating health condition.
6. The coronial investigation was held in abeyance during the criminal investigation and was resumed after the conclusion of criminal proceedings in January 2026.

THE CORONIAL INVESTIGATION

7. Allen'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.
8. 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.
9. 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.

10. To assist in the coronial investigation, Detective Leading Senior Constable Leigh Nicholds of the Major Collision Investigation Unit prepared a coronial brief, which included the criminal Brief of Evidence in relation to the charges against Louis Spadazzi. The coronial brief was provided to the Coroners Court on 28 January 2026.
11. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to this retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

Inquest not mandatory

12. Section 52(3)(b) of the Act provides that a coroner is not required to hold an inquest where a person has been *charged* with an indictable offence in respect of the death being investigated. As Mr Spadazzi has been charged with an indictable offence, I am not required to hold an inquest into Allen's death.

Decision to make findings in regard to the circumstances of death

13. Section 71 of the Act provides that a coroner is not required to make findings specified in section 67 in respect of a death being investigated by the coroner if the coroner has decided not to hold an inquest because a person has been charged with an indictable offence in respect of the death, and the coroner considers that the making of the findings would be inappropriate in the circumstances.
14. In this matter, I have determined that it is appropriate for me to making findings in relation to the circumstances of Allen's death. This is because, having reviewed the coronial brief, I consider that the making of findings is in the public interest.
15. This finding draws on the totality of the coronial investigation into the death of Allen Scott 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

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.

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

Identity of the deceased

16. On 29 October 2024, Allen Scott, born 20 May 1940, was identified by means of DNA comparison.
17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 16 September 2024 and provided a written report of her findings dated 14 October 2024.
19. The post-mortem computed tomography (CT) scan identified a small right sided subdural haematoma, bilateral lung consolidation, anterolateral rib fractures and findings consistent with natural diseases (pulmonary emphysema, coronary artery calcification).
20. Dr Fronczek provided an opinion that the medical cause of death was 1(a) *head and chest injuries sustained in a motor vehicle incident (passenger)*.
21. I accept Dr Fronczek's opinion as to the medical cause of death.

Circumstances in which the death occurred

22. On the morning of 8 September 2024, Allen travelled with a friend, Mr Spadazzi, from his home on Agonis Court, Rosebud. They travelled in Mr Spadazzi's Honda Civic sedan (**the sedan**) to Safety Beach where they intended to visit a friend.
23. At approximately 10:00am, after leaving Agonis Court, Mr Spadazzi turned left into the eastbound lane of South Road.
24. At about the same time, James Stewart was driving a Toyota HiAce van (**the van**) in the southbound lane of Lonsdale Street towards the intersection with South Road. He described seeing "*a red sedan from [his] peripheral vision*" approaching from his left.
25. The relevant section of South Road was a sealed bitumen road running generally south-west to north-east. Near its intersection with Lonsdale Street, South Road comprised a single traffic lane in each direction, separated by painted white line markings. Lonsdale Street ran generally

north-west to south-east and was also a sealed bitumen road, comprising of multiple lanes in each direction. The speed limit on South Road was 50km/h and on Lonsdale Street was 60km/h.

26. South Road and Lonsdale Street formed a cross intersection near Agonis Court. Traffic exiting Agonis Court onto the northeast bound lane of South Road was controlled by a Give Way line marked across the roadway. Give Way signs were also positioned on the splitter islands on either side of the approach.
27. Upon approaching the Give Way line, Mr Spadazzi did not stop or give way and drove into the intersection. Before Mr Stewart could react, the sedan was in front of him. He attempted to steer the van away to avoid a collision, but the van collided with the front passenger side of the sedan (T-bone). The impact pushed both vehicles off the road, where they came to rest to the east of the intersection on the grass reserve.
28. Several eyewitnesses stopped to render assistance and called emergency services. With their assistance, Mr Stewart was able to extricate himself from the van.
29. Ambulance Victoria paramedics arrived at the scene shortly afterwards and extricated Allen and Mr Spadazzi from the sedan. Victoria Police and Fire Rescue also attended. While attending to Allen and Mr Spadazzi, police observed that their seatbelts remained intact; however, the airbags had not deployed.
30. Paramedics conveyed Allen and Mr Stewart to Frankston Hospital and Mr Spadazzi to Dromana Hospital. Later that evening, Allen was transferred to the Alfred Hospital for ongoing management, where he was admitted to the Intensive Care Unit (ICU). On admission, clinicians identified a right parietal subdural haematoma with intact neurology and left-sided rib fractures involving ribs 2 through 6, with a trace haemothorax.
31. Before admission to the ICU, clinicians discussed Allen's goals of care with him. He indicated that he valued a functional recovery and wished to avoid high level of care following discharge. He agreed that escalation to intubation and cardiopulmonary resuscitation would not achieve the clinical outcomes he wanted.
32. In the following days, Allen developed drowsiness and delirium and continued to deteriorate. After a multidisciplinary meeting on 11 September 2024, clinicians decided to transition Allen to end of life care, consistent with his goals of care.

33. Allen was palliated and passed away at 3:05pm on the same day.

Police investigation

34. While Mr Spadazzi and Mr Stewart were admitted to hospital, police obtained blood samples from both individuals for analysis. The analysis did not detect the presence of alcohol or any illicit substances.
35. Senior Constable Daniel Pearce (**SC Pearce**) of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) conducted a mechanical inspection of the sedan. SC Pearce did not find any faults, failures, or conditions with the vehicle that could have caused or contributed to the collision.
36. Detective Leading Senior Constable Michael Hardiman (**DLSC Hardiman**) from CRMIU attended the examined the scene and conducted a collision analysis. In his analysis, he considered the vehicle positions, post-impact movement and the speed of the vehicles.
37. DLSC Hardiman did not identify any obstructions that limited the sedan's driver (Mr Spadazzi) to see the approaching van. He further concluded that he was unable to calculate the speed of the sedan or the van. However, based on his experience and the damage sustained by both vehicles, he opined that the sedan and the van were not travelling in excess of the speed limit at the time of the collision.
38. Police did not identify any other factors, including distraction or fatigue, as having caused or contributed to the collision.

MR SPADAZZI'S DRIVING HISTORY AND LICENCE STATUS

39. At the time of the collision, Mr Spadazzi was aged 91 and his Victorian driver's licence was suspended. His licence was previously subject to a condition that he wear glasses or corrective lenses while driving. While in force, the licence was due to expire on 18 October 2024.
40. Since November 2018, VicRoads required Mr Spadazzi undergo regular medical reviews.
41. In March 2022, Mr Spadazzi became due for a medical review. On 3 March 2022, VicRoads sent him correspondence requesting that he provide a medical and an eyesight report. The correspondence advised that he must provide both reports by 28 April 2022 and that his driver's licence would be suspended on 12 May 2022 if VicRoads did not receive both reports by that date.

42. On 23 March 2022, VicRoads' Medical Review team received Mr Spadazzi's eyesight report, which confirmed his vision met the national medical standards for licensing. On 2 April 2022, the Medical Review team sent Mr Spadazzi a courtesy reminder. The correspondence included:
- an acknowledgement of the receipt of the eyesight report;
 - advice that VicRoads had removed the licence condition requiring him to wear corrective lenses while driving; and
 - that the driving limit (8-kilometre radius of Mr Spadazzi's home) remained in place.
43. The correspondence also noted that the medical report was due on 28 April 2022 and that his licence would be suspended on 12 May 2022 if VicRoads did not receive the report.
44. On 12 May 2022, Mr Spadazzi's driver licence was suspended because he did not provide the requested medical report.² VicRoads confirmed that it did not send any further correspondence or notice regarding the suspension after the courtesy reminder.
45. On 28 August 2022, police intercepted Mr Spadazzi whilst he was driving and informed him that his licence was suspended. They charged him with driving whilst suspended but later withdrew the charge on the basis that it was not in the public interest to proceed with prosecution.

Mr Spadazzi's understanding of licence status

46. As noted above, Mr Spadazzi was charged with driving offences arising from the fatal collision.
47. As part of the ensuing criminal investigation arising from the driving offences, Mr Spadazzi participated in a police interview. During that interview, he was asked about his understanding of the status of his driver licence. Mr Spadazzi stated that he believed he was permitted to drive.

² Pursuant regulation 79(1) of the *Road Safety (Drivers) Regulations 2019 (Vic)*. Under regulation 79(1), the Secretary of Department of Transport and Planning must vary, suspend or cancel the driver licence or learner permit of a person who is required by the Secretary under section 27 of the *Road Safety Act 1986 (Vic)* to undergo a test or assessment in relation to their knowledge of road law or driving ability if the person—

(a) refuses or fails to undergo the test or assessment; or
(b) does not pass the test or assessment.

48. In explaining his belief, Mr Spadazzi stated that, after he was intercepted by police on 28 August 2022 and informed that he was driving whilst suspended, he subsequently received a notice to appear in the Dromana Magistrates' Court in relation to that offence. When his matter was called, he alleged that "*a Sergeant lady*" took possession of his physical driver's licence. Although Mr Spadazzi did not identify the individual by role, it appears likely that he was referring to the police prosecutor involved in the proceedings. He further alleged that after he was informed that the charges were withdrawn on the same day, the prosecutor returned the physical licence to him. It remains unclear whether the prosecutor or court staff informed him at the time that his licence remained suspended when his driver's licence was returned to him.
49. Mr Spadazzi also described subsequent interactions with VicRoads concerning his driver's licence. He stated that sometime in September 2024, he attended a VicRoads customer service centre to renew his vehicle's registration. He said he also attempted to renew his licence but was advised by a staff member that he was one month too early. There is no indication that the staff member checked the status of his licence, which remained suspended at the time.
50. In relation to the medical and eyesight reports required as part of his March 2022 medical review, Mr Spadazzi stated that he had submitted both reports and allegedly had received confirmation from VicRoads that they have been received. He further alleged that he was subsequently "*issued with a licence*". Mr Spadazzi stated that he was unaware that his licence remained suspended "*because [his] licence was handed to [him] twice*". On that basis, he said he formed the impression that he remained authorised to drive at the time of the collision, particularly as his licence bore a further expiry date.

FINDINGS AND CONCLUSION

51. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Allen Scott, born 20 May 1940;
 - b) the death occurred on 11 September 2024 at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from head and chest injuries sustained in a motor vehicle incident (passenger); and
 - c) the death occurred in the circumstances described above.
52. Having considered all of the circumstances, I am satisfied that Allen's death was a result of the collision caused by Mr Spadazzi, who failed to give way at the South Road and Lonsdale

Street intersection. At the time of the collision, Mr Spadazzi was also driving whilst his driver licence was suspended.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments:

53. Under regulation 79(1) of the *Road Safety (Drivers) Regulations 2019 (Vic)* (**the RS(D)R**), the Secretary of the Department of Transport and Planning may suspend a driver licence where a person fails to comply with a requirement prescribed in section 27 of the *Road Safety Act 1986 (Vic)* (**the RSA**) to undergo a test or an assessment to determine their fitness to drive. Further, regulation 82(2)(e) of the RS(D)R provides that in such circumstances, the Secretary is *not* required to give written notice of suspension.
54. By contrast, under section 24 of the RSA, where a suspension arises from a specific administrative decision of the Secretary, written notice of that decision is ordinarily required. Mr Spadazzi's circumstances are distinguishable as his licence was suspended pursuant to regulation 79 of the RS(D)R. In those circumstances, the suspension operates by force of the regulation upon the occurrence of the prescribed condition, rather than as a result of a separate decision of the Secretary and accordingly does not depend on the provision of a separate written notice of suspension.
55. Accordingly, the current legislative framework permits a driver's licence to be suspended in certain medical review cases such as Mr Spadazzi's, without requiring written notice to the driver. Unlike a suspension effected by written notice under section 24 of the RSA, the framework does not require the surrender of a physical or digital licence in these circumstances. Further, while the RSA recognises both physical and digital licence, it does not require surrender or deactivation of either form of licence where a suspension continues under regulation 79.
56. In these circumstances, a driver receives no further notification that their licence remains suspended and continues to retain possession of both their physical licence and digital licences. In a case such as Mr Spadazzi's, this creates a real risk that a driver may reasonably albeit mistakenly form the impression that their licence remains valid, particularly where they continue to hold a licence (in physical or digital form) and receive no further communication from VicRoads.

57. Irrespective of whether Mr Spadazzi's asserted belief was genuinely held, the evidence in this matter raises a broader systemic concern that the current legislative framework may create a risk of confusion for drivers whose licence remains suspended following medical review. This risk may be particularly acute for older drivers, or for those with diminished capacity to navigate administrative processes.

RECOMMENDATIONS

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

- (i) That the Victorian **Department of Transport and Planning** consider implementing additional administrative measures to improve awareness of driver licence suspensions arising from non-compliance with medical assessment requirements. In particular, consideration should be given to ensuring drivers are provided with clear and timely written correspondence regarding any suspension, including explicit advice that the driver is not permitted to drive, irrespective of whether they retain possession of a physical or digital licence.

I convey my sincere condolences to Allen's family and friends for their loss.

Pursuant to section 73(1A) 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:

Cara Perera, Senior Next of Kin

Department of Transport and Planning

VicRoads

Detective Leading Senior Constable Leigh Nicholds, Coronial Investigator

Signature:



Judge Liberty Sanger, State Coroner

Date: 07 October 2026

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.
