Findings of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Scott Roderick Glanville

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Scott Roderick Glanville, with an inquest held at Devonport in Tasmania, make the following findings.

Hearing date

22 July 2022

Representation

S Nicholson - Counsel Assisting the Coroner

N Everett – Counsel for Mrs C Glanville

Introduction

1. Mr Scott Roderick Glanville was born on 3 July 1962 in Wynyard in Tasmanian and died on 25 June 2019 on Frankford Road in Harford, Northern Tasmania. Mr Glanville is survived by his wife, Cindy Glanville, and children Antonia, Nicholas and Samuel.

2. Mr Glanville was an electrician by trade. In August 2018, he commenced working for Shane Hill Electrical, based in Devonport. His employer provided him with a white Mitsubishi van, registration number A87VU. The van had "Shane Hill Electrical" emblazoned on the rear and side of the vehicle.

3. Mr Glanville drove the vehicle daily from his home. The vehicle was recently serviced on 21 June 2019 (which appears to have been arranged by Mr Hill). He died when he was on his way to work in the van. The evidence indicates Mr Glanville lost control of his vehicle in a patch of 'black ice' as he travelled west on the Frankford Highway, which runs more or less east west between Exeter and Port Sorell.

4. His vehicle rolled, but Mr Glanville was only slightly injured. As he waited by the side of the road another vehicle – a Mazda BT 50 flat tray utility, driven by Mr Jack Austin - hit the same patch of black ice and left the road. It also rolled and hit Mr Glanville's vehicle. Mr Glanville was also struck in the crash. He received massive, un-survivable injuries and died at the scene.

The coronial jurisdiction and role

5. Before considering the circumstances of Mr Glanville's death it is necessary to say something about the role of the coroner, and the attendant powers and obligations. In Tasmania, a coroner has jurisdiction to investigate any death that "occurs at, or as a result of an accident or injury that occurs at, the deceased person's place of work, and does not appear to be due to natural causes".[1] Mr Glanville's death meets this definition. The *Coroners Act* 1995 also provides that where a person dies as a "result of an accident or injury that occurred at his or her place of work, and the coroner is not satisfied that the death was due to natural causes", an inquest is mandatory.[2] The requirement to hold an inquest in workplace death cases is subject to a statutory exception. The exception is that if the Senior Next of Kin of a deceased person who died as a result of injuries suffered at work asks a coroner not to have an inquest then, provided the coroner is satisfied that it would "not be contrary to the public interest or the interest of justice", an inquest can be dispensed with.[3] No such request was made in this case. Accordingly, an inquest was held into Mr Glanville's death. I note that an inquest is a public hearing.[4]

6. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. The coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death. The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

7. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

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[1] Section 3 *Coroners Act* 1995.
[2] Section 24 (1)(ea).
[3] Section 26A.
[4] Section 3.

8. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[5] 'How' has been determined to mean *"by what means and in what circumstances"*, a phrase which involves the application of the ordinary concepts of legal causation.[6] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

9. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*,[7] that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.

10. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness. A coroner must ensure that any person (and person includes any legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

Evidence at the inquest

11. Two witnesses were called to give evidence at the inquest:

    a) Mr Jack Austin; and

    b) Constable Sven Mason, the Police crash investigator.

12. In addition, a number of affidavits and documents were tendered. A complete list of the exhibits appears at the end of this finding marked 'Annexure A'.

Circumstances of Death

13. On the basis of the evidence at the inquest make the following findings of fact. At between 6.30 and 6.45am on 25 June 2019, Mr Glanville left his home at Legana in the Mitsubishi van. It was his intention to drive to Devonport, as he often did, and routinely would travel on the Frankford Highway. As he was travelling on Frankford Road between Saxon's Creek and Dalgarth Road, the van rolled on ice.

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[5] Section 28(1)(b).
[6] *March v Stramare* (E&MH) Pty Ltd (1991) 171 CLR 506.
[7] (1938) 60 CLR 336, in particular the judgment of Dixon J (as he then was) at 362.

14. Mr Glanville was able to extricate himself from his vehicle and appears to have been, relatively speaking, injured. At around 7.09am, he rang Mr Hill and told him that he had just rolled the van on a large patch of black ice. Mr Glanville reported that he was "*a bit battered and bruised*" but otherwise okay. Mr Hill told him that he would come out and pick him up shortly.

15. Mr Glanville was seen by a passing motorist Mr Ken Smith around this time, walking on the edge of the west bound lane, giving a thumbs up to the passing vehicle.

16. Mr Jack Austin and Mr Ron Buckingham were also travelling west on Frankford Road that morning from Glengarry towards Baker's Beach in a silver Mazda BT 50 flat tray, registration number H59YV (i.e. in the same direction that Mr Glanville had been travelling). On the tray of the Mazda was a fuel tank containing diesel fuel for use by plant at the quarry where Mr Austin and Mr Buckingham worked. Mr Austin was driving and noticed that there was some ice on the road.

17. They crossed Saxon's Creek, travelled up a slight hill and into a left hand corner. As they were travelling through the corner the back of the Mazda BT 50 started to slide and they saw the Mitsubishi van on its side.

18. Mr Paul Lambeth was driving in the opposite direction and observed the BT 50 to slide out (on its right). He observed that the Mazda slid off to its left onto the grass embankment, and flipping up onto its nose. The Mazda rolled to the left of the road and came to a stop.

19. Mr Lambeth assisted Mr Austin and Mr Buckingham to get out of the Mazda. He noticed that the road was very slippery when he crossed it.[8]

20. Mr Arron Reeve was driving from Glengarry to Shearwater on the Frankford Road. He was waved down by Mr Lambeth, stopped his car and ran to the scene before ringing 000. He found Mr Glanville half lying, half curled up with his head near the under carriage of the van. Mr Lambeth observed that Glanville's shirt was distorted and wrapped into the under carriage.

21. Despite their very best efforts, neither Mr Lambeth nor Mr Reeve were able to find a pulse[9]. They alternated performing CPR with Mr Buckingham as directed by 000 until the ambulance arrived. Ambulance paramedics found Mr Glanville to be initially asystole but with management were able to establish periods of pulseless electrical

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[8] Exhibit C12.
[9] *Supra*, and exhibit C13.

activity and ventricular fibrillation. However, ultimately Mr Glanville was unable to be revived and was pronounced dead at the scene.

Investigation

22. Mr Glanville's body was identified at the scene and then taken by mortuary ambulance to the Royal Hobart Hospital. At the mortuary of the RHH experienced forensic pathologist Dr Donald Ritchey performed an autopsy. Dr Ritchey produced a report after autopsy which was tendered at the inquest.[10] In his report, Dr Ritchey expressed the opinion that the cause of Mr Glanville's death was blunt trauma of the head. He found significant injuries had been sustained including basal skull fractures, fractures of the left side of the maxilla and mandible, widespread scalp contusions, and widespread subarachnoid haemorrhage. Mr Glanville had also suffered significant blunt trauma of chest.

23. The head injury sustained by Mr Glanville which included severe internal bleeding surrounding his brain would, in my view, have caused rapid, if not immediate, death.

24. Samples taken at autopsy were analysed at the laboratory of Forensic Science Service Tasmania. No alcohol or illicit drugs were identified as having been present in Mr Glanville's body at the time of his death.[11]

25. Meanwhile investigations in relation to other aspects of Mr Glanville's death were carried out by police. Mr Austin was subject to the usual post-crash blood testing. An analysis of blood taken from showed neither alcohol nor drugs to have been present at the time he lost control of the vehicle of his vehicle on the Frankford Highway.

26. The Mazda BT 50 utility Mr Austin was driving was inspected by a Transport Safety and Investigation Officer. That Officer, Mr Philip Evans, is a qualified motor and diesel mechanic with over 35 years' experience in that particular field. Mr Evans swore an affidavit which was tendered at the inquest.[12] In his affidavit Mr Evans expressed the opinion, which I accept, that at the time of the crash the Mazda BT 50 utility was mechanically sound and roadworthy. I am satisfied that mechanical deficiency neither caused nor contributed to the circumstances which led to Mr Glanville's death.

27. A detailed investigation of the scene of Mr Glanville's tragic death was carried out by Constable Sven Mason, a transport crash investigator with Tasmania Police. Constable

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[10] Exhibit C5.
[11] Exhibit C6.
[12] Exhibit C9.

Mason gave comprehensive evidence at the inquest which was not challenged and which I accept.

Conclusions

28. Constable Mason's evidence leads me to conclude that Mr Glanville's vehicle hit a patch of "black ice" and left the road. It seems clear enough Mr Glanville suffered only superficial injuries as a result of that incident. He was well enough to bring his boss Mr Hill and arrange to be picked up.

29. Mr Austin's vehicle hit the same patch of black ice and roughly following the same path after hitting the ice also left the road and rolled. As that occurred the Mazda BT 50, or more likely a fuel tank on the tray of it, struck and killed Mr Glanville as he waited by his vehicle. I note the 200 litre drum of diesel which was on the tray of the Mazda BT 50 immediately prior to the crash was, according to Mr Austin, full. Accordingly it weighed in excess of 200 kg. The tank was secured to the tray of the Mazda BT 50 by a ratchet strap. That method of securing the tank was, as Constable Mason pointed out, perfectly adequate while the vehicle was travelling normally. Once the vehicle began to roll however it proved incapable of ensuring that the tank did not leave the tray.

30. I note that as at 25 June 2019, Mr Austin was aged 18 years and was the holder of a first year provisional driver's licence. Necessarily he was relatively speaking an inexperienced driver. However, there is no evidence to suggest his inexperience caused or contributed to the crash. I note Mr Glanville was a very experienced driver, who had participated recreationally in rally driving[13], however, both hit the same patch of black ice with the same result.

31. I note that there is no evidence of Mr Austin was speeding or otherwise driving inappropriately.

32. I am satisfied that neither drugs nor alcohol played no role in the crash which caused Mr Glanville's death.

33. Finally, apart from the presence of black ice on the road, something not particularly surprising considering the time of day and year, there was nothing about the surface of the road or weather conditions which caused or contributed to Mr Glanville's death.

[13] See exhibit C18, affidavit of Cindy Glanville, sworn 15 July 2019, and page 1 of 3.

Formal findings

34. Pursuant to section 28 of the *Coroners Act* 1995 I make the following formal findings on the basis of the evidence at the inquest:

    a) The identity of the deceased is Scott Roderick Glanville;

    b) Mr Glanville died in the circumstances set out in this finding;

    c) The cause of Mr Glanville's death was blunt trauma of head; and

    d) Mr Glanville died on 25 June 2019 on Frankford Road near Harford, in northern Tasmania.

Conclusion and comments

35. The circumstances of Mr Glanville's death do not require me to make any recommendations or comments pursuant to section 28 of the *Coroners Act* 1995.

36. In conclusion I wish to express my sincere and respectful condolences to his family on their loss.

Dated: 2 September 2022 at Hobart in the State of Tasmania

Magistrate Simon Cooper
Coroner

Annexure A

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	Police Report of Death for the Coroner	Sergeant Nicholas Patten
C2	Affidavit of Life Extinct	Dr Nicholas Scott
C3	Affidavit of Identification	S Hill
C4	Affidavit of Identification	Colin O'Connor, Mortuary Ambulance
C5	Autopsy Report	Dr Donald Ritchey
C6	Toxicology Report	Dr Neil McLachlan-Troup
C7	Blood Sample Analysis Report	Juliette Tria, FSST
C8	VACIS Patient Care Report	Ambulance Tasmania
C9	Transport Inspector Report	Philip Evans
C10	Affidavit	Sage Hobbins
C11	Affidavit	Kenneth Smith
C12	Affidavit	Paul Lambeth
C13	Affidavit	Arron Reeve
C14	Affidavit	Troy Wells
C15	Affidavit	Shane Hill
C16	Affidavit	Ronald Buckingham
C17	Affidavit	Jack Austin
C18	Affidavit	Cindy Glanville
C19	Affidavit	Constable Sven Mason
C20	Affidavit & Photographs (Scene)	Constable Dean Wotherspoon

C21	Affidavit & Photographs (Van)	Constable Robert Oberrauter
C22	Affidavit & Photographs (Ute)	Constable Robert Oberrauter
C23	Affidavit & Photographs (Work Shirt)	Sergeant Alastair Watson
C24	Video Reconstruction of Crash	Constable Robert Oberrauter
C25 A	Crash Scene Survey Plan 1	Constable Sven Mason
C25 B	Crash Scene Survey Plan 2	Constable Sven Mason
C25 C	Crash Scene Survey Plan 3	Constable Sven Mason
C25 D	Crash Scene Survey Plan 4	Constable Sven Mason
C26	Report on Crashes	Department of State Growth
C27	Supplementary Affidavit (12.09.2021)	Constable Sven mason