

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2013 4636

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

I, AUDREY JAMIESON, Coroner having investigated the death of BRADLEY ALAN SCOTT without holding an inquest;  
find that the identity of the deceased was BRADLEY ALAN SCOTT  
born on 10 April 1970  
and the death occurred on 13 October 2013  
at 7 Brook St, Wonthaggi

**from:**

1 (a) INCISED RIGHT RADIAL ARTERY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Mr Bradley Scott<sup>1</sup> was 43 years old at the time of his death and lived by himself in Brook St, Wonthaggi. Bradley had joint custody of his daughter, Angel, who stayed with him on alternate weekends.
2. Bradley's extended family lives in Oaks Flat, NSW, and his younger sister Samantha would visit him up to twice a year and spoke to him on the telephone regularly.
3. Bradley was on a disability pension due to a work injury. He had a medical history of diabetes and was a chronic alcoholic, who was known to drink heavily on a daily basis.
4. Bradley was located deceased by police on the front lawn of his house at approximately 9:30am on 13 October 2013.
5. Bradley had been seeing a counsellor regarding his drug and alcohol dependence and on the day of his death various prescribed medications were located in his house including Betamin<sup>2</sup>, Antenex<sup>3</sup> (diazepam) and Baclofen<sup>4</sup>

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<sup>1</sup> Referred to in my finding as Bradley

<sup>2</sup> Used to treat Vitamin B1 deficiency

<sup>3</sup> Used in the treatment of anxiety and acute alcohol withdrawal

6. Following his death Bradley's friends told Samantha's partner that Bradley had been in a state of rapid mental decline in the two to three weeks prior to his death, and that his drinking had increased dramatically. Bradley had also got into a fight at a pub in Wonthaggi the week before he died.

### **Investigation**

7. The purpose of a coronial investigation into a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.<sup>5</sup> In the context of a coronial investigation it is the medical cause of death together with the context of background and the surrounding circumstances of death, which are proximate and causally relevant to the death.
8. The circumstances of Bradley's death have been the subject of investigation by Victoria Police on my behalf.
9. The Coroner's Investigator, Detective Senior Constable Daniel Mason, prepared a coronial brief of evidence comprising a range of evidentiary material with witness statements and visual material.
10. As police had had recent contact with Bradley prior to his death a member from the Victorian Homicide Squad, Detective Sergeant Graham Ross, assisted with the investigation which was overseen by Professional Standards Command (PSC).
11. In August 2015, after considering all the available evidence, I determined that it would not be necessary to hold an inquest to assist me with my investigation of Bradley's death.

### Events of 12-13 October 2013

12. At approximately 1:51pm on 12 October 2013, Bradley's friend Timothy Brind contacted Bradley via SMS. Bradley went to Timothy's home at approximately 2:00pm that afternoon.
13. While at Timothy's house Bradley and Timothy smoked a bong together, having about three pipes each containing marijuana and tobacco, and at approximately 4:30pm they went to the Aldi store in Wonthaggi where they purchased two 750ml bottles of tawny port.
14. After consuming the two bottles of port with dinner Bradley and Timothy went back into town and purchased a further cask of tawny port. CCTV footage from Safeway Liquor depicts Bradley purchasing the cask of port at approximately 7:57pm.
15. At approximately 10:30pm others who were staying at Timothy's house, Melanie Phillips and Damien Ireland, went to bed whilst Bradley and Scott continued to drink the port.
16. Timothy lost count of how many drinks they had, but did notice that Bradley was quite drunk. Timothy invited Bradley to stay at his place and made a bed for him, but Bradley refused as he

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<sup>4</sup> Used as a muscle relaxant and in the treatment of alcoholism

<sup>5</sup> Section 67(1) of the *Coroners Act 2008*

wanted to go home. Timothy tried again to get him to stay, but Bradley was adamant that he wanted to go home.

17. Bradley left Timothy's home on foot some time before 2:30am.

#### Contact with police

18. CCTV footage from the Wonthaggi Workmen's Club (75 Graham Street) captures Bradley at approximately 1:48am as he walks past the front of the Club. Bradley appears to be somewhat unsteady on his feet and staggering slightly. A police divisional van is observed in the footage to drive past in the opposite direction and Bradley watches the van.
19. At approximately 1:57am CCTV footage at the Wonthaggi Hotel (on the corner of Murray and McBride streets) captures Bradley crossing the street and stopping near the corner of the hotel building. Bradley is then seen to move along McBride Street stopping at a doorway to pick something up from the ground.
20. At approximately 1:59am CCTV footage at the Wonthaggi Club (16 McBride Street) captures Bradley moving along McBride Street, looking into rubbish bins and picking up something from the ground.
21. The police who had passed in the divisional van, Constables Goff and Whyte, had seen Bradley bending down and picking things up from the ground. Later in their patrol, at approximately 2:10am, Constable Whyte observed Bradley again, sitting outside the Whistle Stop Bakery. Constable Whyte asked Constable Goff to do a U-turn to see if it was the same male he had seen earlier as he thought it was odd that he was sitting there by himself late at night.
22. Constables Goff and Whyte got out of the van to speak to Bradley and saw that he was siphoning tobacco out of other people's cigarette butts he had collected. Bradley was not bothered by their presence and continued to extract tobacco from the cigarettes.
23. Constable Whyte had never met Bradley before this interaction and observed that he was alcohol affected. He described Bradley as quietly spoken and slurring his words. Constables Whyte and Goff both observed that Bradley was drunk, but that he was co-operative and compliant.
24. Due to Bradley's bodily movements, his dexterity with the cigarettes and communication Constable Whyte did not think that he had to be taken to hospital, or be arrested for being drunk.
25. Constable Whyte asked Bradley how he was getting home and he indicated he didn't know and that he might walk as he didn't have any money for a taxi.
26. In Constables Goff and Whyte's opinion as Bradley's behaviour did not warrant an arrest he was offered a lift home. Both officers state that Bradley voluntarily got into the divisional van, a single cab utility with a pod on the back.

27. In CCTV footage from the Wonthaggi Club a police divisional van can be seen to stop outside the bakery, park and leave shortly afterwards.
28. The running sheet compiled by Constable Whyte on the night indicates that they spoke to Bradley at 2:12am, when he was put in the divisional van. At 2:14am Bradley was dropped at his home address and they recorded leaving the address at 2:17am.
29. A map of the Wonthaggi area illustrates that it would be an approximate 3 minute drive between the Whistle Stop Bakery in McBride Street to Bradley's home address.

#### Events at 7 Brooks St, Wonthaggi

30. At approximately 4:15am on the morning of 13 October 2013 a neighbour drove past Bradley's address and observed what she described as a person sitting on the front lawn with their feet pointing up, slumped forward. This neighbour did not observe anyone else around at the time.
31. At approximately 9:30am another neighbour observed a person lying on his back on his front lawn and immediately contacted '000'.
32. Michael Stead, the second neighbour, recognised it was Bradley when he walked over. He observed a large semi-circular cut on Bradley's right forearm and that the blood he saw on the ground near Bradley did not look too fresh.
33. Emergency Services Telecommunications Authority's report shows an event was created at 9:26am, and a call-back is recorded from the neighbour at 9:29am stating that the patient is beyond help and that he has slash marks to his wrist that looks to have been there for a period of time.
34. An Ambulance Unit attended at 9:32am and confirmed that Bradley was deceased with no further treatment or action taken.

#### Police investigations

35. The police's initial examination of the scene located a significant amount of blood around the door of Bradley's home, on a broken door frame and on the lawn. A significant amount of blood was evident across the front door frame and door mat indicating that Bradley was possibly attempting to enter the front door. Bradley's phone was located on the front door mat and there were blood smears on the door handle and lock of the security door. There was no blood located anywhere inside the premises.
36. Photographs of the scene show Bradley is not wearing any shoes, and it appears he may have removed them at the door step. It appeared that Bradley has then stumbled and fallen onto the wooden/glass doorframe that was propped alongside the pathway near his front door, shattering the glass.

37. Detective Sergeant Graham Ross from the Homicide Squad, once he became aware that Bradley had been conveyed to his home address by police, decided to treat the matter as death following recent police contact and informed PSC accordingly. Statements were obtained by Constables Goff and Whyte by members of the Homicide Squad, overseen by PSC members.
38. Once the forensic pathologist indicated he was satisfied that Bradley had died from injuries to the wrist the investigation remained with the Wonthaggi police members, pending the outcome of the autopsy.

#### Forensic pathology

39. Associate Professor David Ranson conducted a medical examination of Bradley Scott on 14 October 2013 at the Victorian Institute of Forensic Medicine. Associate Professor Ranson identified recent superficial skin loss on the back of Bradley's right foot, and similar superficial abrasions on the right hand, right hip, left forearm and left ankle. A scabbed abrasion was present above the right eyebrow and the right forehead and a superficial abrasion was also present on the forehead.
40. Associate Professor Ranson noted other minor injuries including two areas of local bruising to the front of the abdomen and a number of old partly scarred and partly scabbed abrasions over the body, particularly over the feet. None of the other areas of mild superficial abrasion were associated with significant bruising.
41. Associate Professor Ranson found evidence of extensive natural disease with very severe hepatic cirrhosis.
42. Associate Professor Ranson reported that Bradley's right wrist and forearm was extensively dissected and most of the superficial tendons across the front of the right wrist had been incised in association with the external skin injury. In addition to the tendons other deep structures were severed including muscles and the radial artery. Deep dissection of the incised injury over the front of the right wrist revealed that the injury extended through the joint capsule of the wrist.
43. Associate Professor Ranson observed that incised wounds to the radial artery and the superficial veins would result in considerable blood loss if the bleeding were uncontrolled. In a situation where a person may be intoxicated and unable to protect or control haemorrhage from an artery or seek immediate attention, death may occur as a result of blood loss.
44. Associate Professor Ranson makes further comment that the combined effects of the level of alcohol, sedating drugs and cannabis found on the toxicological tests would cause a significant degree of motor impairment capable of affecting an individual's decision making ability.
45. Associate Professor Ranson concluded a reasonable cause of death was: 1(a) Incised right radial artery.

### Toxicological report

46. Toxicological analysis identified ethanol in the blood at 0.17g/100mL. Cannabis and the following medications: Diazepam, Nordiazepam<sup>6</sup>, Venlafaxine, Desmethylvenlafaxine and Mirtazapine<sup>7</sup> were also identified.
47. It is noted that blood alcohol content in excess of 0.15% can cause considerable depression of the Central Nervous System (CNS) affecting cognition and that other drugs capable of depressing the CNS will increase the effects of benzodiazepines and opiates.

### Police protocols regarding transporting individuals

48. Considering the nature of the police interaction with Bradley on the evening before his death as part of my investigation I requested information specifically around the obligations and policies of Victoria Police in respect to transporting arrested and non-arrested persons in Victoria Police vehicles, transporting persons who have been released from custody, transporting individuals who have not been arrested, and whether Victoria Police allows individual members a discretion to transport a person (including an intoxicated/drug affected person) from one location to another.
49. Sergeant Egan from the Centre For Occupational Safety at the Victoria Police Academy provided a statement to assist with these matters indicating that the Victorian Police Manual Policy Rules (VPMP) Professional and Ethical Standards is applicable to all police conduct, and that the VPMP 'Persons in Police Care or Custody' and 'Safe Management of Persons in Police Care and Custody' guidelines are somewhat applicable.
50. The 'Persons in Police Care or Custody' provides that a person may come into care or custody including when they are ill, in need of assistance or under arrest. Regardless of the situation or location, when a person is in care or custody police assume responsibility for their safety, security, health or welfare.
51. 'Persons in Police Care or Custody' addresses Victoria Police policy in relation to transport of persons in custody or care in a police vehicle and provides that members may only transport persons in a police vehicle where appropriate after undertaking a medical and risk assessment. This medical and risk assessment<sup>8</sup> indicates that a person in care or custody should be assessed by their best verbal responses, and in relation to persons believed to be intoxicated, this should be assessed at least half hourly.
52. 'Safe Management of Persons in Police Care or Custody' guidelines provide direction to members transporting persons in police vehicles and includes that they are to monitor the person and intervene if any health, safety or security concerns arise.

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<sup>6</sup> Both sedatives

<sup>7</sup> Indicated for the treatment of depression

<sup>8</sup> As outlined in 'Safe Management of Persons in Police Care or Custody'

53. Sergeant Egan highlighted that Victoria Police policies and procedures do not distinguish between 'arrested' and 'non-arrested' persons in relation to police obligations when transporting persons, and that there is no Victoria Police policy that deals specifically with the transportation of persons who have been released from custody.
54. While there is no Victoria Police policy or guidelines regarding transporting non-arrested persons home or to a safe place Sergeant Egan outlined '*...that it is not uncommon for police members to do so. Often this type of practice involves transporting vulnerable persons home or to a safe place, particularly when it is late at night. The practice is considered to be a way of ensuring a person's welfare and the overarching consideration is the safety, security, health and welfare of that person and/or the public.*'
55. In respect to the discretion to transport individuals home Sergeant Egan outlined Victoria Police training is designed to equip members with an analytical framework and skill set which enables them to deal with the various situations they may encounter. In deciding to transport members are to consider and be guided by the relevant Code of Conduct, the Charter of Human Rights and the relevant police policies, rules, guidelines and procedures.

#### Care or custody?

56. As Bradley had not been arrested, and the police had no intention to arrest him he was not classified as being in police custody. Common law definitions however are wider than having been arrested. For example in *R v Amad* [1962]<sup>9</sup> Smith J at 546 said that '*...a person is to be regarded as in custody not only after formal arrest, but also where he is in, say a police vehicle..and the police by their words and conduct have given him reasonable grounds for believing, and caused him to believe, that he would not be allowed to go should he try to do so.*' In *Norton v The Queen* (2001)<sup>10</sup> Roberts-Smith J held that '*...a person will be relevantly arrested or in custody if police, by words or conduct, have caused him to believe that he would not be allowed to leave and that belief is reasonable in the circumstances. It does not matter that the police do not intend to convey that impression.*'<sup>11</sup>
57. There is no evidence to indicate that Bradley was going to be arrested, nor any intention to arrest him. Further there is nothing to be gleaned from the established facts, or what can be inferred as to Bradley's belief or state of mind, to indicate he was in custody.
58. The question arises as to whether Bradley was in the care of police at the time of his death. The nexus must clearly be established that Bradley was still in the police's care after he had left the vehicle and proceeded to his home for this to be a relevant consideration.

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<sup>9</sup> VR 545

<sup>10</sup> 24 WAR 488

<sup>11</sup> At [51]

59. Bradley got in the police van voluntarily after agreeing to accept a lift home, colloquially referred to as a 'blue light taxi'. At its highest it may be arguable that Bradley was in police 'care' until he was dropped at home, however he was not in custody under any statutory provision or common law definitions.
60. In respect to the possible argument that Bradley was in 'care' it is clear when police convey someone that the destination should be reasonable but the question that subsequently arises here is at what point are police, in a circumstance such as this, still required to make ongoing decisions consistent with the welfare of an individual.
61. While police procedures cover transferring persons arrested into the care of a family member there are no relevant policies that cover the issue of a 'courtesy' ride home. I note that the practice of police transporting people not in police custody is viewed as a relatively common practice, and it is seen as a good local policing strategy to transfer intoxicated people to safety.
62. Whilst an issue in respect to duty of care arises the police had assessed Bradley as tipsy, quite drunk, but able to walk and converse with them. It is noted that Bradley was an alcoholic, and this may have impacted on his tolerance and the subsequent appearance of the level of intoxication.
63. I do not believe it is necessary considering the circumstances to make a finding as to whether Bradley was still in police care at the time of his death.
64. I believe that the unfortunate accident that befell Bradley was not reasonably foreseeable and I do not believe it is open on balance to conclude, considering applicable police policies and protocols, that the police contributed in any way to Bradley's death, or that it had been so foreseeable they could have intervened to prevent it.
65. There is no contradictory evidence about Bradley's cause of death, and no dispute raised in respect to it.

#### Police contact issues

66. As this matter involved recent police contact it was handled by the Court's independent in-house legal service and due to the sequencing of events associated with Bradley's death the police handled this as a critical incident, with a Senior Homicide Squad Detective having oversight of the matter.
67. A few issues were raised during my investigation, which included a lack of CCTV footage from the back of the divisional van.
68. The Wonthaggi Watch House Duty Officer heard the divisional van radio stating that they had a male on board that they were going to convey to his home address at approximately 2:00am. Constable Goff stated he flicked on the recording switch for the CCTV in the rear of the van prior to driving Bradley home.



69. Detective Sergeant Ross outlined that although officers were following correct protocols by switching the video on they were unaware that the unit was not functioning properly.
70. The Station Commander of the Wonthaggi Police Station, Senior Sergeant Gibson, states that the Wonthaggi Divisional Van is fitted with a CCTV in the rear pod which records to a hard drive fitted with a Secure Digital (SD) memory card. The standard procedure upon the placement of a person in the pod of the van is to activate the camera. Senior Sergeant Gibson indicated that it was his understanding on 12 October 2013 the SD card was full and had not been replaced.
71. An E-crime analysis indicated there was file activity on the card for the 13 October 2013, but that there was no recorded vision. I note that this issue has now been addressed with a regular changeover practice being implemented.
72. Senior Sergeant Gibson also provided a statement detailing the cellblock at Wonthaggi and outlines that in 2011 Victoria Police reviewed the cell structure within all police stations. As a result of the review Wonthaggi was downgraded to being a 'holding cell' only, which means that prisoners cannot be held overnight and that since 2011 the cells are usually used for 'persons in custody awaiting process' or persons charged with 'drunk' and being held under s.15 of the *Summary Offences Act*. Bradley did not fall into either of these categories.
73. Senior Sergeant Gibson states that during his entire career with Victorian Police it has been common practice for police coming into contact with alcohol affected persons, who do not meet the standard of 'drunkenness' under the *Summary Offences Act*, to make an operationally based decision to convey that person to a place of safety, such as their own address.
74. Senior Sergeant Gibson relies on police members to make a judgement call on the available factors present at the time.
75. Bradley's sister, Samantha Scott, expressed doubt to the Coroner's Investigator that Bradley would have willingly got into the back of a police van as he had had a previous incident with police.
76. There are no witnesses to the police dealings with Bradley in the street. Nor are there reports of a disturbance when he was being dropped off by the police.
77. It is unfortunate that there is no footage to show Bradley's demeanour while he was in the divisional van.
78. The CCTV street footage obtained by the Coroner's Investigator shows Bradley's demeanour to be relatively placid and he is clearly content in picking up cigarette butts on the road.
79. Constable Goff states that Constable Whyte asked Bradley if he wanted them to give him a ride to get him off the street, to which Bradley responded appreciatively and was courteous thanking them and shaking his hand when they dropped him home.

80. Constable Goff describes it as follows:

*'The circumstances under which he got into the van was such that we were doing him a favour, and as such, there was no need for me to inform him that he was not under arrest, or anything of that nature. He voluntarily got into the van, and was very grateful and happy to do so. He was most courteous to deal with. I had absolutely no need to have any concern for his welfare after we dropped him off.'*

81. Following Bradley's death when police checked Bradley's house it was established that the front door was unlocked and a key to the front door was located on top of the meter box. There were no signs of forced entry at the premises and no signs of a struggle or a disturbance.

82. As previously outlined blood stains, smears and splatters were found at the base at the steps of the front porch, rear of the front porch on the ground and wall, at the floor of the front porch at the door, on the front door sill, on the front security door, on a bicycle and on various logs of wood. To the rear of the front porch police located a timber framed glass pane wrapped in clear bubble wrap, with the glass pane broken and blood stains on the broken glass panels, timber frame and bubble wrap.

83. Police who attended noted that Bradley was not wearing any shoes on his feet and a shopping bag together with a pair of black coloured slip-on shoes were located at the base of the steps of the front porch.

84. The question as to whether Bradley's death may have been preventable is difficult in this set of circumstances as it is inherently based on a subjective judgement as to whether police should have waited longer once they had dropped Bradley off.

85. Bradley's sister queried if the police did pick up Bradley, from a health and welfare point of view why did they not ensure he was inside his property safely. This raises the issue of where the line is to be drawn when police are dealing with situations of this kind.

86. A likely alternative scenario that Bradley could have entered his house and experienced a similar type of accident irrespective of any police contact. Unfortunately Bradley was unable to utilise his mobile phone to call for help and the neighbour who first witnessed him did not fully appreciate the situation.

87. It is good policing to transport intoxicated persons to safe places, and the timing of this was properly documented in the police records.

88. The running sheet compiled by Constable Whyte on the night indicates that Constables Whyte and Goff had Bradley on board at 2:12am when he was put in the divisional van. At 2:14am Bradley was dropped at his home address, with the police members leaving the address at 2:17am. A printout of the police's Law Enforcement Assistance Program history indicates that a name search was conducted on Bradley at approximately 2:15am by the Wonthaggi divisional van.

89. The police had reasonably transported Bradley to safe premises having made a decision to remove him from the street. In this circumstance I believe it can be described as a terrible accident that could not have been reasonably foreseen by the police who transported Bradley home.

#### FINDINGS

90. On the weight of the evidence available to me, I find that Bradley Alan Scott died as a result of an incised right radial artery on 13 October 2013, in circumstances that equate to misadventure. There is no evidence to suggest that his injury was intentionally inflicted.

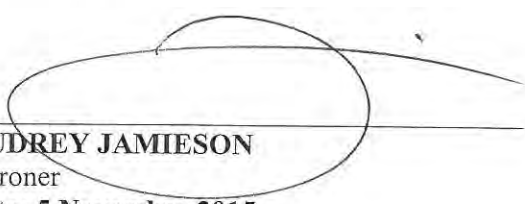
91. AND I further find that the police dealings with Bradley did not directly contribute to his death.

Pursuant to section 73(1A) of the **Coroners Act 2008**, I direct 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 Sandra Scott;
- VGSO, as representatives for the CCP;
- The Coroner's Investigator, Detective Senior Constable Daniel Mason; and
- Detective Sergeant Graham Ross, Homicide Squad.

Signature:

  
**AUDREY JAMIESON**  
Coroner  
Date: **5 November 2015**

