IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004394

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Carl Edward Medlyn
Date of birth:	24 July 1971
Date of death:	4 August 2022
Cause of death:	1(a) ASPIRATION PNEUMONIA 1(b) TRAUMATIC BRAIN INJURY ARISING FROM A SCOOTER INCIDENT 2 METASTATIC SMALL CELL LUNG CANCER
Place of death:	Caulfield Hospital 260-294 Kooyong Road, Caulfield, Victoria, 3162
Keywords:	Electric scooter, eScooter

INTRODUCTION

1. On 4 August 2022, Carl Edward Medlyn was 51 years old when he died at Caulfield Hospital. He had been in hospital and then in rehabilitation since crashing an electric scooter near his home on 14 March 2022. At the time of his death, Mr Medlyn lived at 44 Hoysted Avenue, Cranbourne North, Victoria, with his parents.

THE CORONIAL INVESTIGATION

2. Mr Medlyn'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.

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 with the death under investigation.

5. Senior Constable (S/C) Brent Wiesner acted as the Coroner's Investigator for the investigation of Mr Medlyn's death. S/C Wiesner conducted inquiries on my behalf and compiled a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Carl Edward Medlyn 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.

BACKGROUND

7. Mr Medlyn was born on 24 July 1971 and had two siblings. He remained single for most of his adult life and worked as a butcher after completing an apprenticeship with his father.

8. In 2016, Mr Medlyn was the victim of "king hit" assault. He suffered a fractured jaw, cervical spine injury and began to experience seizures. He was deemed medically unfit to drive because of the seizures and was required to surrender his driver's licence. He also had to cease work.

9. Following the assault, Mr Medlyn also suffered from Post-Traumatic Stress Disorder and depression. He attended upon a general practitioner and a psychologist for treatment of these conditions.

10. Mr Medlyn's mother stated that he consumed alcohol recreationally and cannabis to self-medicate, but he did not use any other illicit substances. She stated that he was a responsible driver.

11. In early March 2022, Mr Medlyn purchased a Janobike T85 5600W electric scooter (**the Janobike**) from his brother-in-law. Mr Medlyn was reportedly very happy with this purchase, as it provided him with more independence, and he spent hours riding it up and down the driveway of his residence.

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

Circumstances in which the death occurred

12. At 11.34pm on Monday 14 March 2022, Mr Medlyn was riding the Janobike east along Hoysted Avenue in Cranbourne North, near the intersection with Candytuft Close. He was briefly recorded by a CCTV camera at 24 Hoysted Avenue, approximately 50 metres from his home.[2]

13. In the CCTV recording, Mr Medlyn can be seen travelling at a fast rate of speed. The Janobike was fitted with a post and saddle and Mr Medlyn rode in a seated position. He did not appear to be wearing a helmet but the headlight was turned on.

[2] The CCTV recording bears a time stamp of 10.34pm, however, the owner of the CCTV system clarified that the time stamp on the recording was one hour behind the actual time.

14. A short time later, Mr Medlyn lost control of the Janobike and fell onto the footpath outside 27 Hoysted Avenue, Cranbourne North.

15. Hoysted Avenue is a residential street with no speed restriction signs and the default speed limit is 50km/h. The road has provision for a single lane in each direction, separated by a solid white line. The relevant section is relatively straight, with only slight bends, and runs east-west. It is bordered on both sides by a concrete kerb and nature strips. The area has street lighting, including a light pole near the corner of Candytuft Close, just west of 27 Hoysted Avenue. The weather was fine, and the footpaths and road were dry.

16. At 12.19am on Tuesday 15 March 2022, a local resident discovered Mr Medlyn lying on the ground next to the Janobike at the intersection of Hoysted Avenue and Candytuft Close.

17. Emergency services were called, and Ambulance Victoria paramedics arrived at 12.36am. Mr Medlyn had suffered a serious head injury and was unresponsive. He was intubated at the scene and transported to the Alfred Hospital where he was placed in an induced coma.

18. A blood sample was taken at the Alfred Hospital at 1.50am and later found to contain Delta-9-tetrahydrocannabinol (THC/cannabis) at 40ng/mL.

19. Victoria Police investigators attended and examined the scene as part of a wider investigation. They found no evidence to suggest that any other vehicle or person was involved. They also found no indication of any hazards on the road that may have contributed to the crash. The Janobike appeared to be in good working order, with no obvious defects.

20. Mr Medlyn woke from the coma after approximately one month and eventually began rehabilitation. He had suffered a severe traumatic brain injury with consequent severe dysphagia requiring PEG[3] feeding. During his rehabilitation, it was discovered that he also had lung cancer.

21. On 1 August 2022, Mr Medlyn developed aspiration pneumonia and he was transitioned to comfort care before he passed away on 4 August 2022.

[3] Percutaneous Endoscopic Gastrostomy

Identity of the deceased

22. On 4 August 2022, Carl Edward Medlyn, born 24 July 1971, was visually identified by his mother, Carol Medlyn.

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

Medical cause of death

24. Forensic Pathologist, Dr Melanie Archer from the Victorian Institute of Forensic Medicine, conducted an examination on 9 August 2022 and provided a written report of her findings dated 22 August 2022.

25. The post-mortem examination showed no evidence of any injuries that could have caused or contributed to the death. The post-mortem CT scan revealed a large craniectomy with fixation over the right frontal parietotemporal region, along with a left frontal burr hole. There was a right lung upper lobe pleural mass, and a left lung upper lobe mass, in keeping with a history of small cell carcinoma. The CT scan also revealed multifocal consolidation of the lungs.

26. Dr Archer provided an opinion that the medical cause of death was 1 (a) Aspiration Pneumonia and 1(b) Traumatic brain injury arising from a scooter incident, with the contributing factor of metastatic small cell lung cancer.

27. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Carl Edward Medlyn, born 24 July 1971;

    b) the death occurred on 4 August 2022 at Caulfield Hospital, 260-294 Kooyong Road, Caulfield, Victoria, from aspiration pneumonia secondary to traumatic brain injury arising from a scooter incident, with a contributing factor of metastatic small cell lung cancer; and

    c) the death occurred in the circumstances described above.

29. Based on the available evidence, it is not possible to conclude what caused Mr Medlyn to fall from the scooter. It may have been a loss of control due to excessive speed, the suspension

and handling limitations of the scooter, a transition from the roadway to the footpath or across a driveway crossover, or combination of these.

30. I am satisfied that Mr Medlyn's THC blood concentration measured from a sample taken approximately 90 minutes after the critical events (40 ng/mL) is indicative of recent cannabis use and it is likely Mr Medlyn was impaired by the drug to some extent. However, I note that Mr Medlyn had a history self-medicating with cannabis and it is not possible to say what the effects of habituation may have been or the degree to which he would have been impaired while he was riding the scooter.

COMMENTS

31. Pursuant to section 67(3) of the Act I make the following comments.

32. I note that the Janobike is apparently capable of speeds of up to 85km/h and it meets the criteria which would classify it as a motor vehicle. Under legislation in place at the time of Mr Medlyn's death, and currently, e-scooters such as these are prohibited from being used on Victorian public footpaths or roads. The power output and speed capability of this scooter have the potential to, very quickly, place a rider in a situation where they are at the limits of controllability. The consequences of a crash at the highs speeds these vehicles are capable of, particularly when the rider has no head protection, are all too likely to be catastrophic.

33. I note that in a report summarising the findings of e-scooter trials conducted by the Victorian Department of Transport and Planning, published in March 2023, concerns were noted about unsafe behaviour by e-scooter users including high speed riding, riding on footpaths, not wearing a helmet, and carrying a passenger. The report also noted that safety risks increased when users did not observe safety-based rules.

34. The Victorian Government has extended the e-scooter trials for a further six months, to 4 October 2024, in order to allow additional time to investigate additional safety and compliance measures. I have directed that a copy of this finding be provided to the Department of Transport and Planning to inform their research in this area.

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

I thank the Coroner's Investigator and those assisting for their work in this investigation.

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:

Carol and Neale Medlyn, Senior Next of Kin

Paige Edwards, Alfred Hospital

Victorian Department of Transport and Planning

Senior Constable Brent Wiesner, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 22 September 2024

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.