IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001160

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Daniel Francis McNeill
Date of birth:	19 March 1983
Date of death:	2 March 2023
Cause of death:	1(a) Complications following extradural haemorrhage (operated) sustained in an electric scooter incident (rider)
Place of death:	Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152
Keywords:	Electric scooter, e-scooter, head injury, road safety

INTRODUCTION

1. On 2 March 2023, Daniel Francis McNeill (**Mr McNeill**) was 39 years old when he passed away at Wantirna Hospital, having succumbed to a head injury sustained in an electric scooter (**e-scooter**) incident on 2 February 2023. At the time of his death, Mr McNeill lived in Croydon with his partner Rebecca and her son.

2. Mr McNeill's medical history included hepatitis C and a history of illicit drug use.

THE CORONIAL INVESTIGATION

3. Mr McNeill'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.

4. 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.

5. 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.

6. The investigation was initially under the purview of then-Deputy State Coroner Jacqui Hawkins, until it was allocated to me in October 2023 order to finalise the investigation and make findings.

7. Victoria Police assigned Senior Constable Fabienne Fanning (**SC Fanning**) to be the Coronial Investigator for the investigation of Mr McNeill's death. SC Fanning conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Daniel Francis McNeill 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]

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

Circumstances in which the death occurred

9. At approximately 6.14am on 2 February 2023, Gregory Kerr (**Mr Kerr**) was driving in an easterly direction on the Maroondah Highway, Ringwood, when he observed a man, Mr McNeill, lying outside a car dealership on the north side of the highway. Mr Kerr immediately pulled over and ran to Mr McNeill, who was unresponsive and appeared to have sustained a head injury. In his statement to police, Mr Kerr recalled observing a mobile phone and an e-scooter on the pavement several metres away. He noticed that Mr McNeill was not wearing a helmet.

10. In closed-circuit television (**CCTV**) footage subsequently obtained by SC Fanning, Mr McNeill is observed to already be in this same position on the ground at approximately 6.10am. There is no footage depicting Mr McNeill's fall from the e-scooter. SC Fanning surmised that Mr McNeill may have been travelling too fast to trigger the motion-activated camera.

11. Mr Kerr contacted emergency services and was advised there was a 40-to-60-minute wait for an ambulance. As Mr McNeill regained consciousness, Mr Kerr advised him that help was on the way. He observed Mr McNeill growing agitated and he encouraged Mr McNeill to remain still. Mr Kerr was joined by another passerby as Mr McNeill became increasingly agitated and abusive.

12. At approximately 6.24am, Victoria Police were alerted to an incident whereby a male reportedly "*collided with a letter box*" and was subsequently verbally abusive towards a passerby who stopped to render assistance.

13. A short time later, Mr McNeill proceeded to mount his scooter and retrieve his mobile phone before riding in an unsteady, "*zig-zag fashion*" down the nearby Mullum Mullum Creek trail.

[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.

In his statement to police, Mr Kerr advised that he suspected Mr McNeill was drug-affected and he was concerned that "*it looked like he was going to fall off again*". After Mr McNeill disappeared from view, Mr Kerr contacted emergency services to cancel the ambulance.

14. At approximately 6.30am, Leora Dobia (**Ms Dobia**) was in bed and overhead someone outside "*moaning and swearing*". Ms Dobia went out to her backyard and heard that the sounds were coming from the driveway running behind her house. At approximately 6.45am, she approached the driveway and found a man, Mr McNeill, in a reduced conscious state, lying on the ground in front of a garage door. Ms Dobia observed that Mr McNeill was bleeding from his mouth and nose and an e-scooter lay on the ground beside him.

15. Ms Dobia tried to engage with Mr McNeill but he was "*in and out of consciousness and incoherent*". She contacted emergency services at approximately 6.51am and Victoria Police and Ambulance Victoria paramedics arrived a short time later.

16. Mr McNeill presented as irritable and resisted the efforts of responding paramedics in assessing his injuries, and assistance was sought from police in placing him on a stretcher for loading into the ambulance. Police and paramedics formed the view that Mr McNeill was drug affected. Paramedics conducted a motor response assessment and assessed Mr McNeill as responsive, with a Glasgow Coma Scale (**GCS**)[2] score of 13.

17. Mr McNeill denied having been in a similar incident earlier that morning. He refused a cervical collar and C-spine precautions and was uncooperative with further assessment in the ambulance. Although he complained of a headache, Mr McNeill refused pain relief. He remained responsive *en route* to Maroondah Hospital.

18. On arrival at the emergency department (**ED**) at approximately 7.30am, Mr McNeill was verbally abusive towards staff. Toxicological analysis of a blood sample taken upon admission revealed the presence of methylamphetamine (~0.30mg/L).

19. During triage at around 7.40am, Mr McNeill was searched by police, who located and seized a mobile phone, car keys, a knife, a pipe, measuring scales, a piece of straw, and multiple

[2] The Glasgow Coma Scale (**GCS**) is a neurological scoring system used to assess conscious level. The GCS is comprised of three categories; best eye response, best vocal response and best motor response. The GCS is scored out of 15, with a score of 15 indicating a normal level of consciousness.

resealable bags containing approximately 15.5 grams of an opaque white crystal substance believed to be ice (methylamphetamine).

20. At approximately 8.00am, Mr McNeill was transferred to a monitored cubicle, where he was "*deeply unconscious*" with a fixed, dilated right pupil and reassessed as GCS 4. A statement was obtained from emergency physician Dr Erin Woodward (**Dr Woodward**), who was alerted to Mr McNeill's condition between 8.10am and 8.20am. Dr Woodward advised that her brief assessment confirmed the observations of assessing nurses and were consistent with a brain injury and build-up of pressure in the brain. Having conducted a full body examination, Dr Woodward observed an abrasion to the back of Mr McNeill's head but did not find any evidence of significant injury.

21. Growing concerned that Mr McNeill had sustained a significant intracranial injury, he was placed in a cervical spine collar and underwent an urgent computed tomography (**CT**) scan at approximately 8.40am. Dr Woodward immediately reviewed the imaging and observed "*a large extradural haemorrhage with associated midline shift (bleed around the brain causing build-up of pressure*". A base of skull fracture and subarachnoid were also apparent.

22. Mr McNeill underwent a further CT scan of his chest, abdomen, pelvis and thoracic lumbar and sacral spine to exclude the presence of other injuries.

23. At approximately 9.15am, Mr McNeill was intubated and sedated with morphine and midazolam. He was also given mannitol to reduce intracranial pressure. Treating clinicians then contacted Adult Retrieval Victoria and the neurosurgical team at The Alfred Hospital to arrange his transfer to a trauma hospital.

24. At around this time, Mr McNeill's mother, Lisa McNeill (**Ms McNeill**) was contacted by the ED Care Coordinator as she was listed as his Next of Kin. According to Maroondah Hospital records, she advised that Mr McNeill also fell from his scooter two weeks prior and struck his head. No further evidence is available as to this assertion, and I note that Ms McNeill declined to provide a statement to the Coroner's Investigator for the coronial investigation.

25. Mobile Intensive Care Ambulance (**MICA**) paramedics arrived at approximately 9.45am and transferred Mr McNeill to The Alfred Hospital.

26. On arrival to the Intensive Care Unit of the Alfred Hospital, Mr McNeill underwent an emergency craniotomy and evacuation of the haemorrhage. Subsequent imaging revealed

fluid build-up around multiple bruises. Mr McNeill's sedation was weaned, however he experienced little neurological improvement.

27. Discussions took place between his family and treating clinicians regarding Mr McNeill's poor prognosis, after which a decision was subsequently made to withdraw active treatment and commence palliative care.

28. On 26 February 2023, Mr McNeill was extubated and his enteric feeds were ceased. He was then continued on a syringe driver of morphine and midazolam.

29. On 28 February 2023, Mr McNeill was transferred to the Palliative Care Unit of Wantirna Hospital for end-of-life care. He was commenced on a continuous subcutaneous infusion.

30. On 29 February 2023, his mechanical ventilation was switched off. Mr McNeill subsequently passed away at 2.00am on 2 March 2023.

Identity of the deceased

31. On 2 March 2023, Daniel Francis McNeill, born 19 March 1983, was visually identified by his partner, Rebecca.

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

Medical cause of death

33. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 3 March 2023 and provided a written report of her findings dated 3 April 2023.

34. Dr Archer reviewed a post-mortem CT scan, which showed multifocal bronchopneumonia, a left occipital fracture extending onto the base of the skull, brain swelling, and evidence of interventions consistent with the emergency craniotomy performed at The Alfred Hospital. On external examination, Dr Archer did not observe any evidence of residual soft tissue injuries.

35. Ante-mortem blood samples were not available for toxicological analysis.

36. Dr Archer provided an opinion that the medical cause of death was *1(a) Complications following extradural haemorrhage (operated) sustained in an electric scooter incident (rider)*.

37. I accept Dr Archer's opinion.

VICTORIA POLICE MECHANICAL EXAMINATION

38. On 3 February 2023, Senior Constable Daniel Pearce (**SC Pearce**) of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) examined Mr McNeill's e-scooter. The black Apollo Phantom e-scooter had been held in secure property storage at Croydon Police Station since the incident.

39. SC Pearce observed general wear and tear, including scuff marks on the left-hand side of the e-scooter's steering shaft, but no major damage. The battery remained at 80% charge and SC Pearce considered the e-scooter to be in a rideable condition. The odometer reading was 870 kilometres.

40. SC Pearce noted that the e-scooter was fitted with two hub-mounted motors, with a combined power output of 3200W. The motors were controlled by a throttle on the right-hand side, comprised of three speed limiter settings or 'gears'. By applying full throttle in each 'gear' with the scooter off the ground, SC Pearce ascertained that gears 1, 2, and 3 were respectively limited to around 38, 62 and 84 kilometres per hour. He was unable to test the power output of the electric motors or measure the scooters maximum speed under load.

41. An examination of the front brakes confirmed they functioned as intended, however the rear brakes were insufficient to lock the wheel and may have contributed to the collision. Having examined the wheels, suspension, and steering, SC Pearce did not observe any other faults, failures or conditions that could have caused or contributed to the collision.

42. SC Pearce described the e-scooter's steering mechanism—a straight shaft fixed to the handlebars and front hub—as being "*sensitive*" to steering inputs. He noted that this sensitivity results in instability and increased risk of collision when the rider conducts sharp turns without leaning into the steering direction, particularly at high speeds.

43. SC Pearce advised that from his experience of examining and riding similar e-scooters, the sensitive steering and upright riding position render the vehicle "*inherently dangerous*", noting that a rider must maintain complete concentration to maintain stability and safety. According to SC Pearce, this danger is amplified by the two high-powered electric motors he observed upon this particular e-scooter.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Daniel Francis McNeill, born 19 March 1983;

    b) the death occurred on 2 March 2023 at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152, from complications following 1(a) Extradural haemorrhage (operated) sustained in an electric scooter incident (rider); and

    c) the death occurred in the circumstances described above.

45. Whilst the precise cause of Mr McNeill's fall from his e-scooter on the morning of 2 February 2023 is unclear, having considered all of the available evidence, I am satisfied that his fall was precipitated by a combination of the following factors:

    a) Mr McNeill was riding an e-scooter capable of speeds up to three times the legal maximum speed for use in public settings;

    b) Mr McNeill's ability to safely manoeuvre the e-scooter was impaired by his consumption of illicit drugs; and

    c) Mr McNeill was at an increased risk of significant head injury due to his failure to wear a helmet.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

<u>The Victorian e-scooter trial</u>

1. From the commencement of the two-year rental e-scooter trial in Victoria in February 2022, e-scooter riders were required to wear a helmet and were subject to the same blood alcohol content (**BAC**) and drug use restrictions as motor vehicle drivers. Further, e-scooters are not permitted on footpaths and have consistently been restricted to a maximum speed of 20 kilometres per hour, with e-scooters capable of exceeding 25 kilometres per hour being classified as an unregistered motor vehicle and illegal for use in public settings.

2. On 5 April 2023, the Victorian trial was extended to privately owned e-scooters, which were subject to the same speed and capability restrictions.

3. Following a trial in regional areas and metropolitan Melbourne, on 4 April 2024, the Victorian Government 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.

4. On 19 July 2024, the Victorian Government announced that e-scooters would be permanently legalised from October, with additional safety and compliance measures. Increased fines for e-scooter riders were subsequently introduced on 4 October 2024, including for riding on a footpath and failing to wear a helmet.

E-scooter injuries and the need to address unsafe riding practices

5. A recent study examining 256 presentations to the Royal Melbourne Hospital between January 2022 and January 2023 following e-scooter accidents found that cranial, facial and cervical spine injuries comprised 53.1% of total observed injuries. Fractures were observed to be the second most common type of injury (47.7%), followed by head injuries (16.4%). Further, the use of recreational drugs and alcohol were observed in 11.3% and 33.6% of riders, respectively, and 26.3% of presenting patients reported failing to wear a helmet.[3]

6. Similar findings were reported by the Alfred Hospital following a review of 272 presentations between 1 January 2017 and 31 May 2022, which demonstrated an exponential increase in the rate of e-scooter related trauma presentations from 2020 onwards. Failure to wear a helmet was a factor in 18% of presentations. Traumatic brain injuries were sustained by 24.5% of patients who had failed to wear a helmet, compared with 5.3% of patients who wore helmets. Alcohol and illicit drug use was noted in approximately 23.9% of presentations, which were in turn associated with higher injury severity.[4]

7. Significant injuries or fatalities associated with the use of e-scooters are certainly not unique to Victoria, or indeed Australia. A increased incidence of emergency department presentations relating to e-scooter accidents has been observed to coincide with the increasing global popularity of e-scooters.[5]

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[3] Cevik, Jevan et al, 'The impact of electric scooters in Melbourne: data from a major trauma service' (2023) 94 *ANZ Journal of Surgery* 572-579.

[4] Mitra, Biswadev et al, 'Electric scooter-related trauma, alcohol and other drugs' (2023) 35 *Emergency Medicine Australasia* 353-356.

[5] See, for example: McGuinness, Matthew, Yvonne Tiong and Savitha Bhagvan, 'Shared electric scooter injuries admitted to Auckland City Hospital: a comparative review one year after their introduction' (2021) 134(1530) *New Zealand Medical Association* 21-29; Moftakhar, Timon et al, 'Incidence and severity of electric scooter related injuries

8. On 5 December 2024, the Victorian Government launched a new road safety campaign directed to e-scooter riders—‘*If you think e-scooters are a toy, think again*’. The campaign ran until 26 January 2025 across several platforms to highlight the risks and consequences of dangerous and illegal e-scooter use.

9. I echo the recent comments of Coroner Lawrie following an investigation into the death of a 51-year-old man from Cranbourne North involving a privately owned e-scooter capable of speeds up to 85 kilometres per hour:[6]

> “*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.*”

10. An investigation into the 2023 death of a 73-year-old man from Cranbourne North was recently finalised by Coroner Simon McGregor and also examined unsafe e-scooter use. His Honour ultimately recommended that the Transport Accident Commission (**TAC**) liaise with the Victorian Department of Transport and Planning (**DTP**) regarding the best approach to improving community education about the conditions and requirements for the safer riding of e-scooters.[7]

11. I endorse his Honour’s recommendation and urge the TAC, when formulating its written response, to consider conducting an evaluation in consultation with the DTP as to the effectiveness of the new campaign in reducing the likelihood of unsafe and dangerous e-scooter use.

12. I consider that this ought to be done with a view of swiftly improving the safety culture of a mode of transport that otherwise appears promising in terms of its ability to reduce environmental impacts, improve urban mobility, and to constitute a more affordable form of transport when compared with cars and other vehicles.

I convey my sincere condolences to Mr McNeill’s family for their loss.

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after introduction of an urban rental programme in Vienna: a retrospective multicentre study’ (2021) 141 *Archives of Orthopaedic and Trauma Surgery* 1207-1213; Karpinski, Elizabeth et al, ‘Characteristics of early shared E-Scooter fatalities in the United States 2018-2020’ (2022) 153 *Safety Science* 105811.

[6] Finding into death without inquest of Medlyn, Carl (COR 2022 4394) (22 September 2024) 6 [32].

[7] Finding into death without inquest of Lui, Martin (COR 2023 7080) (12 December 2024).

DIRECTIONS

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:

Rebecca Paisley, Senior Next of Kin

Lisa O'Neill c/- Katie Minogue, Maurice Blackburn Lawyers

Alfred Health

Eastern Health

Transport Accident Commission

Department of Transport and Planning

Senior Constable Fabienne Fanning, Coronial Investigator

Signature:

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Coroner Ingrid Giles

Date: 05 February 2025

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.