IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6321

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Deceased:	Sebastian D'Imperio
Delivered on:	24 April 2024
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Directions Hearings: 9 Aug 2019; 14 Feb 2020; Inquest: 29 and 30 Nov, 1, 2, 3 and 6 Dec 2021; Written Submissions: 28 Jan to 14 Feb 2022.
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Counsel Assisting the Coroner:	Sergeant Grieg McFarlane, Police Coronial Support Unit
Representation:	Mr D. Oldfield instructed by Zaparas Lawyers appeared on behalf of the family of the deceased. Ms A. Wood appeared on behalf of the Frankston City Motocross Park, Motorcycle Victoria and Motorcycle Australia. Mr N. Boyd-Cain instructed by Meridian appeared on behalf of Frankston City Council.

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INTRODUCTION[1]

1. Sebastian D'Imperio (**Sebastian**) was the much-loved 16-year-old son of his mother Astrid Swietojanski and his father Giacomo D'Imperio (**Mr D'Imperio**). Tragically, Sebastian died at Frankston City Motorcycle Park on 16 December 2017, shortly after failing to negotiate the last jump on the main track and sustaining fatal head injuries.

2. By all accounts, Sebastian was an accomplished and popular young man who is mourned by his family and many others including the staff and students at John Paul College, Frankston, where he was a student.

3. Among his interests and activities, Sebastian enjoyed mountain bike riding and was an accomplished mountain bike rider. Mountain bike riding was an activity he shared with his mother. Sebastian also enjoyed off-road motorcycle riding (motocross), an activity he shared with his father. Sebastian had ridden motocross for about five years, was a keen rider and was working on improving his skills.

4. Sebastian started riding motocross at the Frankston City Motorcycle Park (**FCMP**) when he was about 12 and this was the only venue where he had ever ridden motocross. He had previously ridden smaller, less powerful motorcycles on the smaller tracks at the venue – a two-stroke Suzuki JR80cc which he rode for about three years on the "peewee track" at FCMP considered a beginners' track, then a two-stroke Yamaha YZ85cc which he rode on the more advanced "intermediate track".[2]

5. For the last year or so, Sebastian had been riding a second-hand 2012 model four-stroke Yamaha YZ250cc (**the Yamaha**) which his father purchased for him. Sebastian rode this bike on the "main track" at FCMP and had been largely maintaining the Yamaha himself with assistance from YouTube instructional videos, his father and, to a minor extent, members of the FCMP.

6. On Saturday 16 December 2017, Mr D'Imperio collected Sebastian from his home in Seaford and arrived at the track at about 12.30pm. Sebastian started riding the Yamaha on the main track at about 12.55pm. His first two-three laps were warm-up laps. Sebastian had completed about five

[1] This is a broad overview of the circumstances in which Sebastian's death occurred, intended to assist understanding of the finding. The circumstances will be discussed below in more detail by reference to the evidence. While I understand these to be largely uncontroversial matters, to the extent of any inconsistency, the latter is to be preferred.

[2] The FCMP consisted of five tracks of varying complexity. Broadly speaking, the smaller, less challenging tracks were for younger and/or less experienced riders on less powerful motorcycles. This finding is primarily focused on the main track which was the largest and most challenging track at FCMP where Sebastian came to grief. For a description of the various tracks and who could ride on them see transcript pages 434-440.

laps before stopping to talk to his father, who was also riding the main track, for a couple of minutes and then continuing.

7. Sebastian approached the final jump which is a "table-top" style jump considered one of the smaller less technical jumps on the Freeway straight of the main track, so-called as it abuts the Frankston Freeway. As Sebastian approached the jump from the left side of the track, another rider Alexander Borg (**Alexander**), approached from the right side about 20-30 metres behind him. Sebastian failed to negotiate the jump, losing control of the Yamaha on landing. Alexander was airborne and unable to avoid impact with Sebastian who had fallen into his path. Alexander cartwheeled over the handlebars of his motorcycle and landed in the dirt but was largely unharmed.

8. The circumstances in which Sebastian sustained his fatal injuries and died was the primary focus of the coronial investigation and will be discussed in some detail below. Suffice for present purposes to say that Sebastian sustained multiple injuries including an obvious head injury. Several people came to his immediate assistance including club members and officials who commenced cardiopulmonary resuscitation (**CPR**). Several calls were placed to emergency services seeking an ambulance.

9. Responding Ambulance Victoria (**AV**) paramedics arrived a short time later. The ambulance crew comprised of paramedics Simon Singer and Ellen Dunne who were first to arrive, followed by Mobile Intensive Care Ambulance (MICA) paramedic Brenton Willey. Sebastian's injuries were immediately assessed as life-threatening. Despite the efforts of all concerned, Sebastian could not be saved and was verified deceased at the scene by AV paramedic Singer at 1.47pm on 16 December 2017.

INVESTIGATION AND SOURCES OF EVIDENCE

10. This finding is based on the totality of the material the product of the coronial investigation of and inquest into Sebastian's death. That is, the initial brief of evidence compiled by Leading Senior Constable Susan Russell (**LSC Russell**) from the Somerville Highway Patrol which includes relevant witness statements, photographs, the forensic pathologist's report and medical records. Additional statements were obtained at my direction and added to the brief which was reconfigured by Sergeant Greig McFarlane from the Police Coronial Support Unit (**PCSU**) who assisted me at inquest.[3] This finding is also based on the evidence of those witnesses who were

[3] The compilation of material (designated Exhibit A at inquest) will be referred to as the "inquest brief" in the rest of this finding.

required to testify at inquest and any documents tendered through them; and the final submissions of Counsel for each of the parties.

11. All of this material, together with the inquest transcript, will remain on the coronial file.[4] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

12. The purpose of a coronial investigation of a *reportable death*[5] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6] Sebastian's death clearly falls within the definition of "reportable death" in section 4 of the Act, satisfying both the jurisdictional nexus with the State of Victoria required by section 4(1) of the Act and section 4(2)(a) which includes (relevantly) a death that appears to have resulted, directly or indirectly, from an accident or injury.

13. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[7]

14. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[8]

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[4] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[5] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[6] Section 67(1).

[7] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[8] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

15. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9] These are effectively the vehicles by which the coroner's prevention role can be advanced.[10]

16. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[11]

IDENTITY

17. Sebastian D'Imperio, born 19 July 2001, aged 16, was identified by a family friend Massimo Esposito, who had known him for ten years and signed a formal Statement of Identification to this effect before LSC Russell on 16 December 2017.

18. Sebastian's identity was not in issue and required no further investigation.

CAUSE OF DEATH

19. Sebastian's body was brought to the Coronial Services Centre in Southbank. Senior forensic pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the Police Report of Death to the Coroner (VP Form 83), post-mortem CT scanning of the whole body undertaken at VIFM (**PMCT**) and information on the VIFM contact log and performed an external examination of Sebastian's body in the mortuary.

20. Dr Lynch provided a written report in which he acknowledged the family's preference for no autopsy and confirmed his findings of a serious head injury involving palpable fractures of the cranial vault. Dr Lynch noted that PMCT confirmed the presence of skull vault fractures with

[9] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[10] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[11] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

pneumocranium (air within the cranial cavity) and subarachnoid haemorrhage, and fractures of the maxilla and mandible (cheek and jaw bones).[12]

21. Dr Lynch advised that the medical cause of Sebastian's death could be reasonably attributed to *1(a) Injuries sustained in motor vehicle incident (Motorcyclist),* without the need for autopsy.

22. I accept Dr Lynch's opinion as to the medical cause of Sebastian's death.

23. Subsequently, I asked Dr Lynch to provide a Supplementary Report to help elucidate the circumstances in which Sebastian sustained the injuries that led to his death, in particular to help elucidate the number and, if possible, the sequence of any impacts to Sebastian's head to help me distinguish, if possible, the contribution of the initial fall, the Yamaha and any impact with Alexander and/or his motorcycle.[13]

24. In his Supplementary Report, Dr Lynch stated that the principal injuries he observed on Sebastian comprised bruising and abrasion to the left side of the forehead extending to the left temporal region and left cheek, associated with fractures of the cranial vault (with pneumocranium and subarachnoid haemorrhage) and fractures of the maxilla and mandible.[14] There were no significant injuries to other parts of Sebastian's body. Overall, the injuries identified by Dr Lynch were reflective of non-specific blunt trauma.[15]

25. Neither in his Supplementary Report, nor when called to testify at inquest was Dr Lynch able to apportion the specific contribution made to the injuries by the initial impact that Sebastian's head may have made with the ground, impact with the Yamaha he was riding or any subsequent impact with the following motorcycle.[16] Sequence of impacts aside, Dr Lynch could not determine the number of impacts with Sebastian's head, save to say there was at least one. Nor could he lend any support to a hypothesis that there had been an impact between Alexander and/or his motorcycle and Sebastian's head.[17]

26. As for the utility of a helmet, Dr Lynch expressed the belief that his findings on external examination were consistent with Sebastian wearing a helmet at the time of the incident. He could not say with certainty whether an appropriately fitted helmet, correctly worn, would prevent a

[12] Dr Lynch's formal qualifications appear in his written report which is dated 31 January 2018 and is at pages 17-20 of the inquest brief/Exhibit A.
[13] Dr Lynch's Supplementary Report dated 19 September 2019 is at pages 21-22 of the inquest brief/Exhibit A.
[14] Page 21 of the inquest brief and transcript page 8. Some of these injuries were apparent on external examination and others relied on Dr Lynch's review of PMCT.
[15] Transcript page 9.
[16] Transcript pages 9-10, 11-12.
[17] Page 21 of the inquest brief and transcript pages 11-16.

motorcycle rider sustaining the injuries he observed and expressed the view that a helmet would confer substantial but not absolute protection.[18] At inquest, his evidence was that he certainly sees people who were wearing helmets and are involved in incidents while riding motorcycles who sustain similar, if not identical, injuries to Sebastian.[19]

27. When asked about the survivability of Sebastian's injuries, Dr Lynch described them as the kind of injuries not uncommonly seen in the setting of significant blunt force head trauma following a motor vehicle collision adding that some patients may make a good recovery, some may recover with significant deficits but *"a lot of patients with these kind of injuries would die."*[20]

THE FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

28. Sebastian's identity and the cause of his death were not ultimately controversial and did not form part of the focus of the inquest. The challenges and inherent risks of the sport of motocross were taken as read[21] and provided context for examination of the circumstances of Sebastian's death which were the focus of the inquest, namely –

    a. How Sebastian's injuries were sustained, or the mechanism of injury.

    b. The first aid response.

    c. Track supervision on the day.

    d. Compliance with applicable safety practises.

    e. Maintenance and mechanical condition of Sebastian's bike.

How Sebastian's injuries were sustained

29. As mentioned above, Sebastian attended FCMP on 16 December 2017 with his father and had ridden several laps, apparently without incident prior to the collision. Moreover, shortly before the collision, Sebastian stopped for a few minutes and spoke to his father who was also riding the track. In his evidence, Mr D'Imperio did not mention any concerns Sebastian may have expressed during this conversation either about the track, the performance of the Yamaha or otherwise.[22]

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[18] Page 22 of the inquest brief.
[19] Transcript pages 11-12. *"I'm very confident in [sic] sustained significant blunt force trauma to the head. I'm sure his helmet would have conferred some degree of protection but it's self-evident from the examination that it wasn't sufficiently protective to prevent him suffering the catastrophic head injury."*
[20] Transcript page 10.
[21] Transcript of the directions hearing on 9 August 2019.
[22] Statement of Giacomo D'Imperio dated 10 January 2018 at pages 28-31 of the inquest brief, specifically at page 29.

30. Neither Mr D'Imperio, nor any of the other witnesses who attended the inquest saw Sebastian taking the tabletop jump, saw how he landed the jump, or observed the nature and extent of any impact between Sebastian and Alexander and/or their motorbikes. It follows that the only eyewitness to the incident proper was Alexander, while some others witnessed the immediate aftermath and assisted with the first aid response.[23]

31. Prior to making his first statement to police for the coronial investigation, Alexander gave two earlier, arguably more "contemporaneous" accounts. The first to club president Wayne John Ridley (**Mr Ridley**)[24] who asked Alexander to return to FCMP the day after the incident to 'give him some clarity' about what happened. Alexander and his father met Mr Ridley at FCMP around midday on Sunday 17 December 2017 and Alexander gave an account that was recounted by Mr Ridley in his second statement. As conveyed by Mr Ridley, the account given to him by Alexander is somewhat scant but broadly consistent with Alexander's own statements and evidence at inquest.[25]

32. Later that same day at about 7.30pm, Alexander gave an account of the incident to Glen Capuano, a Motorcycle Victoria official who committed his understanding of the account to writing and submitted it as part of a batch of documents, apparently related to critical incident reporting processes.[26] As documented by Mr Capuano, Alexander gave a more fulsome account than the account recalled by Mr Ridley. However, this is also an account that is broadly consistent with Alexander's own statements and evidence at inquest.[27]

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[23] Transcript page 483

[24] Note that although named Wayne John Ridley, Mr Ridley is known as "Ralph" and was generally referred to as such during the inquest.

[25] Statement of Mr Ridley dated 18 July 2018 at pages 49-50 of the inquest brief - *"…I asked Alex to place the witches [sic] hats where Sebastian was to the left of the ramp, one positioned where he was and the third hat was placed where Sebastians [sic]bike was on the ground. He assured me that when he went over, that Sebastians [sic] bike was already on the ground. He wasn't sure if he ran over Sebastian or his bike. He said he hit the bike and then he went over the handlebars and crashed himself…He wouldn't have any opportunity to change his course of action…Alex told me he was on the right side of the track, he went over the hump and could see Sebastian over the jump and then Alex has gone over the jump and Alex has hit him in that second."* Note that some obvious typographical errors have been fixed in the last sentence.

[26] Exhibit H is a batch of four documents sent by Mr Capuano from Motorcycle Victoria to FCMP at 8.30pm Sunday 17 December 2017 and includes a document referred to as Alex Borg's "statement" although it appears to be Mr Capuano's notes of an account given to him by Alexander bearing no signature or other indication that it was adopted in any way by Alexander.

[27] *"I was coming down the straight heading towards the table top, the other rider was in front of me on the left side of the track I was on the right side of the track, like well out of the clear and then he went over the jump I'm not sure how long after I came over the jump, as I was coming down to land he was pretty much coming off the bike like sloppy and came into my path so when I was coming down into the landing zone of the track I think I struck him or the bike I'm not 100% and it send me flying off the bike and I crashed to [sic]… I think the rider was a good 15 meters in front of me 5 or 6 bike lengths it was a good clearance he was on his side and I was on my side son [sic] I assumed that it was safe to jump he was well in front of me he was on his side and I was on my side as he was coming down he must of [sic] crashed into my path as he was coming off, as I have landed I have struck him or the bike it hard to say…it was all clear until it was to [sic] late and I couldn't do anything about it."*

33. Alexander's first statement included in the inquest brief is dated 4 Jan 2018 and sets out his prior experience riding motocross, the regularity of his attendance at FCMP and familiarity with the track, and his activities at the track on 16 December 2017 prior to the incident, including the fact that he probably rode three to five "site laps" which involves riding the track looking for any changes or new obstacles. The track was not busy, and he rode twice around it without noticing any other riders.[28]

34. In that statement, Alexander stated that he first noticed Sebastian as he (Alexander) was approaching the final table-top jump on the right-hand side of the track and could see him closer to the left of the track, about 20-30 metres ahead. Alexander further stated that Sebastian *may have been going a bit slower* than he was. Alexander took the jump and became airborne clearing the table-top by about one to two metres. While airborne, he saw Sebastian on the ground still on his bike which was out of control. Sebastian's bike then turned directly into his path, and he was unable to alter course as he was in the air. He landed instantly as Sebastian landed in front of him. It was simultaneous. He is unsure if he hit Sebastian or the bike. The collision caused him to cartwheel over his handlebars and flip once or twice before landing in the dirt while his bike also flipped and landed in front of him about five to ten metres away from the impact point with Sebastian. [29]

35. Alexander got up and ran to see if the other rider was okay and found him still under the bike with blood coming of his helmet. He started screaming out and waving his arms to get anyone's attention. A lot of people immediately came over. He remembers hearing something about an ambulance and does not 'really remember much after that as he believes he was in shock.'[30]

36. Alexander's second statement is confined to the meeting between himself, his father and Mr Ridley at the incident site at FCMP the next day. Alexander's account of this meeting was broadly similar to Mr Ridley's as to the time, date and purpose of the meeting and the identity of those participating.[31] Contrary to Mr Ridley's account, Alexander did not recall that he 'laid out cones to show where he was.' Rather, he states that he told Mr Ridley that Sebastian was in front of him and then he stood at the jump and 'visually showed him where the other rider was and where he

[28] Alexander's statement dated 4 January 2018 is at pages 32-34 of the inquest brief.
[29] Page 33 of the inquest brief. Note that I have referred to Sebastian in the finding whereas Alexander refers to "another rider" or "the other rider" in his statement.
[30] Ibid.
[31] Alexander's second statement is dated 1 July 2018 and is at pages 35-36 of the inquest brief. Note that he refers to *"another person who I believe is a club committee member"* whereas at page 49 of the inquest brief Mr Ridley states *"In attendance was myself and Jeanette Wiseman."* whereas Ms Wiseman's statement at page 138 of the inquest brief is silent on this issue.

was and where he (that is Alexander) landed on him.'[32] Alexander stated he believed that Mr Ridley – *"had the mindset that I was right behind Sebastian and I had to show him where I was on the track which was on the far right on the track and that Sebastian was on the far left of the track."*[33]

37. At inquest, Alexander was questioned at length about how the incident occurred and other aspects of the circumstances which will be discussed below.[34] The transcript accurately captures Alexander's confusion between left and right when describing Sebastian's and his position on the track immediately before they took the jump; his consistent use of gestures toward the opposite direction as he used the words "left" and "right" in evidence; and my intervention to ensure the parties and I understood what he meant to convey.[35] Despite this apparent confusion, a fair reading of Alexander's evidence shows it to be consistent with his earlier accounts and his two statements. In other words, his evidence was that as they approached the jump, he was riding on the right side of the track while Sebastian was riding on the left side of the track and that they each took the jump from those positions. [36]

38. According to his evidence, Alexander was mid-way between the last two jumps when he first noticed Sebastian who was 30 metres ahead of him and about ten metres from the top of the jump or nearing the base of the jump. There was no speedometer on Alexander's bike; he could not say how fast he was riding; denied it could have been as fast as 80 kph; but conceded he was riding faster than Sebastian. It follows that Alexander was gaining on Sebastian to some extent as they approached the last jump.[37]

39. Alexander saw Sebastian take the jump, then he took the jump himself and became airborne. Once airborne, he saw Sebastian *"get wonky on landing"* as he was coming down the other side of the jump and steer across into his (that is Alexander's) path as he was landing. Alexander could not

[32] Alexander's second statement at page 35 of the inquest brief/Exhibit A. I note that when Alexander was asked to adopt his second statement at inquest, he did so by amending the sentence *"I visually showed him where the other rider was and where I was and where I landed on him."* to *"I visually showed him where the other rider was and where I was and where I landed just before and then collided."* See transcript pages 20-21 where this amendment is made.

[33] Ibid. While asked about the meeting with Mr Ridley the next day during the inquest, Alexander's evidence was substantially the same as the account in his second statement and differed from Mr Ridley's in that he had no recollection of putting any cones out himself or of anyone else doing so.

[34] I note that Alexander gave evidence voluntarily without making an application pursuant to section 57 which affords witnesses protection against self-incrimination. See transcript page 19 for discussion of this issue.

[35] Transcript pages 27, 56 and 98. It is noteworthy that when asked to mark his position on a photograph of the track in the vicinity of the jump, Alexander placed himself to the right of the track, consistently with his statements and earlier accounts. Transcript page 64 and Exhibit A "Photos at page 191 of the inquest brief marked by witness Borg".

[36] Transcript pages 27-28, 51-53, 65-66, 70, 73-75, 94 and 98.

[37] Transcript pages 27, 67.

steer himself out of difficulty while airborne.[38] When he landed on the down ramp, Sebastian was 'probably a metre or two in front' of him. Alexander landed and then his front wheel struck either Sebastian or his bike, he couldn't say which.[39] He recalled that both Sebastian and his bike were on the ground and added – *"I don't really remember if he was with the bike or not – like fully seated or not. Like, if he was stuck under it or something. I know he was off the bike, like, he wasn't upright with the bike when he's come off. As he's swerved off, he's, you know, come off with the bike. He definitely wasn't upright."* [40]

40. There is a body of evidence from witnesses who arrived at the scene shortly after the incident, before first aid efforts disrupted Sebastian's position on the ground, in particular, relating to the position of his bike.

41. Before turning to the evidence of those witnesses, it is necessary to have some appreciation of the *safety light warning system* as it is described in Mr Ridley's statement.[41] There are a total of ten red warning lights around the main track able to be activated from five locations - two fixed devices, one at each end of the main viewing platform; and three remote devices - one in the marshals' buggy, one mounted on the handlebars of the FCMP marshal's motorbike and one allocated to a third marshal.[42]

42. Once activated, all ten red lights start flashing. As part of their induction, riders are instructed to heed the red flashing lights which indicate a serious hazard somewhere on the track; to slow down; maintain a safe pace; roll any jumps; and exit the track if a marshal is waving a red flag; or slow down if a marshal is waving a yellow flag.[43] The system does not indicate the site of an incident, just that there is an incident somewhere on the main track.

43. Aaron Lee Holland (**Mr Holland**) responded to Alexander waving his arms around and was first to arrive at the scene after the incident. He did not mention seeing the red lights flashing. At inquest he stated Sebastian *"had one arm up over the side of the bike on like the petrol tank and*

[38] The fact that once airborne a rider (other than a professional or 'A' grade rider) would have no ability to steer out of trouble in such a situation was uncontroversial and supported by evidence from a number of witnesses who had experience riding motocross. See Mr Gundry's evidence at transcript page 208, 231; Mr Glucz's at page 270, 275; Mr Fucsko at page 256; Mr Lloyd's at page 406; Mr Ridley's at pages 467-468; and Mr Mestrom's at page 786-7.
[39] Transcript pages 27, 54-56, 93-94.
[40] Transcript pages page 56.
[41] Mr Ridley's statement at page 46 of the inquest brief.
[42] Ibid and transcript pages 443-448
[43] Ibid, especially at page 446.

his helmet, head was underneath the petrol tank on the side, so his head was between the ground and the bike", in keeping with the description in his statement.[44]

44. Jamie Gundry (**Mr Gundry**) arrived at the scene next, at about the same time as Mr Ridley. He was returning to the main viewing platform after visiting the canteen, 'saw the red lights flashing and then saw Alexander with his hands in the air putting them on and off his head'. At inquest, Mr Gundry adopted his statement in which he said about Sebastian that the *"bike was on him from shoulder to head"* before he decided to remove the bike to facilitate first aid. In response to a question from Ms Wood, he added by indicating that the bike was on Sebastian's upper chest, and from there up.[45]

45. Mr Ridley, the FCMP club president, arrived at about the same time as Mr Gundry. He saw other marshals making their way over to the site of the incident and noted the red lights were activated. On arrival he described Sebastian as *"caught trapped, with his head under the motorcycle between the front forks and the tank shrouds. His bike was lying on the ground and his left arm was over the handlebars and the bike was on top of him."*[46] Mr Ridley was not cross-examined about this aspect of his evidence at inquest.

46. Another early arrival after the site of the incident was John Edward Fucsko (**Mr Fucsko**). He had responded to seeing Alexander jumping up and down, waving his arms, rather than the red lights, which he noticed were flashing once he got to the site. In his statement, Mr Fucsko described seeing Alexander on his feet and Sebastian on the ground under his bike. At inquest, he was asked if he could expand on this description and testified that the bike was on top of Sebastian's *"chest upwards…like in upwards, stuck between the front wheel and the frame of the bike"* with the bike on top of his head.[47]

47. Matthew Glucz (**Mr Glucz**) was at the back of the track when he saw suddenly a kid (Alexander) waving his hands around near one of the jumps and went straight over to find *"Sebastian was on the ground…He was tangled up in his bike…his head was under the forks of the bike under the radiator. He was stomach down and he had an arm, I think it was his left arm, draped over the bike."* At inquest he modified his description of Sebastian in relation to his bike by saying that

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[44] Transcript page 109 and page 43 of the inquest brief.
[45] Mr Gundry's statement dated 6 July 2020 is at pages 58-59 of the inquest brief and transcript pages 181, 200, 228-9.
[46] Mr Ridley's first statement dated 17 January 2018 at page 47 of the inquest brief/Exhibit A. Mr Ridley was cross-examined about the sequence of events and what first drew his attention to the incident, see transcript pages 463 and following. It seems unlikely that the red flashing lights could have been activated before the loud over-revving he heard that he attributed to the incident involving Sebastian and Alexander.
[47] Mr Fucsko's statement dated 6 July 2020 is at pages 143-144 of the inquest brief and his evidence on this issue is at transcript page 252.

what he meant was *"he was under the bike sort of chest up but his head sort of in between the radiators and the forks under the bike."*[48]

48. In his statement, Michael Reefman (**Mr Reefman**), an experienced rider and accredited coach, stated he was riding around the track when he saw the flashing lights, looked around to see where the incident was and rode straight over to find Sebastian was *"laying on the ground still on his bike, like he had never let go. His left arm was draped over the handlebar…His head was pushed around into the radiator, between the shroud and the suspension forks."*[49] Mr Reefman was not cross-examined about this aspect of his evidence at inquest.[50]

49. The broad consistency of the above accounts will be apparent, albeit there are nuanced differences and greater specificity in some accounts than others. However, descriptions of the post-impact resting position of Sebastian and/or his bike do not elucidate either the number of impacts suffered by Sebastian or their sequence, nor do they speak to whether there was an impact between the front wheel of Alexander's bike and Sebastian directly, with his bike or both.

50. At my direction, expert evidence was sought from collision reconstructionist Detective Sergeant Dr Jenelle Hardiman (**D/Sgt Hardiman**) who was provided with the inquest brief, digital images of the scene and a DVD containing aerial photographs of the main track of FCMP and asked to comment on the collision that caused Sebastian's death. In her report, D/Sgt Hardiman stated that she was unable to conduct any crash analysis to determine the speeds of either motorcycle (noting that there was no applicable speed limit) and, as she did not attend on the day of the incident, could not attribute any tyre marks to any particular motorcycle (noting that the track appeared to have heavy use with numerous tyre track marks at the scene. She concluded that there was nothing in the inquest brief to suggest that the collision occurred other than as described by Alexander in his statement and that the physical evidence was consistent with his account.[51]

51. Ultimately, my assessment is that Alexander was an honest and credible witness trying his best four years after the event, to recall an incident that was unexpected, sudden and frightening, and

[48] Mr Glucz's statement dated 23 February 2020 is at pages 135-137 of the inquest brief and his evidence on this issue is at transcript pages 269-270.
[49] Mr Reefman's first statement dated 13 August 2018 is at page 37 of the inquest brief.
[50] The main thrust of cross-examination was about the condition of Sebastian's bike, the extent of his involvement with the bike on an occasion about two weeks before Sebastian's death and his inspection of the bike in company of Mr Ridley while it was stored in the clubhouse maintenance room on 21 December 2017. See transcript pages 290-330.
[51] D/Sgt Hardiman's report dated 28 August 2019 is at pages 116-120 of the inquest brief.

associated with the death of another young man and risk of injury to himself.[52] He was the only witness to the incident and there is no good reason not to accept his evidence at face value.

The first aid response

52. While it is clear the red flashing light system was activated, the investigation has not identified the person who activated the system or what caused them to do so, nor the elapsed time between the incident and Alexander drawing attention to the incident. In the absence of any suggestion that Alexander was injured or suffered a loss of consciousness, it is reasonable to infer that he was waving in distress and drawing the attention of others within moments of Sebastian being injured.

53. As noted above, first to arrive at the scene were Mr Holland, Mr Gundry and Mr Ridley who arrived at about the same time, Mr Fucsko and Mr Glucz who arrived at about the same time, shortly after. There is some inconsistency in their accounts in terms of the order in which they arrived which is not unusual in such situations and not material to the circumstances. Despite this inconsistency, there is evidence that within one or two minutes of Alexander attracting their attention, members of FCMP including marshals were at Sebastian's side, CPR had commenced, and emergency services had been called.[53]

54. Several witnesses facilitated CPR or assisted in its deliver. Mr Holland recalled picking up Sebastian's bike and loosening his helmet with Mr Ridley's help. Others arrived but he could not say who they were. He supported Sebastian's head as Mr Ridley commenced CPR. After some time, Mr Gundry relieved him and then AV paramedics arrived at the scene.[54]

55. Mr Gundry held a Level 2 First Aid qualification. He placed Mr Holland at the scene before him and recalled helping Mr Ridley remove Sebastian's helmet before commencing CPR with 'breaths and pumps' while he, that is Mr Gundry supported Sebastian's head in position and called emergency services at the same time. He stayed on the phone communicating with the emergency call-taker and relaying CPR instructions until AV paramedics arrived. He could not say how long but estimated they were doing CPR for about 15 minutes until AV paramedics arrived.[55]

[52] Transcript pages 19-98.
[53] Note that there were several calls to emergency services as evidenced by the Event Chronology at pages 227-243 of the inquest brief. The chronology also conveys the desperation of the callers and their efforts to save Sebastian's life.
[54] Inquest brief at page 43 and transcript pages 108-109, 116, 120.
[55] Inquest brief pages 58-59 and transcript pages 201.

Furthermore, he estimated that two to three minutes passed between the incident and his call to emergency services.[56]

56. Mr Ridley also held a Level 2 First Aid qualification. He estimated that it took him about 15 seconds to get from his position on the centre track across to the scene after seeing Alexander waving in distress.[57] Having established that Alexander was okay he went straight over to Sebastian.[58] Without going into detail about the signs of trauma he found, it is clear that Mr Ridley was integral to the provision of CPR to Sebastian which he also estimated was ongoing for some 15 minutes before AV paramedics arrived.[59]

57. While AV paramedics were not required to provide statements or attend the inquest to testify, AV VACIS patient care records were included in the brief. There is nothing on the face of those documents to suggest that the attending paramedics were not dispatched and did not respond in a timely fashion, or that they had any concerns about the administration of CPR that was underway when they arrived at the scene.[60]

Track supervision on the day

58. There is an obvious overlap between the issue of track supervision on the day and compliance with applicable safety standards. In this section, I will address track supervision in the sense of who was marshalling on the main track immediately before and at the time of the incident, their vantage points or marshalling positions, and whether the number of marshals complied with the requirements agreed between FCMP and Motorcycling Victoria (**MV**) in the aftermath of the death of Danny Leigh Edlington at FCMP in 2015.[61] As regards the latter (although not as clear as it might be in the documentation provided to the court and referred to by the relevant witnesses in evidence) it was uncontentious and understood that MV required three marshals on the main track

[56] Transcript page 212. Note that there were several calls to 000 as evidenced by the ESTA Chronology Report Event ID 88370348 at pages 227 and following.
[57] Transcript page 465.
[58] Transcript page 482.
[59] Inquest brief pages 47 and 56
[60] Inquest brief pages 79-185.
[61] Mr Edlington died at FCMP on 4 April 2015 from a head injury sustained when he fell while negotiating a two-stage jump and was impacted by another rider and his motorcycle. I finalised the coronial investigation of Mr Edlington's death in chambers and made some prevention-focused comments and a recommendation such that the finding was published on the CCOV's website in accordance with the practice in this jurisdiction. Note that Mr Edlington did not fall at the same jump as Sebastian but at a two-stage jump further back along the main track. FCMP was closed for some time after Mr Edlington's death and did not re-open until November 2015 when Frankston City Council was satisfied that it was safe to do so. This will be discussed in some detail below at paragraphs 85 and following.

if there were between ten and 20 riders.[62] For convenience the document will be referred to as the "procedures" hereafter.[63]

59. When she attended FCMP immediately after the incident, coronial investigator LSC Russell obtained a copy of a document entitled "Motorcycling Victoria Inc. List of Officials at the Meeting" for 16 December 2017 (**the first list**). At a later time, LSC Russell obtained a number of documents from MV including a different version of the "Motorcycling Victoria Inc. List of Official at the Meeting" also dated 16 December 2017 (**the second list**).[64] The discrepancies between the two documents are striking, unsubtle and potentially colourable. They *suggest* that acceptance of FCMP documentation at face value may be problematic.

60. A comparison of the first list and the second list shows many points of differentiation.[65] Most relevantly, the list of names of officials has grown from six on the first list to eight on the second list, with the addition of Mr Ridley and Mr Lloyd, and the addition of the Motorcycle Australia Licence numbers where appropriate and Official Levels (all purportedly Level 2).[66] It does not follow that there were eight, or even six marshals on the main track immediately before and at the time of the incident.

61. According to Mrs Melinda Lloyd, the established practice at FCMP was to use one list to cover all five tracks including the main track, the focus of this investigation, without differentiating on which track the named individuals were marshalling, or whether they were simply supervising their own children, as some were in fact doing nothing more than that. Nor did the list stipulate

[62] The document bearing the insignia of MV and the Frankston City Motorcycle Park is at pages 211-219 of the inquest brief. On its face, it is identified as Version 5 October 9th 2015 and was described by Mr Mestrom in evidence as a "guideline". As discuss below, it was arrived at after a series of meetings between MV and FCMP.

[63] In its preamble on page 212 of the inquest brief, the document is described as an *"overview of processes/procedures that should be followed on any given date the track is open."*

[64] See LSC Russel's second statement at page 128 of the inquest brief and page 177 for the version obtained by the CI from FCMP on 16 December 2017 and page 178 for the version provided to the CI by MV.

[65] Note that to the extent that there was a suggestion that there had been a change in date from 13 to 16 December 2017 that was colourable, I accept Mrs Lloyd's explanation about closure of FCMP on 13 December 2017 due to "heat wave" conditions and that the alteration in the date was innocent rather than colourable. See transcript pages 5750576; page 176 of the inquest brief which is the altered document and Exhibit E which are coloured photocopies of the documents at pages 176 and 177 of the inquest brief. This is consistent with Mr Ridley's and Ms Lloyd's evidence that FCMP was closed on 13 December 2017.

[66] The first list appears at page 177 of the inquest brief and the second is at page 178. Both lists are difficult to read due to the handwriting of those apparently adding their names to the lists. However, it is tolerably clear the first list comprises Aaron Holland; an illegible name with initials O M; Alex Terry; Matt Glucz; Kodi surname illegible; Jamie G (for Gundry); while the second list comprises all these names plus Wayne Ridley on the sixth line and Matt Lloyd on the eighth.

the times during which the named individuals were marshalling, when they took meal or rest breaks, and which marshalling positions or vantage points they were occupying.[67]

62. In short, the list of officials cannot be relied on as a list of officials at all, and certainly not as a list of officials on the main track at the material time. There is therefore a need to rely on the evidence of those FCMP members who provided statements and/or testified at inquest to elucidate just who was marshalling on the main track immediately before and at the time of the incident.

63. Although on the list of officials, it is now clear that Mr Holland was on the main track supervising his own children, filming his son Lucas who was an intermediate rider but was riding on the main track at about the time of the incident.[68] According to Mr Holland, there were only two or three other riders on the main track at the time. Mr Holland himself was not riding and at inquest he stated he *"was just there to keep an eye on"* his kids. He did not purport to be performing the role of marshal and agreed that he was not in a position to dispute the evidence of those who said they were,[69] save that he agreed that there was a marshal monitoring riders coming onto and leaving the main track.[70]

64. Mr Gundry acknowledged his Level 2 first aid qualification but could not recall having qualified as a Level 2 marshal.[71] Nevertheless, he testified that he was marshalling on the main track earlier in the day in the club buggy. At the time of the incident, he was nearby, returning to the main track after having organised lunch for the committee members.[72] He described traffic on the main track that day as maybe moderate but definitely not heavy.[73] It is worth noting that he did not speak in terms of absolute numbers or refer to the requirement for three marshals when there were between ten and 20 riders on the main track, either explicitly or implicitly.[74] When asked to nominate those who were marshalling on the main track that day, he named Mr Ridley, Mr Lloyd

[67] Transcript page 572-574. Mrs Melinda Lloyd was not asked to provide a statement for the inquest brief (see transcript page 584) but was asked to attend the inquest to testify to shed light on some of the processes in place at FCMP, in particular as regards documentation. Mrs Lloyd's evidence begins at transcript page 569 after a "recording malfunction" noted by the transcript provider.

[68] Transcript pages 102-104. This anomaly appears to be a breach of the applicable safety standards that was condoned in practice and will be discussed below.

[69] Transcript pages 120-122.

[70] Transcript page 119.

[71] Transcript page 183-185, 239. Mr Ridley and Mrs Lloyd both gave evidence that Mr Gundry had undergone the necessary training and was indeed a Level 2 qualified marshal as at the date of the incident. See transcript page 453 for Mr Ridley's evidence and page 584 for Mrs Lloyd's evidence in this regard.

[72] Transcript page 186. Mr Gundry testified that it was about 12.30-12.45pm when he decided to walk off the main track and go to the canteen.

[73] Transcript page 185.

[74] See pages 212 of the inquest brief for the relevant procedures.

and Mr Glucz. With prompting from Ms Wood, Mr Gundry agreed that Mr Fucsko and Mr Clough were also marshalling on the main track.[75]

65. At inquest, Mr Gundry marked an aerial photograph of FCMP to indicate the usual marshalling positions around the main track with commentary about the best vantage points.[76] He testified that marshals rotated positions during the day so as not to become fatigued and they communicated via a two-way radio system.[77] In re-examination, Mr Gundry clarified that he could not actually say how many marshals were on the track at the time of the incident, or when he left the track shortly before the incident.[78]

66. Other than saying that he and Mr Ridley were at two positions near the pump shed prior to his meal break, with a good view of the fifth and sixth straights (the latter being the Freeway straight), he could not say where any other individual marshals were positioned.[79] Although he nominated Mr Lloyd as someone who was marshalling immediately prior to the incident, Mr Gundry conceded that he could be wrong about that and would defer to Mr Lloyd' evidence on this issue.[80]

67. According to Mr Gundry, marshals were required to ensure the track remained safe at all times, attend to riders who came off their bikes, operate the emergency lights when required, and view the bikes as the go past. Personally, he had a particular focus on flat tyres, loose parts on bikes, maybe a loose chain. If he saw something of concern, there would be a quick consult with other marshals and a decision whether to slow or close the track. Because of the potentially broad range of skills in riders, there was also a focus on ensuring that higher skilled riders do not race against less experienced riders or behave immaturely.[81] Mr Gundry disagreed with Ms Duffin's description of the riding culture at FCMP and stated that if he had seen such conduct, he would certainly have pulled the riders up and told them not to ride like that.[82]

68. As at the date of the incident, Mr Fucsko had been a member of FCMP for ten years, a committee member for five years, a qualified first aider and an accredited Level 2 marshal.[83] He testified that

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[75] Transcript pages 187-188.
[76] Transcript pages 189 and following, most helpfully described at pages 196-197, 226-227.
[77] Transcript pages 194, 224.
[78] Transcript page 237
[79]Transcript page 192, 194, 222, 224.
[80] Transcript page 225.
[81] In answer to a question from Ms Wood about how he would know riders were acting immaturely, he answered – *"You could generally tell. Um, if they're laughing under their helmet, they'll make a noise or they'll make a gesture. Um, just the way that they don't zig-zag or they ride straight, their jumping techniques. Um, generally, like you would see on a freeway, the car. You would see someone driving erratically and you would say, no, that's not right, that's not the way we ride here…Yeah, just stop them immediately. Pull them aside and say, that's not what we're about.* Transcript page 199.
[82] Transcript pages 199-200, 202-203, 236-237.
[83] Transcript pages 247-249.

he was marshalling on the main track on the day, positioned near the main track from where most of the track was visible.[84] He described the track as perfect and said there were 'not many riders' on the track before the incident, probably 'ten or so riders'. He did not recall any trouble with any behaviour or any dangerous riding.[85]

69. Mr Fucsko's evidence was that apart from himself, those marshalling at the time of the incident were Mr Ridley; Mr Holland; Mr Glucz 'in the buggy'; another marshal at the entry point whose name he could not recall but then identified as 'one of two Steves'; Jamie who was 'floating around somewhere' but he could not say where; Mr Graydon who was a parent/marshal in the same vicinity as 'John F'; and Steve Gryls.[86] Mr Fucsko disagreed with the suggestion that there was inadequate supervision of the track on the day of the incident.[87]

70. As at the date of the incident, Mr Glucz had been a member of FCMP for two years and had only joined the committee a 'month or two' before. In his statement, he recalled 16 December 2017 as a 'very quiet day' with only about ten to 12 riders. His recollection was that there were three marshals around the track ('John', 'Ralph' the club president, and himself), as well as 'Steve' on the gate and 'Jamie' sweep riding.[88] He described the latter as a roving marshal wearing a distinguishing vest who rides around the track and can stop and help as required. [89]

71. At inquest, Mr Glucz testified that he was not an accredited Level 2 marshal, and described himself as an unofficial marshal who volunteered his services and positioned himself wherever Mr Ridley wanted him. He described the role of the marshal as 'keeping an eye on the track and making sure everyone is doing the right thing and following the rules'[90] by which he meant the rules as depicted in the induction video.[91]

72. He could not comment on Ms Duffin's criticisms of culture at FCMP as her attendance pre-dated his membership at FCMP. In terms of his experience, while he conceded that riders sometimes 'showed off, they did not normally do so near other riders'. He only recalled sending one rider off

[84] Mr Fucsko's statement is at pages 143-144 of the inquest brief and his diagram depicting the main track and the positions of some of the marshals at page 145.
[85] Transcript page 249, 261.
[86] I note that Steve Gryls was not mentioned by any other witness, nor does his name appear on either the first or the second list, although it has to be said they are difficult to decipher.
[87] Inquest brief page 145 and transcript pages 252-255. It is tolerably clear that the reference to 'Jamie' refers to Mr Gundry, 'John F' on the diagram is a reference to himself, and 'Steve' at the entry point is Steve Clough – see paragraph 75 below.
[88] Mr Glucz statement dated 23 February 2020 is at pages 135-137 of the inquest brief and transcript pages 266-268. Although he did not give their full names, it was uncontentious that he was referring to Mr Fuscko, Mr Ridley and himself being spaced around the main track, Steve Clough on the gate and Mr Gundry as the sweep rider.
[89] Transcript page 266.
[90] Transcript pages 265-266.
[91] Transcript page 273.

the track the whole time he was there and that was for 'being stupid'. Mr Glucz had not observed any concerning behaviour in the lead up to the incident and agreed with Mr Fucsko that it was a 'rather quiet day' with adequate supervision from five or perhaps six marshals.[92]

73. As president of FCMP and someone who was almost always there when the FCMP was open to the public, Mr Ridley was responsible for organising marshals. In his absence, another committee member would organise them. Communication between committee members would be via the club's Facebook account, by telephone or simply by discussions on the previous day when the park had been open. Mr Ridley would allocate marshalling positions ensuring there were sufficient marshals depending on the number of riders, three marshals if there were between ten and 20 riders.[93] Communication between marshals on the main track was via radio if someone needed relieving or wanted to rotate positions during the session.[94]

74. At inquest, Mr Ridley testified that he was marshalling on the main track immediately prior to the incident in which Sebastian was fatally injured. When asked to recall who else was marshalling at that time, Mr Ridley nominated John Fucsko as being 'on a corner behind the tabletop', Jamie Cisco acting as a roving marshal, Matt Glucz, Steven Clough at the entry/exit gate and there may have been others out there 'but under what capacity he couldn't recall'.[95]

75. When asked to explain the marshal's role, Mr Ridley said they were to 'report on any accident, to monitor the track, monitor the riders, make sure everyone is compliant within the way they should be riding, to report on any matters concerning the track and looking out for any bad riding behaviour'. He would 'absolutely' expect a marshal to put a stop to any bad behaviour, to get the rider's attention and deal with it and in the case of more serious behaviour disciplinary action may be taken or a warning issued. Mr Ridley testified that an obvious breach of something depicted in the induction video 'would stand out like a sore thumb' and the rider would be immediately flagged off the track.[96]

76. Several witnesses referred to Steven or Steve Clough, as marshalling at the entry and exit point to the main track at the time of the incident. Mr Clough was not asked by LSC Russell to provide a statement for the inquest brief and was not required to attend the inquest. In submissions, Ms Wood relied on LSC Russell's diary entry regarding Mr Clough which was to the effect that Mr

[92] Transcript pages 267-268.
[93] Transcript page 449.
[94] Transcript page 450.
[95] Transcript pages 453-454. The name 'Jamie Cisco' was not mentioned by any other witness and does not appear on either the first of the second lists although it has to be said the lists are very difficult to decipher.
[96] Transcript page 452.

Clough was on 'gate duty only' and did not approach the site of the incident.[97] The inference was that he would not be in a position to elucidate the circumstances in which Sebastian died and was not asked to provide a statement.

77. Mr D'Imperio's evidence about track supervision as I have defined that expression for present purposes is significantly different from the evidence of those associated with the FCMP. In his statement, Mr D'Imperio agreed that track was in good condition, the weather sunny, perhaps 22 or 23 degrees and there was no sun glare. He recalled there were 'more than 20 riders on the track' on the day and only 'five riders stopped on jump number 7 and perhaps a couple on the second last bend' at the time of the incident. He maintained that there was only one marshal on the track, positioned at the second last bend, who he identified as 'John' and no others, although he had observed there had been more marshals, perhaps three or four, on the track when it first re-opened after Mr Edlington's death.[98]

78. At inquest, Mr D'Imperio stated that when they arrived at FCMP at about midday the car park was full to overflowing and it was a 'busy day' not a 'quiet day' as had been described by previous witnesses. According to his evidence, he only saw one marshal and confirmed that it was John Fucsko, but otherwise maintained that he saw no one else marshalling at the time of the incident. In terms of his experience of marshalling at FCMP on prior occasions, Mr D'Imperio testified that he had previously seen two or three marshals on the main track, but never as many as five, six or seven as might be inferred from aspects of the evidence given at inquest by FCMP officials.[99]

79. None of the witnesses who attended the inquest and said they were marshalling on the main track at the relevant time could give specific examples of action they had taken in respect of concerning rider behaviour in the past, that is before 16 December 2017. This was somewhat surprising and *may* be explained in part by the effluxion of time as the inquest was some four years after Sebastian's death, and the FCMP had been closed in the interim. It was also unfortunate, but not entirely surprising given the size of the main track, its undulations and configuration, that Sebastian's failure to negotiate the last jump and the nature of any interaction or impact with Alex

[97] Exhibit I was LSC Russell's diary note dated 27 February 2018 at 1000 hours was in the following terms – *"Spoke to Steven Clough (marshal @ track) did not go over to scene and was on gate duty only. Observed red light system on, locked gates so no further riders would enter. Nil further to do with collision. Nil statement required."*

[98] Mr D'Imperio's statement dated 10 January 2018 is at pages 28-31 of the inquest brief. His observations about the (lack of) marshals are at pages 29-30.

[99] Transcript pages 638-640, 677-678, 680. I note that Mr D'Imperio's evidence was also different from the evidence of others in respect of who was at the scene by Sebastian when he arrived, and who and how many people were assisting with CPR. Transcript pages 648, 686, 692.

was not actually witnessed by any of the marshals. Whether this also speaks to an inadequacy in the number of marshals or their inattention is difficult to determine.

80. Nevertheless, there was no good reason not to accept their evidence that they were marshalling at the time of the incident. Thus on my assessment of the witnesses, the weight of evidence supports a finding that immediately before the incident there were four marshals on the main track – Mr Clough at the entry and exit point, Mr Ridley, Mr Glucz and Mr Fucsko at various vantage points around the main track – and that they had a common understanding that they were expected to keep an eye on the riders to ensure their safety and to take action immediately if they observed any concerning behaviours on the part of riders.

Compliance with applicable safety practices.

81. There was a body of evidence suggesting that there was a poor safety culture at FCMP and begging the question as to whether this culture caused or contributed to the incident.

82. Ms Duffin[100] was a parent who attended FCMP with her teenage son in about March 2013 and a couple of times in about early December 2015, after the track re-opened following Mr Edlington's death. She noted some positive changes in terms of the induction video and sign in processes but maintained that nothing had changed in her observation in terms of the culture that she considered a safety risk – it was a very busy track with a large volume of riders, riders of differing abilities were still riding the main track at the same time, motorcycles were not being checked by officials and four or five riders would still take jumps at the same time. She did not see any marshals curbing the behaviour she considered problematic.[101]

83. As part of her investigation into Sebastian's death, the coronial investigator, LSC Russell attended another motocross facility unannounced. She observed how the track was run, what safety precautions were in place, both in general and when there was an on-track incident. Her conclusion was that rider safety was paramount at this facility – all riders kept a clear distance between each other, a good distance was observed when any rider negotiated a jump, there was an abundance of marshals at each track, and a process in place when a rider came off their bike. LSC Russell was also able to inspect that club's official documentation and found it legible, complete, and not requiring further explanation. This compared favourably with FCMP documentation which she found incomplete, barely legible and requiring deciphering.[102] I note that by the time LSC Russell

[100] Maryanne Duffin's statement dated 18 January 2018 is at pages 79-81 of the inquest brief and her evidence at pages 130-178.
[101] Transcript pages135-138.
[102] LSC Russell's statement dated 4 April 2018 is at pages 121-125 of the inquest brief, esp. page 123 on this issue.

attended FCMP on 16 December 2017, the track was closed to riders and she did not have the opportunity to observe how the park was managed in order to complete her comparison.

84. In the course of her investigation of Sebastian's death, LSC Russell also viewed numerous pieces of Go-Pro or similar style footage on the internet published showing riders ostensibly at FCMP involved in collisions and demonstrating multiple safety breaches both prior to the collisions and in their aftermath.[103] The problem with such evidence (in common with most "evidence" gleaned from the internet) is its lack of provenance and specificity. The date on which it is taken, may not be the date on which it was posted. It is also not apparent that the footage was taken at a time when FCMP was open to the public and other riders were on the track.

85. Finally, LSC Russell obtained footage of a professional rider, Adam Monea, riding three laps of the main track at FCMP at speed with numerous riders doing much slower speeds in the background, others stopped on the track and an apparent absence of marshals. LSC Russell confirmed that this footage was posted on 20 March 2014 and was therefore taken prior to Mr Edlington's death and pre-dated the changed track and new procedures in place after FCMP re-opened November 2015.[104]

86. An appraisal of compliance with the applicable safety practices or standards, requires some appreciation of Frankston City Council's (**Council**) role in management of FCMP. While, Council owns the land, FCMP is responsible for the operation, use and management of the facility pursuant to the terms of its lease. Historically, FCMP has been operated without direct managerial input from the Council and this remained the situation following Mr Edlington's death.[105] However, there were changes made after Mr Edlington's death in terms of safety improvements to the main track and Council's requirement that FCMP needed to be affiliated with MV as a condition precedent to FCMP being allowed to re-open the track to the public.[106]

87. Prior to May 2015, Council required independent annual audits of the track be undertaken. In practice, these audits were limited to consideration of the safety of the track itself considering issues such as riding speeds suitable for certain sections of track, the configuration of the track and

[103] Appendix 4 of the inquest brief is one such piece of footage which shows a race being started by a person believed to be Mr Ridley standing on the track, not wearing any high visibility gear; there are no marshals on the track; and no emergency lights activated after the collision.
[104] Appendix 5 of the inquest brief. LSC Russell confirmed that this footage was posted on 20 March 2014 and was therefore taken prior to Mr Edlington's death and re-dates the changes procedures in place after FCMP re-opened in November 2015.
[105] Statement of Mr Dennis Hovenden, Chief Executive Officer of Frankston City Council dated 9 January 2018 at pages 104-107 of the inquest brief.
[106] Pages 105-106 of the inquest brief and evidence of Mr Chris Innes, Co-ordinator Risk Management, Frankston City Council at transcript pages 540 and following.

the management of hazards such as trees abutting the track. Council worked with FCMP to ensure audit recommendations were implemented.[107] Through its witness, Chris Innes, Coordinator Risk Management, and in its submissions, Council maintained that the behaviour of participants, be they riders or spectators, was outside Council's remit.

88. Immediately after Mr Edlington's death, Council directed that FCMP be closed to consider whether it could and should be re-opened in a safe manner.[108] A transition committee was formed including representatives from Council, MV and FCMP. Ultimately, the lease arrangements between Council and FCMP were amended to incorporate a requirement that FCMP become affiliated with MV and remain affiliated with MV in order to continue to operate as a public facility.[109]

89. From the Council's perspective, the purpose of this affiliation was two-fold. Council wanted to provide a recreational (as opposed to a competitive racing) facility to deter riders from riding illegally in parks and recreational areas but recognised it did not have the experience or knowledge to operate such a facility itself. Affiliation with MV was considered by Council as the best way to facilitate the continuing operation of the park whilst ensuring, to the greatest extent possible, the safety and enjoyment of patrons and the broader public.[110]

90. Thus, the arrangements in place when FCMP re-opened in November 2015 became aligned with other sporting facilities provided on council land such as AFL football, netball and basketball via exclusive leases and seasonal tenancies. In each case, the guiding rules and standards for the undertaking and management of each sport, including the behaviour of participants and spectators, falls within the remit of the club operating the facility and its peak body, not the council.[111]

91. To be clear, there was no readily accessible and unambiguous safety code for motorcross riding. At least not one that was brought to my attention in the course of this investigation. At a practical level, the applicable safety standards are to be found in the procedures agreed between FCMP and MV following Mr Edlington's death and the induction video which participants were required to view on each occasion when they signed-in to ride at FCMP.[112]

[107] Transcript page 552.
[108] Transcript page 557.
[109] Pages 106 of the inquest brief and transcript pages 556-557.
[110] Transcript pages 545-548.
[111] Transcript pages 543-545.
[112] The induction video was the first of its kind (to Mr Mestrom's knowledge) and the use of such a video was recommended by MV to a number of clubs but has not been mandated at this stage. Transcript pages 293-793.

92. The relevant aspects of the procedures which occupied the inquest were the number of marshals required around the main track at the time of the incident and the concurrent use of the track by riders from different age groups – under and over 16 being the relevant demarcation. While the interest in the induction video was focused on the two riders taking a jump at the same time.

93. Mr Vic O'Driscoll had been a race official for fifty years, was retired and did voluntary work with MA and MV and was a licensed venue inspector. He attended several meetings of the transition committee established after Mr Edlington's death and re-designed the main track at FCMP to improve safety and worked collaboratively with Beau Crichton who undertook the work to ensure the track was fit for purpose as a recreational track.[113] He saw several iterations of the procedures and contributed suggestions and recommendations. Mr O'Driscoll described the procedures not as rules that needed to be followed but as 'a guideline for good operational procedures the very nature of which would suggest a high level of compliance unless there was compelling reason for not doing so'.[114]

94. When asked by Sgt McFarlane, Mr O'Driscoll did not recall discussing with Mr Ridley the permissibility about 'a child riding with seniors' and stated, 'it would go against many years of training and experience'.[115] When asked more specifically about the permissibility of junior and senior riders sharing a recreational (as opposed) to racing track, his stance softened and he allowed of the possibility subject to 'an ongoing observational skills assessment.[116]

95. Mr O'Driscoll's evidence about riders taking a jump at the same time was similarly nuanced. While he agreed that riders should not be going over jumps 'at the same time' or 'be lined up abreast', when Alexander's evidence about approaching the jump was put to him, he opined that 'generally riders as they ride around together are assessing the capabilities of other riders and would stay very well away' from someone who appeared unsafe.[117]

96. Mr Robert Mestrom had been the CEO of MV since September 2016 and was himself an experienced motorcycle rider of some 40 years' experience.[118] He testified about the role played by MV in the aftermath of Mr Edlington's death and the preparation for FCMP to re-open in

[113] Transcript page 599.
[114] Transcript page 601.
[115] Transcript page 603.
[116] Transcript page 604.
[117] Transcript page 607 and at page 609 *"You know, one has got to assume…an element of common sense in just being aware of where you are, doing what you're doing."* It is worth noting that Mr O'Driscoll accepted the risk of falling on the track and being impacted by a following rider as an 'inherent risk' in the following terms *"It is inherently dangerous. You can't eliminate risk. You can only do what you can do to minimise it."* Transcript pages 609-610.
[118] Mr Mestrom's statement dated 17 May 2019 is at pages 84-86 and a second statement dated 2 January 2020 is at pages 87-88 of the inquest brief.

November 2015. MV were involved in the drafting of the procedures, referred to by him as "guidelines" in evidence; the training of marshals to MV level 2 accreditation; the modification and re-configuration of the track to make it safer, involving changes to the dimensions of jumps, the distances between jumps, widening the track to about seven metres, removal of some hazards and re-alignment of the track away from hazards that could not be removed (such as some trees);[119] about 12 months supervision by MV officials by their presence at FCMP on each day when it was open to the public; and on an ongoing basis thereafter, receiving reports from FCMP after each day it was open to the public.[120]

97. Relevantly, he confirmed the requirement for two officials to be on the track for up to ten riders and three officials for between 10 and 20 riders. Mr Mestrom clarified that the officials did not all need to be level 2 accredited marshals but could be adults that were given 'on the spot training'.[121] However, in the interests of safety, one of the officials needed to be level 2 first aid qualified as a minimum. In terms of topics addressed in the level 2 marshal accreditation training, Mr Mestrom set out the contents of the two session of four hours each of training that was undertaken at FCMP which was the usual MV course for accreditation for level 2 marshals.[122]

98. Mr Mestrom also explained the concept of a rider "holding their line" as they progressed around the track which was one of the safety instructions in the induction video introduced by FCMP after Mr Edlington's death and testified about the safety considerations when two riders attempted to take the same jump at or about the same time. A number of other witnesses had been cross-examined about their understanding of what "holding the line" meant in this context and had expressed their opinions about the permissibility of two riders taking a jump at the same time.

99. However, given Mr Mestrom's extensive experience and role as CEO of MV at the time of the inquest, I have accepted his evidence as definitive on these two issues. As regards the safety instruction to hold the line, Mr Mestrom's evidence was *"…now, hold the line, what that means is there's a preferred riding line and it will apex from left to the right, depending on where the corners are. So it won't be run around the left side of the track like you do on your road out here…And hold your line means stay on that riding line, and anyone who is faster than you, it's*

[119] Transcript pages 782-783.
[120] Mr Mestrom was still CEO of MV when he gave evidence at inquest in December 2021. He had been a level 3 accredited official/marshal for 18 years and an MV accredited track inspector for the same period. His experience was mostly in offroad riding and occasional motocross riding. Transcript pages 777-780 and following where he was taken by Ms Wood to the procedures, specifically the section entitled "Sessions" on page 217 of the inquest brief and where he discussed the extent of the supervision of FCMP each day it was open by MV officials for a 12-14 month period before they re-opened after Mr Edlington's death. Exhibit M tendered at transcript page 781 was a pro forma checklist completed by MV official in respect of each day FCMP was open during this supervision period.
[121] Transcript pages 777-778.
[122] Transcript pages 779.

their responsibility to get around you safely, provided you stay on that line…it also references don't look behind, because as soon you've got the handlebars like this here and you look behind, what did I just do? My – my arms took the bike in that direction…"[123]

100. Mr Oldfield referred Mr Mestrom to the evidence of previous witnesses about the merits or otherwise of riders riding over and taking jumps at the same time and asked if he thought it was an appropriate and reasonable practice to permit riders to jump in tandem on a recreational track. His response was *"Yes…as long the track's wide enough and with seven meters wide it's plenty wide enough ah, there shouldn't be an issue with that…"* Later, in re-examination by Sgt McFarlane, Mr Mestrom testified that *"being seven metres wide, as long as one rider was over to the right and the other one was over to the left, that should've been safe and normal circumstances."*[124]

101. Mr Mestrom confirmed that FCMP was one of nine exclusively recreational parks in Victoria and the only one was affiliated with MV at the time it first became affiliated. Since then, two other clubs had also become affiliated, otherwise MV their membership consisted of clubs that were primarily racing clubs but ran recreational sessions at times. The procedures that were arrived at by the transition committee were described by Mr Mestrom as a "one-off" document based on MV procedures for its other affiliates modified to some extent for use by FCMP. Mr Mestrom testified that the procedures used terminology that he would not have used and noted that he 'didn't write the document'.[125]

102. At inquest, Mr Mestrom advised that in late 2019, MA developed the Ride Park Australia Rules (**Rules**) which were trialled at Koo Wee Rup (Victoria) and a few clubs in other States, before being widely distributed around Australia.[126] According to Mr Mestrom, whereas previously it was an 'unwritten rule' that a suitably experienced younger rider 14-year-old rider could be on the main track at the same time as 16-year-old and older, the new Rules recognised and allowed this to occur. Relevantly, the new Rules also do not proscribe two riders taking a jump at the same time. [127]

[123] Transcript pages 789-790 and the explanation continues until page 792.
[124] Transcript page 805.
[125] Transcript pages 794-795 and as to the provenance of the FCMP/MV procedures see transcript pages 799-800. Note that in late 2019, MA developed the Ride Park Australia Rules which were trialled at Koo Wee Rup (Victoria) and a few clubs in other States, before being widely distributed around Australia. Transcript pages 800-802.
[126] Transcript pages 799-802.
[127] Transcript pages 803-804.

Maintenance and mechanical condition of Sebastian's motorcycle.

103. In common with other motocross enthusiasts Sebastian and his father maintained their own motorcycles. Specifically, Sebastian's Yamaha had not been professionally serviced since it had been purchased by Mr D'Imperio about one year earlier. Sebastian had maintained the Yamaha himself with assistance from YouTube instructional videos. Being a recreational facility and not a racing venue, there was no formal scrutineering of motorcycles. In any event, the condition of a rider's motorcycle remained the responsibility of the rider.[128]

104. Sebastian's motorcycle was not seized by LSC Russell immediately following his death. After being moved off Sebastian to facilitate CPR, the Yamaha remained in the custody of the FCMP where it was stored for about five days within their clubrooms until Sebastian's family took it into their possession and stored it in a garage. The Yamaha was inspected by a mechanic on the family's behalf on 13 September 2018 and then stored in the garage again until taken into the possession of Victoria Police.[129]

105. The Yamaha was then inspected by Dale Westoboy Woodland (**Mr Woodland**) from the Collision Reconstruction and Mechanical Investigation Unit of Victoria Police in December 2018, some 12 months after Sebastian's death.[130] While I accept (and it was not contentious) that the Yamaha had not been ridden since Sebastian's death, this is a significant time period and the absence of a chain of custody for the Yamaha over this period is problematic at least in terms of the weight to be attached to this evidence.

106. In his report, Mr Woodland concluded that the Yamaha was in poor operating condition when he inspected it. Specifically, he found the front suspension operating mechanism was not rebounding as intended. Although not defined in Mr Woodland's report, the process of rebounding refers to a motorcycle's suspension returning to its normal position after being compressed. Having removed and dismantled the front forks he drained 140mls oil from the right front fork which he described as a low level; and an even lower 50mls from the left fork. He opined that 'it was most likely oil was leaking prior to the collision'.[131] While there was no catastrophic failure of the front forks,

[128] See Mr Mestrom's evidence about scrutineering at race meeting at pages 773 and following.
[129] Following my perusal of the first version of the inquest brief, I asked LSC Russell to obtain a mechanical inspection of the Yamaha and to enquire about the feasibility of obtaining expert evidence from an accident reconstructionist to further elucidate the circumstances if possible.
[130] The expert report of Dale Westoboy Woodland is at pages 108-112 of the inquest brief. While the report is undated, it related to an inspection conducted within a secure area at Sheen Towing, 12 Tooyal Street, Frankston on 13 December 2018. Mr Woodland described himself as a Mechanical Investigator Forensic Officer Grade 3, from the Mechanical Investigation Unit, Macleod.
[131] Page 110 of the inquest brief. Note that according to Mr Woodland, *"The standard oil level per fork leg is approximately 332mls per fork."*

the low oil levels *would have* been a contributing factor to the rebound operation, and this *may* have been a contributing factor in the collision.[132]

107. Not surprisingly, Mr Woodland was cross-examined in some detail about his report, in particular, about his opinion that the front forks were most likely leaking oil prior to the collision.[133]

108. Ultimately, apprised of the fact that the Yamaha had not been ridden in the twelve months between Sebastian's death and his inspection, Mr Woodland maintained that the degradation of the seals which facilitated the oil leak he observed was most likely a function of degradation over time during normal usage of the motorcycle rather than the result of a hypothetical impact during Sebastian's fall or impact with Alexander's motorcycle. In that sense, the effect of Mr Woodland's evidence was that – that it was most likely that oil had been leaking from the Yamaha' front suspension forks prior to the collision due to normal wear and tear, and that the resultant suboptimal rebound performance of the front suspension *may* have been a contributing factor in the collision.[134]

109. Mr D'Imperio commissioned his own mechanical inspection of the Yamaha and, during his evidence at inquest, produced a MotoGo Tax invoice dated 13 September 2018 which documented a vehicle inspection undertaken at the firm's premises that day.[135] The document takes the form of a list of items inspected and, where indicated, suggests repairs. It does not explicitly address the performance impacts of any deficiencies found. However, the document is consistent with Mr Woodland's inspection in that it identifies a need to replace both front fork seals and the oil.[136]

110. There was also some evidence from Mr Lloyd, a light vehicle motor mechanic, about the condition of the Yamaha. In his statement, Mr Lloyd said that immediately after the collision, he checked the suspension by pushing down on the seat and noticed it seemed stiff and that the front forks did not appear to be properly assembled.[137]

111. Mr Reefman did not have any formal mechanical qualifications but had been racing motorcycles for about 39 years and had always undertaken his own mechanical maintenance and repair work.

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[132] Page 111 of the inquest brief. Mr Woodland also noted that the rear suspension was adjusted to a soft setting and was operating correctly. See also, transcript page 713 where Mr Woodland explained that the soft setting would have been selected to absorb any rebound and make the ride softer especially if you were going over jumps. Otherwise, Mr Woodland noted minor damage to the handlebars and raised no issues with the steering, brakes or tyres.

[133] Cross-examination by Mr Oldfield at transcript pages 716-722, 728-731. Cross-examination by Ms Wood at transcript pages 722-725, 733.

[134] Transcript pages 731-733.

[135] Exhibit J was a 'bike inspection invoice' produced by Mr D'Imperio.

[136] Transcript page 673 where the document is called for.

[137] This is a partial paraphrase of Mr Lloyd's observations about the Yamaha at page 61 of the inquest brief.

He inspected the Yamaha in the clubrooms five days after the incident. He noticed it was not in the greatest condition; the front forks and suspension were out of alignment and really tight; the rear linkage was cracked; (he thought) the rear shock absorber was worn and in need of a service; and, when they pushed down on the back of the Yamaha it sprung straight back up and felt like it had no gas in it. Mr Reefman stated that all these factors would contribute to making the Yamaha a lot harder to ride, especially for a rider of Sebastian's experience level.[138] When taken to Mr Woodland's report at inquest, Mr Reefman agreed that his observations of the Yamaha were consistent with his own observations on 21 December 2017.[139]

STANDARD OF PROOF

112. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, having regard to the 'Briginshaw sliding scale'.[140] When finding facts, a coroner has to reach a comfortable or reasonable satisfaction having regard to all of the available evidence relevant to the questions in issue in the investigation.[141] When considering whether that level of satisfaction has been achieved, regard must be had to the seriousness of the allegation; the inherent likelihood or unlikelihood of an occurrence of fact, and; the gravity of the consequences flowing from a particular finding.[142]

113. This is particularly so with regard to adverse comments or findings about an individual in their professional capacity which should only be made when a coroner has reached a state of comfortable or reasonable satisfaction based on the evidence that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death.[143]

114. It is axiomatic that the materiality of <u>any departure from applicable standards must be assessed without the benefit of hindsight</u>, only on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may become apparent subsequently or may even be obvious once the tragic outcome is known,

[138] Pages 39-40 of the inquest brief. At a more general level, Mr Reefman had the impression that Sebastian and Mr D'Imperio 'did not have much of an ability or awareness about servicing and maintain motorbikes'.
[139] Transcript page 323. Mr Mestrom also gave evidence about his experience with leaking fork seals and stated that he expected that such a leak would be a slow process usually occurring while the motorcycle was in use – transcript pages 807-808.
[140] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336.*
[141] *Anderson v Blashki [1993]2 VR 89 at 96; Secretary to the Department of Health and Community Services v Gurvich [1995] 2 VR 69 at 73;*
[142] *Briginshaw v Briginshaw, op cit, at 362.*
[143] *Ibid.*

are to be eschewed in favour of a fair assessment made from the perspective of the individual at the material time.

FINDINGS/CONCLUSIONS

115. Applying the standard of proof to the evidence before me, I find as follows:

a. The identity of the deceased is Sebastian D'Imperio born 19 July 2001, aged 16.

b. Sebastian died at Frankston City Motorcycle Park, 102 Old Wells Road, Seaford, Victoria 3198, on 16 December 2017.

c. The medical cause of Sebastian's death is injuries sustained in a motor vehicle incident as a motorcyclist.

d. Sebastian's injuries were sustained while he was negotiating the last table-top jump on the Freeway straight of the main track.

e. Sebastian failed to land safely after the jump, lost control of the Yamaha and moved across the track to his right, into the path of Alexander who was airborne and unable to avoid impact with either Sebastian, the Yamaha or both.

f. There were multiple potential impacts that may have led to Sebastian's head injuries – Sebastian falling from his bike, his bike falling on him prior to any impact with Alexander, direct impact with Alexander's front wheel or indirect impact caused by the impact between Alexander's front wheel and Sebastian's bike.

g. I am unable to determine which of these potential impacts led to the head injuries which caused Sebastian's death.

h. The first aid response on the part of FCMP officials who came to Sebastian's assistance immediately after the incident was timely and appropriate and those involved are to be commended for their efforts to deliver CPR until Ambulance Victoria paramedics arrived at the scene.

i. The weight of the evidence supports a finding that there were four marshals on the main track immediately before and at the time of the incident, namely Messrs Fucsko, Glucz, Ridley and Clough.

j. The weight of the evidence supports a finding that there were no more than between ten and 20 riders on the main track immediately before and at the time of the incident.

k. It follows that there was compliance with the procedures which mandated three marshals for this number of riders.

l. The weight of the evidence supports a finding that those marshalling at the time of the incident were aware of their obligations to monitor rider behaviour and to curb any unacceptable behaviour as and when it was observed.

m. The available evidence does not support a finding that there was a poor safety culture generally at FCMP at the relevant time or that such a culture caused or contributed to the incident in which Sebastian sustained the injuries that led to his death.

n. Motocross riding is an inherently dangerous sport that carries a risk of injury, including serious injury and fatality that can and should be minimised as far as possible but cannot be entirely negated.

o. FCMP officials were motocross enthusiasts and volunteers who gave generously of their time so that the park was available to themselves, their children and others who wished to participate in the sport of motocross riding.

p. Following the death of Mr Edlington, there were significant changes made to the main track at FCMP that were overseen by MV with a view to improving rider safety.

q. There were also new procedures agreed between FCMP and MV for the operation of FCMP and a process of supervision by MV officials and ongoing mentoring that was reasonable and appropriate and also aimed at improving rider safety.

r. The language in which the procedures are drafted is not entirely appropriate to a recreational as opposed to a racing or competitive park and could be expressed in clearer language, for example by stipulating different requirements for officials at specific tracks and by articulating the discretion to allow young riders to share a track/session with older riders and how and by who that discretion is to be exercised.

s. Some of the FCMP documentation that came to light in this investigation was incomplete, unclear, misleading and poor by reference to normal business records. It follows that such documentation would not allow MV to effectively oversee FCMP or audit their compliance with the procedures agreed between them on the basis of documents alone.

t. That said, there is no plausible causal connection between any such deficiencies and the incident in which Sebastian sustain the injuries that led to his death.

u. The weight of the evidence does not support a finding that FCMP documentation listing officials on 16 December 2017 was intentionally falsified or altered to give an inaccurate picture of the number of marshals on the track at the time of the incident.

v. Because continuity of the Yamaha was not maintained after the collision, I am not satisfied to the applicable standard that suboptimal performance of the front suspension of the Yamaha *probably* caused or contributed to the collision, however, this remains open as a *possibility.*

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order.

DISTRIBUTION OF FINDING

I direct that a copy of this finding be provided to:

Astrid Swietojanski c/o Zaparas Lawyers

Giacomo D'Imperio c/o Zaparas Lawyers

Frankston City Motorcycle Park

Motorcycle Victoria

Motorcycle Australia

Chief Executive Officer, Frankston City Council c/o Meridian Lawyers

Mr Chris Innes, Coordinator Risk Management, Frankston City Council c/o Meridian Lawyers

Leading Senior Constable Susan Russell, Somerville Highway Patrol Unit

Signature:

Paresa Antoniadis Spanos

Deputy State Coroner

Date: 11 June 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.