CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Scott Orrock
Hearing dates:	12-13 May 2025, Lidcombe Coroners Court
Date of findings:	24 June 2025
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner, Magistrate Devine
Catchwords:	CORONIAL LAW – Death as a result of motor vehicle collision; M4 Motorway James Ruse Drive Exit westbound; manner of death
File number:	2020/102734
Representation:	Counsel Assisting the inquest: Michael Dalla-Pozza of Counsel instructed by Lara Shepherd, Crown Solicitors Office Transurban Limited: Kirsten Edwards SC of Counsel instructed by Erica Elliot Transport for NSW: Nicholas Condylis of Counsel instructed by Kate Dwyer
Findings:	**Identity of deceased**: Scott Orrock **Date of death**: 2 April 2020 **Place of death**: M4 Motorway Westbound, Clyde NSW 2142 **Manner of death**: Motor vehicle collision **Cause of death**: Multiple blunt force injuries
Recommendations:	Nil

Publication orders:	Protected Information Orders apply to the evidence in this inquest. A copy of the orders made can be obtained from the Court Registry.

FINDINGS

Introduction

1 These are the findings following an inquest into the circumstances of the death of Scott Orrock on 2 April 2020, then aged 55. Scott died following a motor vehicle collision where he was the rider of a motorcycle. The accident took place on the westward bound lanes of the M4 Motorway, before the James Ruse Drive exit, following an earlier accident at the same place.

2 I would like to begin these findings by expressing my sincere condolences to the family and friends of Scott for their loss, particularly his widow, Lili Orrock. It is important to acknowledge that Scott's death in such circumstances continues to be felt by her and other family members and will be for the rest of their lives. They have endured a great tragedy.

3 It is also important to recognise that the coronial process represents an intrusion by the State into what is a most traumatic event in the lives of family members and that an unfortunate aspect of the coronial process is that it can require a family to re-live distressing memories. That was painfully obvious in this matter and again I express my condolences to Scott's family and friends for their loss.

Legal Framework

4 Under the *Coroners Act* 2009 (the Act), a Coroner has the responsibility to investigate all reportable deaths. Reportable deaths are defined in section 6 of the Act and include deaths which have not occurred naturally, such as in the present case.

5 The primary purpose of a coronial inquest is to make formal findings as to the following five aspects of a death pursuant to s81 of the Act: (1) the identity of the person who died, (2) the date they died, (3) the place they died, and what was (4) the cause and (5) the manner of that person's death. The inquest investigates the facts and circumstances of a death, places them on the public

record, and in certain cases will examine recommendations that could be made to prevent similar deaths in the future.

6 An inquest is not a forum where a Coroner sets out to prove any allegation or proposition or attribute blame or responsibility. Rather, an inquest is an inquisitorial exercise in fact finding, aimed at discovering what occurred, and it is this principle that steers the approach taken by a Coroner in evidentiary and procedural matters.

The evidence

7 A coronial investigation precedes an inquest. During the investigation, considerable evidence, in the form of witness statements, expert opinions, reports, business records, photographic evidence and more are obtained by, and provided to the Coroner. A report as to the cause of death (a post-mortem report) is provided by a forensic pathologist.

8 In the case of the investigation into Scott's death, a three-volume brief of evidence complied by the Officer in Charge of the coronial investigation, Senior Constable Brian Villamoran, and supplemented by the Assisting team, was tendered to the Court and became Exhibit 1.

9 Although I will touch on aspects of this evidence that I consider important, and not make mention of other aspects, I have had the opportunity to consider the entirety of this material during the coronial process.

10 About what happened on 2 April 2020, the brief was very thorough and clear. Consequently, Counsel Assisting was able to prepare a summary of that evidence. In relation to non-contentious factual matters and issues I have drawn extensively from that document and the submissions of Counsel Assisting. I am enormously grateful to Counsel Assisting, the parties, and their legal representatives for their assistance in this regard.

11 During the inquest, the court also heard oral evidence from:

(1) Mark Hughes, Traffic Control Room Operator

(2) Jason O'Toole, Traffic Control Room Operator

(3) Craig Moran, Executive Director Operations Management, TfNSW

(4) Elizabeth Waller, Head of Road Safety, Transurban Limited

12 As with the brief of evidence, I will touch on aspects of their evidence that I consider important but have had regard to the entirety of what they said.

Scott Orrock's Background

13 The police brief does not disclose much of who Scott was as a person beyond the fact that he was born on 25 March 1965, and he was a member of a motorcycle club.

14 From Ms Orrock's family statement, delivered at the end of the evidence, it became clear that Scott was a much-loved family member, particularly to his twin daughters, Olivia and Crystal. Ms Orrock spoke eloquently of how she met Scott and the times they shared together around his love and talent for art and music.

15 She went onto speak of his daughters' fond memories of being taught how to drive, ride and tattoo and how Scott dealt with issues at their school. She spoke of the children feeling not just the loss of the best father they could have hoped for but their best friend.

16 Ms Orrock continued that Scott was not just a much-loved family member, he was a friend to many and a man who, despite some negative media reports and time in custody, showed real kindness and generosity in his local community.

17 The inquest into Scott's death was reported to the Office of the State Coroner on 2 April 2020. It was not a matter where an inquest was mandatory, and I accept the observation of Counsel Assisting that but for Ms Orrock's strong and persistent advocacy on Scott's behalf an inquest may not have been held.

The events of 2 April 2020

18 As already noted, Scott Orrock died on 2 April 2020, following a motor vehicle accident, where he was the rider of a motorcycle.

19 The accident took place on the westward bound lanes of the M4 Motorway before the James Ruse Drive exit. The eastbound and westbound lanes of the motorway are separated by concrete jersey barriers. There are five westbound lanes, three of which continue on to the M4, and the other two separate off to the James Ruse drive exit. The speed limit for this section of road is 90km/h.

20 At the time of the accident, the weather was overcast, and the road was dry. The area where the accident took place was covered by CCTV.

21 For the purposes of these findings, the furthest outside (or kerbside) lane will be referred to as lane 1, and then the lanes will be sequentially numbered toward the centre most lane, to the left of the concrete jersey barrier, that lane being lane 5.

22 At 12:49pm on 2 April 2020, an accident occurred on the westward bound lanes of the M4 Motorway, east of the James Ruse Drive exit. This accident did not involve Scott.

23 The accident occurred in the area where lanes 1 and 2 begin to divide from lanes 3, 4 and 5 toward the James Ruse Drive exit. At the beginning of this division (between lanes 2 and 3) was a dividing space marked with white chevrons.

24 Mr Sidhu, the driver of a Coles delivery truck, was travelling along the M4 towards Blacktown in lane 3. Ms Pellegrin, the driver of a blue Commodore SV6, was travelling in lane 4 at about 90km/h. Mr Jason Corliss was driving a Mazda BT50 in lane 5, travelling at about 100km/h.

25 Ms Pellegrin told police she felt the Coles truck in the lane to her left coming closer to her in lane 4. The CCTV depicts the truck coming close to her vehicle, though not entering the lane. Ms Pellegrin reacted by steering her vehicle away

from the Coles truck, and subsequently from lane 4 into lane 5, colliding with the front of Mr Corliss' ute travelling in lane 5. The collision caused Mr Corliss' vehicle to collide with the concrete jersey barrier.

26 After colliding with Mr Corliss' ute, Ms Pellegrin told police that she mounted the concrete jersey barrier bordering lane 5 and travelled back across several lanes of traffic before coming to a complete stop in the chevron area. The impact Ms Pellegrin had, if any, with the concrete jersey barrier is unclear from the CCTV of the incident.

27 Mr Sidhu told police that he heavily applied the brakes of the Coles truck at about the same time as Ms Pellegrin's vehicle collided with Mr Corliss' ute. Mr Sidhu then stopped his truck behind Ms Pellegrin's Commodore in the Chevron area between lanes 2 and 3 where the lanes divide off the exit. Mr Sidhu told police he stayed in his truck for approximately 5 minutes before alighting to speak to Ms Pellegrin.

28 Mr Corliss told police that he felt like the front tyres of his vehicle had locked up before his vehicle came to a complete stop. Mr Corliss turned the hazard lights of his vehicle on and remained in lane 5 in his vehicle. He told police he did this as he did not feel safe to exit his vehicle. The damage to Mr Corliss' ute made it undrivable. At about 12:52pm, Mr Corliss called his employer and then at 12:54pm he phoned triple zero and reported the accident to police.

29 At 12:56pm, Scott was riding his black Harley Davidson motorcycle in lane 4.

30 In lane 5 there was a truck slightly ahead of Scott's motorcycle. The truck merged from lane 5 into lane 4. No statement was taken from the driver of this truck as they were never located by police.

31 At around the same time as the truck merged into lane 4, Scott merged into lane 5. Scott almost immediately collided with the rear of Mr Corliss' ute at 12:56:19. Mr Corliss told police he felt the collision with his vehicle.

32 Scott was thrown from his motorcycle and slid 25-30m across lanes 4, 3, 2, and into lane 1, of the James Ruse Drive exit. One second after the initial collision, at 12:56:20, Scott was hit by a Woolworth's truck in lane 1. The truck, driven by Mr Heer, braked and swerved in an attempt to avoid Scott.

33 Mr Heer was travelling in lane 1 at a speed of 85km/h. He told police that he had noticed Mr Sidhu's Coles truck stopped in the chevron area and the traffic braking in lanes 5, 4, and 3. He had applied his brakes, not knowing what was going on, and then saw a body come across the lanes which came to rest in lane 1 in front of him. He swerved into lane 2, as there is no emergency lane or hard shoulder left of lane 1, and was three quarters of the way into lane 2 when he ran over what he thought was a leg. He then swerved back into lane 1 to avoid colliding with Mr Sidhu's Coles truck. Mr Heer stopped his vehicle partially on the road shoulder and partially in lane 1, 100-200 metres further west down lane 1 from Scott's body.

34 Scott suffered catastrophic head injuries, internal injuries, and leg injuries, and died at the scene.

35 New South Wales Police determined not to charge any drivers for their conduct. The Crash Investigation Unit did not attend the scene.

36 It is not contentious that WestConnex (WCX, part of the Transurban Limited group of companies) is responsible for the section of the motorway where both accidents took place and that Traffic Control Room Operators (TCROs) employed by WCX failed to detect the first accident until after the second involving Scott. Further, it was not until after the accident involving Scott that a road safety plan was put into action that included dropping the speed limit.

The Post-Mortem

37 Dr Jennifer Pokorny performed an external post-mortem examination of Scott's body on 6 April 2020 at the Forensic Medicine Centre, Lidcombe. Having considered the information provided and her findings on examination, Dr Pokorny opined that Scott's cause of death was 'multiple blunt force injuries.'

38 In particular, she noted multiple open comminuted fractures of the facial bones and cranial vault, open comminuted fractures of the right lower leg and palpable fractures of the left elbow.

39 Scott's blood was tested for alcohol, common medications, and common drugs, with none being detected.

40 I accept Dr Pokorny's opinion as to Scott's cause of death.

The issues examined at the inquest

41 The issues to be explored in the inquest were distilled down prior to and during the course of the inquest that was held from 12 to 13 May 2025. They were:

(1) The findings required by s 81(1) of the Act.

(2) The appropriateness of the response of WCX in the period between the initial accident at 12:49pm, and the later accident involving Scott at 12:56pm. In particular, why the earlier accident did not come to the attention of the relevant authorities before the occurrence of the later accident.

(3) Whether it is necessary or desirable to make any recommendations arising out of the circumstances of Scott's death pursuant to s82(1) of the Act.

42 Given the nature of coronial proceedings, the conflicting opinions expressed by police and the focused nature of this inquest it is not necessary, nor do I make, any finding as to who was responsible for the collisions that took place. As Counsel Assisting said during the course of his opening submissions, it is not so much who was at fault but the fact that the first collision was not identified for some minutes (and not prior to the second collision) which is the subject of interest in this inquest.

The Evidence Considered

TCRO's – Mr Hughes & Mr O'Toole

43 Mr Mark Hughes and Mr Jason O'Toole provided information in the investigative stage of the inquest and gave sworn evidence in relation to their work as TCROs with WCX. They impressed me as honest and reliable witnesses. Noone submitted otherwise.

44 From the totality of their evidence and a statement from Mr Peter Redwin (the head of Operations and Maintenance at Transurban when he made his statement) the following conclusions can be drawn:

(a) Mr Hughes and Mr O'Toole worked in a Traffic Control Room in Homebush. Mr O'Toole was the more experienced TCRO – having started with WCX in 2017 whilst Mr Hughes started in January 2020.

(b) On 2 April 2020, they were responsible for monitoring the motorway and ensuring it ran smoothly during a 12-hour shift that started at 5:30am that morning.

(c) As such, they had to monitor live-streamed CCTV for any accidents that might occur on the section of the M4 where the two collisions occurred but also monitor background facilities such as fire detection, electrical, water, communication, lighting, ventilation, and hydraulic systems.

(d) It also meant managing the incident response team, monitoring maintenance activities, engaging technicians for technical issues, using systems and traffic plans for the motorway. They also needed to interact with stakeholders, such as police.

(e) TCROs are required to make contemporaneous notes and logs of tasks when workload permits and/or at the end of a shift in a notebook.

(f) TCROs are in frequent communication with the Traffic Management Centre (the TMC) run by Transport for NSW (TfNSW). When an incident happens on the motorway, they communicate with the TMC and seek and provide updates. WCX has its own accident procedures, but the TMC can also provide assistance and, if necessary, change signage on *other* sections of the motorway.

(g) On 2 April 2020, the WCX Traffic Control Room was set up with 3 TCRO workstations. Each workstation was equipped with 4 monitors on a desk, a PC, multiple phones (4-5), push to talk radio and internal phones.

(h) In front of the workstations was a video wall with approximately 60 screens. There were approximately 700 CCTV cameras in motorway tunnels and 30-40 cameras on surface roads and footage from those cameras would scroll through on the video wall. Between Mr Hughes and Mr O'Toole, they had responsibility for monitoring *all* the CCTV displayed and that was normal practice.

(i) TCROs are classroom trained and get on the job training in the use, and monitoring, of CCTV. They have additional training in traffic control room operations and traffic control plan implementation. Mr O'Toole also had considerable experience monitoring CCTV before starting with WCX.

(j) TCROs work 4 day on / 5 days off or 2 days / 2 nights and 5 days off 12 hour shifts. WCX has fatigue management policies and Key Performance Indicators that encourage wellness in place. Mr Hughes and Mr O'Toole have also developed their own strategies for managing fatigue. Their strategies include getting up and going for a walk, looking away from the screens, taking a break, getting a coffee and looking between screens and the video wall.

(k) When monitoring the CCTV for any accident, TCROs often look to congestion, traffic coming to a standstill, traffic swerving, brake lights or anything "abnormal" to alert them to an issue. At times they would being looking for these things in CCTV images depicted on their screen in an area 2-3cm wide and 2cm high.

(l) In the absence of anything "abnormal" it is very hard to detect a stopped vehicle on the motorway. The small CCTV image size referred to and the quality of the image can make it challenging to detect any issue on the motorway.

(m) Mr Hughes and Mr O'Toole did not become aware of the first collision on 2 April 2020 until after the collision involving Scott and consequently took no action in relation to the first collision until after the second.

(n) When they became aware of the collision involving Scott, they took immediate steps to implement accident procedures i.e. they implemented a Traffic Control Plan (TCP).

(o) A TCP is provided for by the Motor Vehicle Accident Procedure found in the brief. That plan involves changes to signage and reduction of the speed limit to 40km/h. Further documentation concerning the detection of and response to accidents or stationary vehicles requires a response to an incident occurring within 2 minutes.

(p) Within 2 seconds of the TCROs implementing the TCP, changes were signposted alerting drivers to the fact there was an incident ahead and advising them to reduce speed.

Kirsty Whalan's Review

45 Mr Hughes and Mr O'Toole's conduct on 2 April 2020 was reviewed by Kristy Whalan, Senior Traffic Control Room Officer – Training Co-ordinator at WCX the same day. In an email published 3 April 2020 she stated that they

performed their job to the best of their ability and that "there was nothing else they could have done" leading up to Scott's accident.

46 In reaching those conclusions Ms Whalan notes that, relative to other control rooms dealing with the Eastern Distributor and M5E tunnel environment, picking up an incident quickly was difficult for reasons including:

(a) Low traffic volumes: this makes it difficult to pick up an incident quickly because there is no grouping of traffic or brake lights to observe;

(b) The number of cameras TCROs must scroll through while actively monitoring the motorway;

(c) The number of camera "tours" TCROs must watch whist actively monitoring the motorway;

(d) Other TCRO jobs that are necessary in the control room;

(e) There were a number of alarms or faults with the system that needed to be dealt with by the TCROs that day;

(f) There were faulty cameras; &

(g) The video wall was faulty.

47 Ms Whalan notes some of what happened in the hour leading up to the first collision and makes other observations to the effect that on 2 April 2020 contractors were doing works around the time, a workstation froze in the hour before the incident and had to be re-started, the system lost communication for a period and needed to be re-set, one of the TCROs was grabbing lunch at about the relevant time and the TCROs were also involved in a de-briefing at the time of the collisions.

48 In their oral evidence, Mr Hughes and Mr O'Toole spoke to the detail of the technical systems and alarms issues that had been ongoing for some months

in the lead up to 2 April 2020. Concerning 2 April 2020 specifically, Mr Hughes and Mr O'Toole spoke of Mr O'Toole's workstation crashing and needing to be re-set prior to the collisions and of being able to juggle their monitoring responsibilities whilst being briefed by "Adam" about a TCRO work related matter. They could not speak to the issues of faulty cameras or the faulty video wall and these matters remain opaque.

49 Over and above the matters referred to by the TCROs and Ms Whelan, the CCTV available to the TCROs on 2 April 2020 was played in Court. From that I observed that the camera was some distance from where the collisions took place and the footage was of relatively poor resolution and colour quality. It does not clearly show traffic consistently slowing and building up or (because traffic is moving towards the camera) vehicle brake lights.

Transurban / Westconnex

50 Ms Elizabeth Waller, Head of Road Safety for Transurban Limited provided two statements in the investigative stage of the inquest and gave sworn evidence for the Transurban group of companies (including WCX). She previously held the role of Acting General Manager of Health Safety and Environment with Transurban and has over 20 years experience in road safety.

51 In her current role she is responsible for leading a team that is responsible for

(a) embedding a safe system approach in designing and building new roads, operating and maintaining assets, and developing and communicating driver behaviour change programs; &

(b) working closely with research institutes on improving safety for motorists, vehicle occupants (including children) and new vehicle and road safety technologies.

52 As at April 2020 she was the Manager Road Safety with Transurban.

53 In oral evidence, Ms Waller told the inquest that the TCROs' 12 hour shifts were industry standard and similar to the shifts required by TfNSW. She said there

were strategies in place to manage fatigue. She spoke to those and of her general understanding of the training given to TCROs and reviews of their performance.

54 Ms Waller declined to adopt Ms Whalan's assessment of the TCROs' performance on 2 April 2020 but agreed that they work in a complex environment and that the task of identifying a stopped vehicle purely by CCTV can be difficult for a TCRO.

55 Ms Waller's first statement details the results of a Road Safety Audit undertaken of the M4 Motorway crash site by RoadNet in April 2020. The audit identified 2 high risk safety findings, namely:

(1) Configuration of the westbound carriageway requires drivers to make a quick decision about which of 2 lanes going to the same direction they should be in and that any poor decision-making in that regard could result in erratic manoeuvres (such as incautious rushed lane changes) and contribute to crashes; and

(2) The combination of a dip in pavement level and the angle of an expansion joint spanning lanes 3 and 4 could impact upon vehicle stability under hard braking.

56 In relation to the first finding, Ms Waller told the inquest that Transurban engaged Samsa Transport Planning & Traffic Engineering (Samsa) in 2021 to assess if additional direction and/or lane designation information for M4 Motorway westbound traffic approaching the JRD off-ramp was warranted.

57 Samsa produced a report dated 18 May 2021 which concluded that the existing signage and lane designation generally provide satisfactory guidance and was sufficient but recommended that "an additional VMS providing directional / lane designation information would potentially provide additional directional information in conjunction with the existing, adjacent signage and pavement markings information (both upstream and downstream)".

58 VMS is an abbreviation for Variable Message Sign. It can deliver information to drivers about specific road conditions or incidents. Transurban accepted Samsa's recommendation to install an additional VMS and moved to obtain TfNSW approval for its installation in 2020.

59 Negotiations were protracted. The reasons for that, beyond some generalities spoken of by Ms Waller, are not adequately explained in the evidence. TfNSW ultimately approved the installation of a new VMS about 500m east of the JRD off-ramp in October 2023.

60 Unfortunately, the installation of the VMS *is* a complex and lengthy process and it was yet to be installed at the time of this inquest. Ms Waller sets out some of the complexities in her statement but appeared to recognise the overall delay involved in its installation was unsatisfactory. She told the Court it was her understanding the additional VMS would be operational by the end of May 2025.

61 In addition to what was proposed in the Samsa report, in September 2023, WCX installed yellow plastic bollards at the chevron divider at the James Ruse Drive off-ramp. Their purpose is to provide earlier visual warning to drivers that a lane change may need to be made. Data analysis conducted by Transurban suggests it has reduced the incidence of harsh swerving and braking by 49% and 46% respectively.

62 Transurban did not accept a recommendation in the Samsa report that separate M4 arrow and JRD arrow pavement markings should be implemented in light of the anticipated benefits the additional VMS would bring.

63 In relation to the second finding of the April 2020 Road Safety Audit, Scott was an experienced and skilled motorcyclist and there is no evidence to suggest the dip and expansion joint played a role in his death. In those circumstances, it is sufficient to note that, according to Ms Waller, Transurban has engaged in regular inspections of the expansion joint as part of its maintenance program and it was procuring replacement in 2024.

64 The April 2020 Road Safety Audit prepared by Roadnet also contained 5 “notes” regarding safety issues.

65 The most important of those in this inquest was the note that the motorway management systems used on the M4 be reviewed to see whether improvement is warranted (in the context of an observation that with a 4/5 lane wide motorway section, there is virtually no chance of a disabled vehicle accessing the kerbside shoulder area and as such the safety of the motorway in relation to secondary crashes is absolutely reliant on advance driver warning systems being deployed in a very rapid and effective way).

66 The other notes relate more to the visibility of signage at night. Again, these are important but given the two collisions in this matter happened during daylight hours and at a time when conditions were clear, neither the notes nor WCX’s response to them needs to be canvassed in these findings.

67 About the first note then, Ms Waller provided evidence that Transurban regularly reviews its incident response plans and procedures and that, in 2023, Transurban consolidated all WCX operations centres under one roof at the Motorway Control Centre at St Peters (the SPI Control Centre). The management systems located within the SPI Control Centre include a new WCX Control Room and the Incident Control Room (the ICR) located next to it.

68 The new WCX control room contains a 60-panel video wall from which all WCX motorways are monitored with more than 1000 cameras, Transurban’s surveillance and detection systems and VMS. The ICR becomes the central command centre if a major incident or emergency occurs (i.e. an event that threatens the safety or well-being of the community, employees, stakeholders of the motorway or major motorway assets).

69 In the new WCX control room motorway incidents are still typically (but not exclusively) identified through CCTV. In tunnels, Transurban also utilises an Automated Vehicle Incident Detection (AVID) system. This system is configured to detect stopped vehicles, wrong way vehicles, smoke, pedestrians/animals, debris, queued traffic, slow traffic and overspeed traffic.

When it detects these things the system sends an alarm to the TCROs who can then verify the matter and put an automated Traffic Control Plan in place.

70 Ms Waller, having heard the evidence of Mr Craig Moran that TfNSW was trialling an AVID system on the Sydney Harbour Bridge (see below), spoke of AVID currently being fit for purpose in tunnels (where a controlled environment exists) but not open roads such as where the collisions in this inquest took place. She said Transurban would be open to liaising with TfNSW about the trial and that if the technology proved reliable and improved road safety Transurban would be open to it being utilised.

71 In her second statement Ms Waller provided additional information concerning the SPI Control Centre including images of it and the former WCX M4 control centre (that is no longer in use). It is clear from this material and her further oral evidence that:

(a) The video wall available to the TCROs is bigger and contains more screens that show more locations. There is also a situational awareness map in the centre of the video wall that shows traffic build up across the WCX network.

(b) The SPI Control Centre has a total of 6 employees on shift at any one time, 24 hours a day, 7 days a week. There are 5 TCROs and 1 Senior Network Operator (SNO).

(c) The SNO is present throughout the shift and provides a layer of leadership, guidance and support for the TCROs on shift.

(d) It is no longer the case that 2 TCROs are necessarily responsible for monitoring the M4 corridor. The entire network is monitored by all 5 TCROs on duty and there is a high level of flexibility in how that is managed by the TCROs under the SNO including when staff take breaks.

(e) The number of TCROs allocated was based on evidence and the WCX Control Room had been operating successfully since 2023.

72 Ms Waller could not speak to the quality of the CCTV installed at the JRD interchange nor the suitability of having a single dedicated screen for the CCTV installed there.

73 About an ARRB Safe System Assessment undertaken of the WCX motorway project in 2020, where motorcyclists are identified as being at high risk (moreso at the JRD interchange), Ms Waller said that level of risk "just is" because motorcyclists are vulnerable and that the only feasible thing that could be done to reduce that risk would be drop the speed of the motorway to less than 60kph.

74 She denied it was feasible to have a dedicated motorcycle lane (that would be safer) because of the low volume of motorcyclists using the motorway.

75 In defending these views, Ms Waller spoke of the steps taken by Transurban to improve safety generally (not all of which are touched on in these findings), a willingness to bring best practices to the motorway, her attendance at international conferences on road safety, sharing literature on measures to improve safety and not having a closed mind to future developments including AVID systems.

76 Her evidence concerning the changes made by WCX was buttressed by Mr Hughes and Mr O'Toole who agreed that the systems issues that confronted them in 2020 have mostly resolved and that the physical and staffing changes implemented by WCX had helped make the onerous work of a TCRO easier.

77 Overall, Ms Waller impressed me as being genuinely concerned for road safety and the loss suffered by Scott's family.

Transport for NSW

78 Mr Craig Moran provided a statement in the investigative stage of the inquest and gave sworn evidence in his capacity as Executive Director of Operations

Management for TfNSW (having previously held the position of Executive Director, Customer Journey Management).

79 As at 2 April 2020 he was the Chief Operating Officer at the TMC and as such held responsibility for the operational management of the TMC.

80 Upon conclusion of the evidence, Counsel Assisting did not address me or seek to be heard on what took place after the second collision. It follows that whilst there was considerable cross-examination on that issue it need not be canvassed in these findings.

81 Mr Moran's evidence establishes that TfNSW also has a monitoring role and some capacity to respond to incidents on the M4 Motorway. I note, in particular the following:

(1) WCX is responsible for having an Incident Response Plan (IRP) with a system in place for monitoring, detecting, responding to and recovering incidents on the section of the M4 which it manages (including where the first and second collisions took place). There is a separate protocol that defines the roles and responsibilities of the WCX TCROs, the TMC and how they interact with each other.

(2) The TMC monitors sections of the M4 motorway that are outside the operation and control of WCX in addition to having oversight of the entire state road network. The TMC monitors CCTV in real time as part of that overview.

(3) The TMC can become aware of incidents on a motorway via several channels. They include:

(a) An incident reporting line, where members of the public can make a report directly to the TMC of an incident impacting the road network;

(b) The Inter-CAD Electronic Messaging System (ICEMS), which is a centre-to-centre electronic messaging system that enables two way messaging between the TMC and emergency services such as NSW Police, State Emergency Services and Fire & Rescue NSW;

(c) Visual observations made by the TMC's control room operators who monitor live CCTV camera feeds across the state road network including 190 CCTV cameras on the M4 corridor for which TfNSW (not WCX) is responsible.

(4) At approximately 12:55pm on 2 April 2020, the NSW Police Control Room advised the TMC of the first collision via ICEMS. The TMC became aware of the second collision a short but unspecified time later. It is not known how the TMC was made aware of the second collision.

(5) Having regard to an WCX M4 Incident Report prepared by Ms Whalan and other WCX records, the TMC reported the first collision to WCX TCROs at 12:58pm (i.e. 3 minutes after receiving notice of it from the NSW Police). That is not unusual and is consistent with the close and collaborative working relationship between WCX TCROs and the TMC. The TMC advised WCX TCROs of the second collision at about 1:05pm.

(6) The TMC dispatched resources after receiving notice of the first collision in accordance with standard incident management practices. It cannot change the speed limit for the section of the road where the collision took place.

(7) Installation of a Variable Messaging System (VMS) east of where the two collisions took place would require WCX to obtain the approval of TfNSW. Mr Moran has had no involvement in that process and could not speak to issues concerning it.

(8) Mr Moran is aware of Automated Vehicle Incident Detection Systems (AVIDS) being deployed in tunnels to detect stopped vehicles and further

that TfNSW is currently trialling an AVIDS system on Sydney Harbour Bridge.

82 Mr Moran's evidence was, ultimately, not controversial.

Determination of Issue no. 1:

Statutory findings required by s 81(1)

83 Having considered the documentary tendered and oral evidence heard, I make the following findings:

Identity of deceased: Scott Orrock

Date of death: 2 April 2020

Place of death: M4 Westbound, Clyde NSW

Manner of death: Motor vehicle collision

Cause of death: Multiple blunt force injuries

Determination of Issue no. 2:

The Appropriateness of the Westconnex Response in the time between the first and second collisions

84 Counsel Assisting noted some ambiguity in the WCX Incident Response Plan contained in the brief (i.e. as to the "occurring" of an incident) and submitted that the evidence did not establish a breach of any relevant policy by WCX in its response to the first collision.

85 He made the further argument that, having regard to their responsibilities and the particular difficulties they faced on 2 April 2020, it would be unrealistic to expect the TCROs to have noticed the first collision in the 7 minutes before the second collision or to be critical of their failure to do so. He did not seek to address the Court on the WCX response to the second collision.

86 Counsel for WCX and TfNSW enthusiastically joined in these submissions. Counsel for WCX added that Scott's death is a tragedy but that the TCROs did their best in the circumstances that confronted them at the time.

87 I accept the submissions of the parties on this issue.

88 I find that the role of the TCROs was a critical one and that there are compelling reasons why a stationary vehicle should be identified and responded to at the earliest opportunity (more so given the unconventional design of the M4 at the JRD exit). Making allowance for the benefit that hindsight brings, I accept that the TCROs performed their duties to the best of their ability and that it would be unrealistic, given the matters outlined in these findings to expect the TCROs to have noticed the first collision in the time until the second collision or to be critical of their failure to do so.

Determination of Issue no. 3:

Whether it is necessary or desirable to make any recommendations arising out of the circumstances of Mr Orrock's death pursuant to s82(1) of the Act.

89 Counsel Assisting made the following submissions:

(1) That I should accept Ms Waller's evidence that installation and operation of the additional VMS was imminent and that in those circumstances there might be benefit in the Court being provided with an update concerning that issue by the end of June 2025.

(2) That I should accept Ms Waller's evidence regarding the physical and staffing changes made regarding the WCX Control Room, that the changes were working well and that in those circumstances further recommendations for change were not required.

(3) That whilst there was no evidentiary basis for recommending that AVID be installed near the JRD off-ramp (given its current technical limitations), the Court could recommend that WCX actively engage with TfNSW about its trial of the AVID system on Sydney Harbour Bridge and

whether the results of that trial warrant installation of AVID elsewhere – particularly where the collisions happened in this matter.

90 The submissions of Counsel Assisting were embraced by Counsel appearing for WCX and TfNSW.

91 Counsel for WCX went on to urge the Court to find that WCX is committed to improving the safety of road users and had successfully addressed problems identified in the evidence. She added that the WCX organisation did not pay lip service to safety and that on Ms Waller's evidence it had looked into what could be learnt and gone beyond what was required to address safety concerns.

92 Consistent with the submissions made, on 18 June 2025 the Court was advised firstly, that installation of the additional VMS was completed on 27 May 2025 and that it should be fully operational by the end of July 2025 and, secondly, there was a meeting scheduled for 19 June 2025 between representatives of TfNSW and WCX to discuss and share relevant information regarding the AVID trial on the Sydney Harbour Bridge.

93 That meeting took place and the report from it is that TfNSW shared relevant information with WCX regarding the AVID technology and both organisations have committed to maintain their engagement and for TfNSW to provide additional information on the technology as it becomes available.

94 In all the circumstances, I accept the submissions made and am satisfied that it is neither necessary nor desirable for me to make any recommendations.

Concluding remarks

95 I will close by conveying to the Orrock family and friends my sympathy for the tragic loss of Scott. He is forever lost to them. This loss is felt not just by them but by the broader community.

96 I thank the officer in charge for his work in conducting the investigation and compiling the brief of evidence.

97 Even more so, I thank the Assisting team for their outstanding support in the conduct of this inquest.

I close this inquest.

Magistrate S Devine
Deputy State Coroner
Lidcombe

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