MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to s. 57(1)(c) of the Coroners Act 1995.)

I, Simon Cooper, Coroner, having investigated the death of Mr S

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

(a) The identity of the deceased is Mr S;

(b) Mr S died in the circumstances outlined further in these findings;

(c) Mr S died as a result of multiple injuries due to a motor vehicle collision with a tree;

(d) Mr S died on 2 January 2014 at Powranna Road, Powranna in Tasmania; and

(e) Mr S was born in Dunedin, New Zealand on 7 May 1970, and was aged 43 years at the time of his death; he was separated from his first wife and was employed as a truck driver when he died.

Introduction

Mr S died in the circumstances set out below in this finding. A preliminary issue needs to be considered. The issue is whether in terms of the *Coroners Act* 1995 an inquest is mandatory. If Mr S died in circumstances in which he was, for the purposes of the Act, "in custody" then an inquest would be mandatory (see section 24(1)(b) of the Act).

For reasons which will emerge further in this finding I am satisfied that at the time of his death Mr S was not in custody in terms of the Act. As a consequence I am satisfied that an inquest is not mandatory.

Circumstances Surrounding the Death

Mr S commenced a relationship on the internet with Ms P in December 2009. The relationship became permanent in December 2010. Near Christmas 2012 Ms P told police Mr S assaulted her and a police family violence order was made against Mr S. Ms P and Mr

S continued to live together but their relationship was punctuated by further incidents of domestic violence.

After an argument in June 2013 Ms P says Mr S threatened to commit suicide by driving a car into a tree.

On 21 August 2013 Mr S badly assaulted Ms P and the relationship came to an end.

There was a short reconcilation in September, but the relationship ended, again, in Novemeber 2013 when Ms P left Mr S and reported aspects of his behaviour to police. Those complaints led to Mr S being arrested and, *inter alia*, an interim family violence order being made. Mr S was bailed. A condition of his bail was that he was required to live at the residence of a friend, Mr R.

At the time of his death a full "non-contact" interim family violence order was in place against Mr S. In addition to charges of family violence, he was also facing charges of breaching an interim family violence order and various breaches of bail.

Mr R's daughter lived at the residence of Mr R from time to time (she divided her time between her mother and father who were separated).

On 12 December 2013 Mr. R's daughter disclosed to her father conduct on the part of Mr S which, if proved, would have amounted to an indecent assault upon her. Mr R asked Mr S to leave his address. Mr R reported the matter to police and the daughter made a statement.

On 23 December 2013 Detective Senior Constable Barrett of the Launceston CIB contacted Mr S. He had a conversation with him by telephone. In that conversation Detective Senior Constable Barrett outlined the allegations that Mr R's daughter had made against him, and made arrangements for Mr S to attend the Launceston Police Station on 2 January 2014 for an interview.

Between Christmas and New Year Mr S was in contact with Ms P. That contact involved a trip to Deloraine and to Tasmania Zoo. On 1 January 2014 Ms P and Mr S went to the cinema together. Ms P reports on that occasion Mr S was "crying and upset saying that he was fearful of going to the police and was afraid of going to jail and wasn't a paedophile".

Ms P spoke with Mr S by telephone between noon and 1.00pm on 2 January 2014. A little later Mr S rang and spoke with Detective Senior Constable Barrett and another detective. During this phone call, Mr S expressed his intention to commit suicide by driving his car into a tree but refused to divulge his location. Detective Senior Constable Barrett, a trained negotiator, attempted to negotiate with Mr S. He recorded the conversation he had with Mr S on his personal iPhone. Contact was made with police radio dispatch services (RDS) and efforts were made immediately to locate Mr S. That was done by mobile phone triangulation. Two police units were dispatched to the general area of Mr S's location, which was determined to be in the junction of the Midland Highway and Powranna Road. The units tasked were specifically instructed not to approach Mr S's car but to await instructions. The evidence from the officers involved, as well as objective evidence obtained during the investigation in relation to the circumstances surrounding Mr S's death from, *inter alia*, the police AVL system, demonstrates that they followed these instructions. No unit approached to within a kilometre of Mr S's vehicle.

It is clear from the conversations had between Mr S and Detective Senior Constable Barrett that at no stage did Detective Senior Constable Barrett ever indicate to Mr S that it was his intention to arrest him or take him into custody. In fact Detective Senior Constable Barrett indicated quite the opposite.

While Mr S seems to have been conscious that police were in his general vicinity it is quite clear to me, and I find, that that awareness had no impact whatsoever upon his decision to take his own life.

Throughout his conversations with Detective Senior Constable Barrett, Mr S resolutely indicated an express intention to commit suicide by driving his vehicle into a tree at high speed. He indicated that he had already had a "practice run". Unfortunately, Mr S terminated the call despite admirable efforts by Senior Constable Barrett to dissuade him. Mr S then drove at very high speed in a westerly direction on Powranna Road straight into a large gum tree. One of the attending officers describes the car as erupting into flames after the collision. The vehicle was unrecognisable and debris was scattered over a wide area. Mr S was killed instantly. So severe were the flames at the scene, attending police could do nothing to assist him.

Uniform, forensic and CIB officers all attended. So did personnel from Tasmania Fire Service and the on-call coroner. An investigation was commenced at the scene.

Mr S's body was subsequently removed from the wreck of the vehicle and transported to the mortuary at the Royal Hobart Hospital. After formal identification utilising DNA, an autopsy was undertaken. The autopsy was carried out by Dr Christopher Hamilton Lawrence, the State Forensic Pathologist. Dr Lawrence expressed the view after autopsy that Mr S died of multiple injuries due to a motor vehicle collision. The autopsy revealed that he had suffered traumatic injuries to his aorta, chest, pelvis and possibly to the skull. The absence of clear soot in the upper airway and carbon monoxide in his blood indicated that he had been killed instantly and did not die as a result of smoke inhalation. I accept Dr Lawrence's opinion.

Samples taken at the autopsy were subsequently analysed at Forensic Science Service Tasmania and nothing of any significance emerged from that analysis.

I am satisfied that Mr S died in the circumstances described in this finding. Specifically, I am satisfied that on no view of his interaction with Tasmania Police on 2 January 2014,was Mr S in custody in terms of the *Coroners Act* 1995. He was not under arrest. No attempts were made to arrest him or intercept him; indeed police at all times kept well clear of him. At its highest, his interaction with police involved Detective Senior Constable Barrett negotiating with him with a view to attempting to persuade Mr S not to commit suicide. For these reasons I am satisfied that Mr S was not "in custody" at the time of his death.

I am satisfied that the acts which caused his death were voluntarily undertaken by him with the express intention of ending his own life.

Comments and Recommendations:

Nothing about the circumstances surrounding the death of Mr S requires me to make any recommendations or comments pursuant to section 28 of the *Coroners Act* 1995.

Dated: 30 October 2015 at Hobart in the State of Tasmania.

Simon Cooper
Coroner