MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Jeremy Dacre Ball

With an inquest held in Launceston on 3 March 2016 find as follows

Jurisdiction

Mr Jeremy Ball was at the time of his death the Deputy Mayor of Launceston. The fact of, and circumstances surrounding, his death attracted a significant degree of attention and was widely reported in local media.

Section 3 of the *Coroners Act* 1995 (the 'Act') defines a reportable death as a death, *inter alia*, which occurred in Tasmania and "appears to have been unexpected, unnatural … or to have resulted directly or indirectly from an accident …".

Section 21 of the Act provides that "a coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death". Self-evidently, given the circumstances in which Mr Ball died, his death was reportable and as such within the jurisdiction of the Coronial Division of the Magistrates Court.

Section 24 (2) of the Act provides that "a coroner may hold an inquest into a death which the coroner has jurisdiction to investigate if the coroner considers it desirable to do so".

Given the public position occupied by Mr Ball prior to his death and the wide reporting of the circumstances of his death I determined it was desirable to hold an inquest into that death. "Inquest" is defined in the Act as meaning a "public inquiry".

Non-publication Order

Mr Ball's widow, Ms Stojansek, the senior next of kin in terms of the Act, applied prior to the commencement of the inquest for an order forbidding the publication of all of the evidence at the inquest. That application was repeated at the commencement of the hearing of the inquest.

The power to order non-publication of proceedings in an inquest is to be found in section 57 of the Act. That section provides:

> "57. Restriction on publication of reports
>
> (1) A coroner may order that a report of an inquest or a report of any part of the proceedings of, or any evidence given at, an inquest not be published if the coroner reasonably believes that –

(a) it would be likely to prejudice the fair trial of a person; or

(b) it would be contrary to the administration of justice, national security or personal security; or

(c) it would involve the disclosure of details of sensitive personal matters including, if the senior next of kin of the deceased has so requested, the name of the deceased."

Subsections (2) and (3) deal with the consequences of breaches of an order and are not relevant to the present application.

It is a fundamental rule that generally the administration of justice is open to public scrutiny and comment.

This has been the case since at least *Scott v Scott* (1913) AC 417.

In *R v Matterson and anor ex parte Moles (No. 2)* [1993] TASSC 75, Underwood J (as he then was) said that any application to suppress from public scrutiny either a part or the whole of a judicial proceeding is of fundamental concern to the Court. He observed that publication of proceedings was a basic attribute of any court. Whilst His Honour was dealing with the common law position and the now repealed *Coroners Act* 1957, in my respectful view, the principles to be taken from his judgment remain apposite, notwithstanding section 4 of the Act.

At paragraph 7 of *R v Matterson (supra)* His Honour said open justice "is required in order to maintain public confidence in our system of justice and to safeguard against judicial arbitrariness".

Underwood J referred to *Scott v Scott* [*supra*], and referred with approval to the speech of Lord Shaw at page 477. In that passage of the report His Lordship referred to the great jurist Bentham, who in turn emphasised the fundamental importance of publicity, Bentham describing it as "the very soul of justice".

Whilst section 57 provides a statutory power to depart from the general position, the fundamental position is that inquests are public hearings (the definition makes so much plain) and as such are to be conducted with public scrutiny and are able to be reported. This is a position not to be departed from without sufficient reason. The power to order suppression of a report is delimited by section 57. In this instance no issue of prejudice of a fair trial arises. No issue arises with respect to the publication being contrary "to the administration of justice, national security or personal security".

Conceivably the only head of power, in the circumstances of this particular case, which could provide a basis for orders of the type sought, is that found in section 57(1) (c). However none of the matters raised by the senior next of kin provided any sufficient reason, in my view, to depart from the general principle and therefore, aside from two orders made relating first, to a specific part of the evidence of one witness, and second, generally with respect to the children of Mr Ball and Ms Stojansek, I declined to make the orders sought.

Formal Findings

In every case where a coroner has jurisdiction to investigate a death, and whether or not an inquest is held, a coroner is obliged by the Act to make findings, if possible, in terms of section 28 of the Act. The standard to which the coroner must be satisfied is the civil standard of proof, that is to say, on the balance of probabilities. The evidence with respect to the mandatory findings was in no way in dispute. My formal findings in respect of those matters are as follows:

a) The identity of the deceased is Jeremy Dacre Ball;

b) Mr Ball died in the circumstances set out further in this finding;

c) Mr Ball died as a result of multiple blunt traumatic injuries sustained in a motor vehicle crash;

d) Mr Ball died on 15 September 2014 on the Bass Highway near Hadspen in Tasmania; and

e) Jeremy Dacre Ball was born in Wonthaggi, Victoria, Australia on 10 August 1968 and was aged 46 years of age at the time of his death; he was a married man who was the Deputy Mayor of Launceston.

Background

After a number of years spent overseas, Jeremy Ball returned to Launceston. He was in a relationship with Karina Stojansek for 9½ years prior to his death (the couple married in 2007) and together they had two sons.

Mr Ball was first elected an Alderman on the Launceston City Council on 2 November 2007. On 28 October 2011 he was re-elected, and on the same day elected as Deputy Mayor. He was in this position at the time of his death. It is quite clear that Mr Ball was a very popular and passionate servant of his local community. He was running for re-election at the time of his death but several witnesses said, and I accept, such was his popularity that his re-election was all but a foregone conclusion.

Ms Stojansek gave evidence that she and Mr Ball had been “struggling” in their relationship for the couple of years leading up to his death. There was evidence, which I accept, that the couple had been to joint marriage counselling and each saw their own counsellors as well.

Comprehensive evidence was received from Dr Philip Cassidy, a general practitioner who saw Mr Ball shortly prior to his death. I accept Dr Cassidy’s evidence in its entirety. He impressed as a methodical and careful witness. He said in his reports that given “the tragic and well-publicised death of Mr Ball, the details of his consultation was imprinted” on his memory.

Dr Cassidy said Mr Ball’s medical notes indicated that he had presented to Dr Luttrell at the same practice on 15 May 2014. On that occasion the notes from the consultation indicated

that Mr Ball was suffering from ongoing stress, anxiety and relationship issues. He was referred to Mr Tim Feeley, a psychologist. Other evidence makes it clear that Mr Ball did not consult with Mr Feeley as a result of that referral.

When Mr Ball consulted with Dr Cassidy on 12 September 2014 he told the doctor he had a history of a recent "flu" and that he had been unwell with that flu for approximately eight days prior. He described himself as feeling "zingy". Dr Cassidy observed that he had had a large number of consultations with patients suffering "flu" but that no one had ever described feeling "zingy". Upon further elaboration Mr Ball offered that the feeling of "zingy" was both a physical and emotional symptom.

Dr Cassidy concluded after further examination that Mr Ball was likely to be suffering from the after-effects of a recent viral type illness but was not satisfied that that accounted for the entirety of Mr Ball's presentation. Because Dr Cassidy was aware of the previous consultation with Dr Luttrell on 15 May 2014, he made an inquiry of Mr Ball as to how the appointments with Mr Feeley had progressed. Mr Ball explained he had not attended any consultations with Mr Feeley at all, saying that he had been "too busy" or that he had "probably lost the referral".

Mr Ball told Dr Cassidy that there were ongoing stresses with respect to his relationship and the matter was explored in more detail. As a consequence of these discussions, Dr Cassidy asked Mr Ball if he would like to be referred to a psychologist again. He said that he would. Dr Cassidy explained in his evidence that he then prepared a GP mental health care plan using a template on the Best Practice IT system. That information was reproduced for the purpose of the inquest and tendered. It includes under the heading 'presenting issues' an entry "stress, anxiety and relationship stressors". Significantly, having been assured by Mr Ball that he was at no risk of self-harm, a notation appears that there was no self-harm risk.

Dr Cassidy made a preliminary diagnosis of anxiety disorder, which diagnosis I accept. He provided Mr Ball with a copy of the referral plan in a sealed envelope with Mr Feeley's contact details on the outside of the envelope. That envelope was subsequently found open, but empty, at Mr Ball's office at the Council after his death.

Dr Cassidy said that before any consultation he "summarised the situation as [he] had discerned it". Dr Cassidy expressed the view that he considered that Mr Ball had suffered a significant viral illness and had some residual physical and emotional effects from it, which were to be expected. Dr Cassidy expressed the view that he considered Mr Ball was also suffering a contribution from his psychological stressors and that he should make time to have those aspects addressed. Dr Cassidy said, and I accept, that he asked Mr Ball to self-monitor and to return to see him at any time should he experience any deterioration in his mental or emotional state.

The possibility of medication was raised by Dr Cassidy with Mr Ball. Mr Ball indicated he was against taking such medication. Mr Ball then left. Dr Cassidy did not see him again nor have any contact from him.

After the hearing of the inquest, but before this finding was complete, Dr Cassidy sent what might be termed a supplementary medical report to the Coronial Division of the Magistrates

Court. The report was unsolicited. The forwarding of it was irregular and inappropriate. It seemed premised upon the assumption that aspects of Dr Cassidy's evidence were unclear. There was no such lack of clarity. Had there been then a report would have been requested and the inquest resumed.

However the report, having been received, needed consideration. Ms Stojansek was afforded the opportunity to make submissions about the report.

In the event I have decided to have regard to the contents of the report generally and I note Ms Stojansek's submissions about it. Neither the report nor the submissions change in any way the conclusions reached as a result of the hearing of evidence at the inquest. I return to that evidence.

All members of Mr Ball's family who saw him in the lead up to his death gave evidence as to the deterioration of his physical appearance which caused all of them significant concern. Ms Stojansek also spoke of Mr Ball's concerns, completely unfounded, about the upcoming council election.

On Saturday 13 September Mr Ball spoke with his brother, Julian Northmore, by telephone for 42 minutes. The conversation occurred when Mr Ball was returning from a community event at Ravenswood at which he had been the Master of Ceremonies. In that conversation with his brother Mr Ball revealed that he was feeling suicidal and that he had considered driving under a semi-trailer.

On Sunday 14 September Mr Ball spent the day at the beach with his partner and children. During the day he told Ms Stojansek that he "couldn't do it any more". In her affidavit made on 15 September 2014 Ms Stojansek said that in that conversation Mr Ball had told her that he wanted to kill himself. She said she did not know how to help him and was hoping that he would settle enough over the weekend so as to get him through to Monday when some help for him could be organised.

On the morning of Monday 15 September Ms Stojansek had a conversation with Mr Ball. She described him sitting on the edge of the bed and saying to her: "I'm sorry. I'm sorry but I can't do it any more". She reassured him and told him that she would get some help.

Mr Ball got out of bed, had breakfast and departed for work telling Ms Stojansek that he needed to get a bit of normality into his life and he was sure that going to work would make him feel better. The evidence is that Mr Ball made an attempt to secure an appointment with Mr Feeley. He was unable to obtain one until the following week. He then attended a meeting of the Council where his colleagues, Mayor Albert van Zetten and Alderman Danny Gibson, both noticed he was extremely quiet – in contrast to his normal appearance and demeanour. As the morning wore on Ms Stojansek was able to secure an appointment with the psychologist, Mr Feeley, for Friday.

The meeting concluded at about noon. As it finished Mr Ball paused to speak briefly to colleagues. Alderman Gibson commented to him that he was quiet. Alderman Gibson described Mr Ball replying in a "really focused way" that he was just listening.

Circumstances Surrounding the Death

It is apparent, and I find, that Mr Ball immediately upon the conclusion of the meeting left the Launceston City Council offices in the CBD of Launceston and got into his white Suzuki Vitara wagon. He drove his vehicle out of Launceston and then west on the Bass Highway (which runs from Launceston through to Marrawah on the far North West Coast of Tasmania). There was no reason for him to be on the highway at that time.

Several witnesses gave evidence as to the circumstances surrounding the fatal crash. Their statements were read at the inquest. I find that at 12.34pm on the Bass Highway, 500 metres east of Illawarra Road, a blue and white Mack prime mover, driven by Mr Damon Strickland, and loaded with logs, was travelling east (after entering the highway from Illawarra Road).

Mr Ball's Suzuki Vitara wagon crossed into the path of the Mack prime mover. Mr Strickland has steered left in an unsuccessful attempt to avoid a collision.

The Suzuki impacted with the front right of the Mack truck. Mr Ball was killed instantly. Fortunately Mr Strickland only suffered minor injuries. The road was closed and traffic diverted for several hours due to the extensive damage and for removal of the logs and vehicles from the scene.

An investigation in relation to the crash commenced at the scene. Within a short time of the crash having occurred First Class Constable Nigel Housego, an experienced crash investigator, attended the scene and took responsibility for the investigation. I accept Constable Housego as an expert. He gave evidence at the inquest. The report he prepared (in the form of an affidavit) was tendered. I accept Constable Housego's methodology and the conclusions that he expressed. Constable Housego said that there was nothing about the road surface or the weather conditions that caused or contributed to the happening of the crash. He said mobile phone records for Mr Ball showed that Mr Ball was not using his mobile phone at the time of the crash. Constable Housego gave evidence that markings on the road, caused as a result of the impact, made it clear that the point of impact was well inside the lane where Mr Strickland's truck was lawfully travelling. Constable Housego said, and I find, that there was nothing at all Mr Strickland could have done to avoid the crash.

Significantly, there was nothing on the road to suggest pre-impact braking by Mr Ball in the nature of skid marks and also the brake lamps from the vehicle (subsequently examined by a Transport Inspector) showed no evidence whatsoever that the brakes of the Suzuki had been applied prior to the crash.

Mr Strickland gave evidence at the inquest. He was an impressive and obviously honest witness. His evidence was corroborated in every material particular by other drivers and also the objective findings of Constable Housego. He said that in the lead up to the crash he was travelling in an easterly direction on the Bass Highway when he first saw what he thought was a white Prado (subsequently identified as Mr Ball's car) travelling in the opposite lane. He said he saw that the car had its driver's side right wheel on the double white line. His initial thought was that the driver of that car was not paying attention and he moved his truck over a little to the left side of the road to give the driver room just in case he hadn't seen him.

He described there being no change in the movement of Mr Ball's car and that it kept driving on the double white line. Mr Strickland said he had no time to do anything and that Mr Ball "then just swerved across into the front of [his] truck". Significantly, he said he thought the driver (Mr Ball) might have been looking at him just before the impact and said he remembered he was sitting up and did not look like he was asleep. I am satisfied that at the time of the happening of the crash Mr Ball was awake.

Mr Strickland was interviewed by police at the scene. He was transported to the Launceston General Hospital where a blood sample was taken from him for subsequent analysis. The analysis of that blood sample, carried out at the laboratory of Forensic Science Service Tasmania, did not reveal the presence of any alcohol or drugs in his system at the time of the crash. Mr Strickland said that he was appropriately rested in the lead up to the crash and I accept his evidence.

Mr Ball's body was removed from his motor vehicle and transported by mortuary ambulance to the mortuary at the Royal Hobart Hospital. There, on 16 September 2014, forensic pathologist, Dr Donald McGillivray Ritchey, performed an autopsy. As a consequence of the autopsy Dr Ritchey expressed the opinion that the cause of Mr Ball's death was multiple blunt traumatic injuries which he sustained in the motor vehicle crash. He described widespread trauma of the head, chest, abdomen, pelvis and extremities that resulted in near instantaneous death. I accept Dr Ritchey's opinion.

Samples taken at autopsy from Mr Ball's body were subsequently utilised to enable a formal identification of his body to be made by use of DNA comparison. Evidence was received in this regard from a scientist at Forensic Science Service Tasmania's laboratory in Hobart. I accept that evidence. Samples were also analysed for the presence of any alcohol or drugs in Mr Ball's body at the time of the crash but none were detected.

Both vehicles involved in the crash were seized and impounded for subsequent examination by a Transport Inspector. That examination did not reveal any defects in either vehicle which may have caused or contributed to the happening of the crash.

I am satisfied that the crash which claimed Mr Ball's life occurred in the circumstances set out in this finding. I am well satisfied that Mr Strickland bears no responsibility whatsoever for the happening of the crash. I am satisfied to the requisite standard that Mr Ball deliberately steered his motor vehicle into the path of a prime mover driven by Mr Strickland. I am satisfied that the actions undertaken by Mr Ball which caused his death were undertaken by him with the express intention of ending his own life. This is not a conclusion reached lightly. However, I am satisfied to the requisite standard that it is the only proper conclusion for several reasons. First, there was substantial and persuasive evidence in relation to the relationship difficulties experienced by Mr Ball. Second, there was clear evidence at the inquest of Mr Ball's previous consultation with his general practitioner and his unkept referral to a psychologist. Third, the evidence of Dr Cassidy as to Mr Ball's presentation and the history given by him and the further referral to the psychologist. Fourth, the evidence from both Mr Ball's brother and partner as to his articulation of suicidal ideation, and, in the case of his brother, the very mechanism of his death is especially important. Finally, the objective evidence as to the circumstances surrounding the crash suggests very

strongly a deliberate act on Mr Ball's part. Considered together the evidence allows of only one conclusion.

For all these reasons, I am satisfied that Mr Ball was suffering from an untreated mental illness which either caused, or at least contributed to, the decision he took to drive his vehicle into the path of Mr Strickland's truck.

Comments and Recommendations

The circumstances of Mr Ball's death do not require me to make any recommendations pursuant to section 28 of the Act.

I comment that suicide, especially amongst males of Mr Ball's age group, is a major public health issue in this country. In common with so many men aged between 45 and 65 who choose to end their own lives, Mr Ball had love and support and ostensibly much to live for. Many areas of support are available, whether from health care professionals or the myriad of organisations of which Lifeline and Beyond Blue are perhaps the most prominent. Mr Ball had received two referrals to a psychologist – neither of which he kept. Perhaps if he had then he may have been diverted from the path he took. I urge anyone in need of help or support to seek assistance and follow through with treatment or referrals.

In concluding, I convey my sincere condolences to Mr Ball's family and friends on their loss.

Dated: 30 June 2016 at Hobart Coroners Court in the State of Tasmania.

Simon Cooper
Coroner