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, have investigated the deaths of Daniel Michael Kulla and Malcolm Edward Macleod

With an inquest held in Launceston on 26 February 2016

Jurisdiction:

1. Malcolm Edward Macleod died in a motor vehicle crash whilst the subject of a treatment order made pursuant to the *Mental Health Act* 2013. Section 24 of the *Coroners Act* 1995 provides that an inquest must be held if the deceased "was immediately before death a person held in care".

2. Section 3 of the *Coroners Act* 1995 defines a "person held in care" to mean, *inter alia*, a person who is the subject of an order of the type that applied to Mr Macleod at the time of his death.

3. Daniel Michael Kulla died in the same crash.

4. On 12 February 2016 the delegate of the Chief Magistrate made an order pursuant to section 50 of the *Coroners Act* 1995 that both deaths were to be investigated at the one inquest.

Formal Findings:

5. In every case the subject of a coronial investigation, section 28 of the *Coroners Act* 1995 requires a Coroner to make, if possible, various findings. In that regard, the evidence at the inquest persuades me that the following findings should be made:

Malcolm Edward Macleod

a) The identity of the deceased was Malcolm Edward Macleod;
b) Mr Macleod died in the circumstances set out further in this finding;
c) The cause of Mr Macleod's death was multiple injuries sustained in a motorcycle crash;
d) Mr Macleod died on 14 December 2013 at Main Road, Perth in Tasmania; and
e) Malcolm Edward Macleod was born in Launceston, Tasmania on 9 December 1984 and was 29 years of age; he was unemployed and unmarried.

Daniel Michael Kulla

a) The identity of the deceased was Daniel Michael Kulla;
b) Mr Kulla died in the circumstances set out further in this finding;

c) The cause of Mr Kulla's death was multiple injuries sustained in a motorcycle crash;
d) Mr Kulla died on 14 December 2013 at Main Road, Perth in Tasmania; and
e) Daniel Michael Kulla was born in Launceston, Tasmania on 14 August 1982 and was 31 years of age; he was unemployed and unmarried.

Circumstances of the Crash:

6. At about 10.00pm on Saturday 14 December 2013, Daniel Michael Kulla was riding an unregistered and un-roadworthy motorcycle with his friend, Malcolm Edward Macleod, as pillion passenger. Mr Kulla was unlicensed. He had a therapeutic level of the drug citalopram in his blood but a high level of cannabis. The motorcycle he was riding was an off-road type with no lights fitted and no brakes that worked properly.

7. Neither Mr Kulla nor Mr Macleod were wearing helmets, or indeed any protective motorcycle clothing.

8. They had been seen by a number of witnesses in the lead up to the crash travelling in a manner dangerous to themselves, and the public at large, on various streets in the Launceston area heading towards Perth. Not far north of Perth, near Gibbet Hill, a member of the public, Ms Monica Rolls, was so concerned by the manner in which the motorcycle was being operated that she contacted police. She later told investigators that the motorcycle with the two men on it accelerated away from her as she followed it in to Perth. Ms Rolls slowed her vehicle to 60 km an hour on entering Perth (the speed limit), and she said the motorcycle appeared to be travelling at 80 – 90 km an hour on Main Road, Perth in a southerly direction.

9. Mr Shane Triffitt was at the same time driving his 2002 Nissan Patrol flat tray ute with his 14-year-old son Brandon as a passenger. He travelled west along Illawarra Road until that road's intersection with Main Road, Perth, near the roadhouse. He slowed as he approached the intersection and indicated to turn left. Seeing no vehicles approaching (it was dark) he entered Main Road and immediately indicated to turn right onto Clarence Street. Having turned on to Main Road he had to wait for a van which was travelling south towards Hobart. Once the van had passed he looked again and saw no vehicles (or at least no lights of any vehicles) behind it and started to turn right. As he did so his son yelled a warning. Mr Triffitt immediately applied the brakes of his vehicle and brought it to a stop. When stationary, the motorcycle ridden by Mr Kulla with Mr Macleod as passenger collided with the Nissan utility.

10. Mr Kulla and Mr Macleod were thrown from the motorcycle. They both suffered grievous injuries as a result. Several members of the Perth volunteer fire brigade, who were present at the Perth station for the purpose of a brigade Christmas party, rushed to the scene. Commendable efforts were made to provide first aid to both men but both were beyond help and died at the scene.

11. Police and emergency services attended. A police crash investigator, First Class Constable Anthony Purcell, commenced an investigation at the scene. Constable Purcell gave evidence at the inquest. He said that the road surface in the vicinity of the crash was in good condition with no apparent damage or deformity which could have contributed to the happening of the crash. I accept his opinion. He also said that the road at the time of the crash was dry and that weather conditions were fine and mild with no noticeable wind. I accept this evidence.

12. He said that the crash site was a straight length of road with a clear view for a distance of approximately 200 m and that the road was divided into lanes; the south bound lane being 5.5 m wide and the north bound lane being 6 m wide. Constable Purcell described the road as being in good condition with centre lines and the like clearly marked and visible. No speed analysis was conducted although a witness whose evidence has already been mentioned, Ms Monica Rolls, reported the motorcycle accelerated away from her as she travelled at 50 to 60 km an hour. I accept her evidence about this and I accept her estimate of the speed of the motorcycle as being in the vicinity of 80 – 90 km an hour immediately prior to the crash.

13. I am also satisfied by Constable Purcell's evidence that at the time of the crash Mr Kulla was in control of the motorcycle and that Mr Macleod was the pillion passenger. Constable Purcell explained the reasoning for reaching this conclusion. In part it relied upon an acceptance of witness accounts with respect to clothing seen on the rider and pillion passenger in the lead up to the crash, and in part relied upon injuries found on the body of Mr Kulla. I accept both the methodology and reasoning of Constable Purcell. I am satisfied to the requisite degree that Mr Kulla was the rider of the motorcycle at the time of the crash.

14. The bodies of both men were removed from the scene by mortuary ambulance and transported to the Royal Hobart Hospital for autopsy. The motorcycle and the utility were both seized and transported to the police compound in Launceston for subsequent investigation. The scene itself was comprehensively measured, examined and photographed.

15. Mr Triffitt was conveyed by police to the Launceston General Hospital where he was directed to furnish a sample of blood for a blood test. That blood was subsequently analysed at the laboratory of Forensic Science Service Tasmania. No alcohol was found to be present in that blood. No drugs were detected as being present in that sample either.

16. Autopsies were carried out upon both bodies after they were formally identified. The same pathologist, Dr Donald McGillivray Ritchey, carried out both autopsies. After autopsy, Dr Ritchey expressed the opinion that the cause of death in each case was multiple blunt traumatic injuries sustained in a motorcycle crash. Both men were found to have massive multiple injuries which would have resulted, in the opinion of Dr Ritchey, in near instantaneous death in both cases. I accept Dr Ritchey's opinion.

17. Samples were taken from the bodies of both men at autopsy and submitted to the laboratory of Forensic Science Service Tasmania for analysis. Both samples were found to have cannabis present, and in the case of Mr Kulla the drug citalopram was found to be present. Citalopram is an antidepressant agent which has the potential to result in somnolence, fatigue, decreased alertness, dizziness and weakness. Cannabis causes cognitive, perceptual and behavioural changes. In Mr Macleod's case, in addition to cannabis being found to be present, the drug olanzapine was also located at an apparently therapeutic concentration. Olanzapine is an atypical antipsychotic agent used in the treatment of schizophrenia and related psychosis. Like citalopram it can cause drowsiness, weakness, dizziness as well as confusion, fatigue, agitation, tremor and slurred speech.

18. Both vehicles involved in the crash were subsequently the subject of examination by a Transport Inspector. That Inspector, Michael Ronald Leonard, prepared an affidavit pursuant to the *Coroners Act* 1995 as a result of his examination of both vehicles. The affidavit was tendered at the inquest. His examination of the Nissan Patrol utility led him to express the opinion that the vehicle had no-fault or failure that may have

caused or contributed to the crash. I accept Mr Leonard's opinion in this regard.

19. Mr Triffitt's vehicle was found to have been over loaded at the time of the crash. However, I am satisfied to the requisite standard that this fact had no bearing whatsoever upon the happening of the crash.

20. Mr Leonard expressed the opinion that the motorcycle had very many defects which caused or contributed to the crash. Those defects included a front tyre not designed for highway use, an inefficient and a defective rear braking system, the absence of any headlights, indicators, tail lights, brake lights, or any warning lights, low tyre pressure (which can adversely affect the handling of a motorcycle), no mirrors or reflectors, and the fact that the motorcycle was not designed to carry a pillion passenger, having no rear foot pegs. I accept Mr Leonard's opinion as to the deficiencies associated with the motorcycle upon which Mr Kulla and Mr Macleod were travelling at the time of the crash.

21. Mr Triffitt's evidence as to what occurred was contained in an affidavit made under the *Coroners Act* 1995 and tendered at the inquest. The substance of his evidence was corroborated in an affidavit made by his son Brandon. It was also corroborated by Constable Purcell's evidence of his observations at the scene and the observations of other independent witnesses. I am satisfied that the crash occurred as described and that Mr Triffitt is in no way to blame. The fault in relation to the crash lies entirely with Mr Kulla. The cause of the crash was in my view excessive speed on the part of the motorcycle; the fact that the motorcycle had no operative rear brakes and no headlights meant that it was unable to stop in time to avoid colliding with the Nissan, and that the driver of the Nissan, Mr Triffitt, was unable to see the motorcycle before the crash. In addition, the absence of helmets and any safety apparel on the part of Mr Kulla or Mr Macleod was a significant factor in the injuries they sustained which caused their deaths.

22. The coronial investigation revealed that Mr Macleod was at the time of his death an abscondee from the Northside Mental Health Unit of the Launceston General Hospital. The evidence was that he had self-presented to the Launceston General Hospital's Accident and Emergency Department in an acutely psychotic state in the evening of Sunday 1 December 2013.

Report on Mr Macleod's Care:

23. Section 28 (5) of the *Coroners Act* 1995 provides:

> "If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."

There is a very sound policy reason underpinning this legislative requirement. It is fundamentally important that the death of every person who is detained in any State-run institution by reason of an order of a court, tribunal, or the executive is carefully and transparently examined.

24. As was noted above Mr Macleod self-presented at the Launceston General Hospital on 1 December 2013. He was assessed by an on-call psychiatric registrar and as a consequence of that assessment was made the subject of, properly in my view, an

involuntary order and admitted to the Northside Mental Health Clinic for treatment and further assessment. Amongst other things, and aside from his presentation, the history taken during assessment indicated that Mr Macleod had been non-compliant with his prescribed medication for a four month period leading up to his presentation. The history taken also reveals he was consuming cannabis (subsequently confirmed in a urine sample, and subsequently confirmed on autopsy). The file indicates he was regarded as an absconding risk.

25. For the next week Mr Macleod was continually assessed. He was found to be delusional and suffering from hallucinations.

26. Formal assessment of him was undertaken on Sunday 8 December 2013. He was again assessed as being a risk of absconding. Less than one hour after being identified as a risk of absconding he absconded from the ward. A search of the general area was conducted, police were notified of his absence, and an order for his return was issued. He returned voluntarily at about 5.50pm. Upon his return Mr Macleod apologised to staff indicating that he "needed to get out for a while" and that whilst absent from the clinic he had consumed cannabis. It was subsequently ascertained that he had simply walked out the front door in the company of other visitors to the ward.

27. In response to his absenting himself a decision was taken by medical staff to cancel his leave and he was, according to records, assessed as being rated at category two (2) 'Close Care', which *inter-alia* required staff to ascertain and record his whereabouts every 15 minutes.

28. The next day Mr Macleod was assessed as being sufficiently settled to be authorised escorted leave to visit an ATM within the hospital.

29. On 10 December 2013 he was granted a further short period of escorted leave. Arrangements were made for him to speak to a representative of Aboriginal Legal Aid in relation to a matter that he had pending before court. Records note that he had settled behaviourally but was still delusional and somewhat irritated by the restrictions placed on his movement. He was seen on occasions by staff to be attempting to open doors and gates in the courtyard. He advised staff that he did not wish to stay at Northside.

30. On 12 December 2013 Mr Macleod's involuntary order was reviewed by the Mental Health Tribunal. As a result of that review the Tribunal made a "continuing care order" pursuant to section 28 of the *Mental Health Act* 1996. The order was expressed to remain in force until 1 April 2014 (I do note there was an inconsistency on the face of the original record relating to the correct expiry date of the order, although nothing turns on this). This order was in place at the time of Mr Macleod's death.

31. On the afternoon of the same day, at about 3.45pm, staff discovered that Mr Macleod was not on the ward. A rear door to the ward was found to have a broken lock. Mr Macleod's absence was reported to Tasmania Police; however he was unable to be located by police until the happening of the crash the subject of this investigation.

32. The consulting psychiatrist with ultimate responsibility for Mr Macleod's care, Dr Franco Giarraputo, gave evidence at the inquest. He explained, and I accept, that there was, and always is, tension between ensuring a patient remains where she or he needs to be, and a proper respect for the patient's autonomy and dignity. He told the inquest that Northside Clinic consists of a secure forensic ward and a less secure general mental health ward. At all relevant times Mr Macleod was housed in the latter

part of the facility. Dr Giarraputo said that a decision had been made upon the second occasion of Mr Macleod's absenting himself from the clinic that, upon his return, he was to be transferred to the secure forensic unit.

33. Dr Giarraputo gave evidence in relation to steps that have been taken since to ensure that the facility generally is more secure. He said that the rear exit door from which Mr Macleod made his escape had been completely sealed and that an airlock had been created at the front entrance to endeavour to minimise unauthorised exits from the main front door of the facility. I am satisfied that these steps are an appropriate response to this unfortunate incident.

34. I am also satisfied that the care afforded to Mr Macleod was appropriate and in line with contemporary standards and requirements.

Comments and Recommendations:

35. The circumstances of the unfortunate deaths of these two men are not such as to require me to make any additional comments; neither do they call for any recommendations pursuant to section 28 of the *Coroners Act* 1995.

36. I thank Constable Purcell for his comprehensive and professional investigation.

37. I commend in particular the efforts of those members of the Perth Volunteer Fire Brigade who assisted at the scene.

38. In conclusion I extend my sincere condolences to the families and friends of Daniel Michael Kulla and Malcolm Edward Macleod.

Dated: 18 March 2016 at Hobart in the State of Tasmania

Simon Cooper
Coroner