MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of DI.

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

a) The identity of the deceased is DI;
b) Mr I died as a result of injuries sustained as a result of driving his motor vehicle into the path of an oncoming truck with the intention of ending his life;
c) The cause of death was head injuries; and
d) Mr I died on 5 September 2017 at Latrobe, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr I's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; an opinion of the crash investigator; police and witness affidavits; medical records and reports; forensic evidence and a review conducted by police Professional Standards.

I make the following further findings, based upon the evidence, as to how Mr I's death occurred.

Mr DI was born in Tasmania in October 1986. He lived south of Devonport and was employed as a support worker and carer.

Mr I had been in a de-facto relationship with Ms MQ since May 2015. In about July 2016 he commenced living with Ms Q and her daughter. They purchased an investment property together in February 2017 with a view to later purchasing a larger home.

The evidence in the coronial investigation, particularly that contained in the comprehensive affidavit of Ms Q, indicates that Mr I had a difficult childhood, with his father passing away from cancer when he was about 16 years of age and his mother leaving the family just before that time. Ms Q stated that Mr I suffered from a noticeable lack of emotional resilience in many situations and outlined that some of Mr I's siblings had been treated for mental health issues.

It appears that Mr I had difficulties managing relationships. He had previously been in a relationship with Ms LN. The affidavit evidence in the investigation appears to indicate that this relationship was dysfunctional. This relationship ended in December 2014 but

they remained in contact. Ms N, in particular, created opportunities for herself and Mr I to meet and she became angry that Mr I would not leave Ms Q.

As outlined by Ms Q, Mr I also had “snap chat” interactions with other females whilst in a relationship with her. Ms Q stated that these matters created significant trust issues in their relationship which she attempted to resolve with Mr I.

On 31 August 2017, after lengthy discussions between Mr I and Ms Q regarding the issues in their relationship, Mr I went to stay with his brother, Mr PE, and his partner, Ms SJ, in Launceston. Ms Q stated that the purpose of having a short break was to allow them to consider how to best resolve the trust issues and move forward in the relationship. The evidence does not indicate that it was intended to be a permanent separation.

At about 6.30am on 5 September 2017 Mr I left his brother’s residence, waking Ms J and telling her he was leaving. Ms J believed that Mr I was leaving for work in Devonport.

At 6.45am Mr I telephoned Ms Q, crying and upset, and told her that he loved her, that he could not “do this anymore” and “this is goodbye”. Ms Q told him that she loved him and that he should come and be with her at home so that they could talk. Mr I was not responsive to Ms Q’s suggestions.

At 7.00am Mr I telephoned Mr E, very upset, telling him that he was not able to “do it anymore” and that he wanted to be cremated like his father.

At 7.07am Mr E rang Ms J, who was still present at home in Launceston, asking where Mr I was. She told him that he had left for work in Devonport. Mr E told her of the conversation with Mr I and his apparent intention to end his life. Ms J said that she would go and look for him. She therefore commenced driving towards Devonport.

At about the same time, Ms Q rang the police radio room and detailed her concerns for Mr I’s safety. By that time, Ms Q had become aware that Mr I had telephoned friends, also signifying to them a clear intention to end his life.

Police formulated a plan for a co-ordinated response to locate and assist Mr I. Devonport and Railton police were tasked with the job of trying to locate him and check his welfare. Officers attended his workplace but Mr I had not arrived at work. Other officers attended his normal place of residence where they remained with Ms Q.

At 8.00am Ms J located Mr I at the Parramatta Creek rest area. He was seated in the driver's seat of his sedan vehicle drinking alcohol and smoking. She parked beside him and got into his vehicle, sitting in the front passenger seat. On three occasions he told her to leave. The tone of his voice frightened her and so she alighted from his vehicle. He then drove off, throwing a stubby of beer and a packet of cigarettes out the window.

Mr I then travelled west towards Devonport. Ms J telephoned Ms Q and was advised by police to follow at a distance and provide regular location up-dates. Ms J followed Mr I to the 90km/h zone at Wattle Hill.

At 8.04am Mr I tried calling Ms J but he did not make contact. Ms J returned Mr I's call. Mr I said to her "what are you doing?" to which Ms J replied "I'm following you". He then informed her that she "might want to look away from what's about to happen next" and then he hung up.

Ms J then observed Mr I swerve towards on-coming trucks twice before veering back onto his side of the road. She eventually pulled over.

At 8.08am Constable Craig Dawkins and Constable Phillip Money, who were driving a police vehicle on the Bass Highway and attempting to locate Mr I, sighted his vehicle heading past the Latrobe Council works in the opposite direction in which they were travelling. They continued and then performed a U-turn to follow behind Mr I's vehicle at a distance of about 300 metres. Whilst following behind his vehicle, they had deactivated their vehicle's lights and sirens.

At this same time, Mr GW, an experienced truck driver, was driving a red Australia Post truck on the Bass Highway in the opposite direction to that of Mr I. The truck was a rigid 10 wheeler, 11 metres in length and 3.9 metres in height, with a Gross Vehicle Mass of 23 tonnes.

Mr W had left his home at about 3.15am to commence work at 4.00am at the Australia Post Depot in St Leonards. He loaded his truck with various pallets and conducted his usual pre-departure check before travelling to the Launceston Airport to collect more items. Mr W then drove to Sassafras where he stopped and bought breakfast before continuing on to Ulverstone where the majority of the mail was unloaded. He filled in his logbook, had a required 30 minute break and helped unload before continuing back towards Latrobe via the Bass Highway.

Before encountering Mr I's vehicle, Mr W had negotiated his way around the roundabout at Moriarty Road and was travelling east to Wattle Hill to re-fuel. He slowly accelerated up to a speed of about 80km/h. He saw vehicles approaching but observed nothing out of the ordinary in the driving of any other vehicles on the road. Upon reaching an area of painted traffic islands he first noticed a white oncoming vehicle, being Mr I's vehicle, which was about to go under the front right corner of his truck. This vehicle had veered suddenly across the painted traffic island dividing the east lane from the west lane and into the path of his truck. It made contact with his truck in an offset head-on collision, front right corner to front right corner. Constable Dawkins, Constable Money and other motorists (who have provided affidavits for the investigation) witnessed Mr I's vehicle crossing the centre line of the highway and being driven directly into the path of the truck.

Mr W provided an affidavit in this investigation. He described the collision and his truck subsequently veering to the left hand side of the road and into a large ditch, where it came to a stop. Fortunately, Mr W was able to climb out and was un-injured, but realised that the driver's side door of the truck had been torn off.

Constable Dawkins and Constable Money arrived shortly at the crash scene, having been in their vehicle at a distance of 360 metres from the crash when it occurred. They noted that Mr W was conscious and moving and then proceeded to the driver's side of Mr I's vehicle. Mr I was unresponsive. Constable Dawkins cut his seatbelt and removed him from the vehicle, assisted by a member of the public. They could not detect a pulse and he appeared to have severe head trauma. They commenced CPR and called for an ambulance. Upon arrival of the ambulance, Mr I was transported to the Mersey Community Hospital under resuscitation but was unable to be revived and was pronounced deceased.

An autopsy was performed by the State Forensic Pathologist, Dr Christopher Lawrence, who concluded that Mr I died as a result of massive traumatic injury to the head. He observed that the head injuries would have caused almost instantaneous death. Toxicological testing of Mr I's blood revealed that he had consumed some alcohol prior to his death, consistent with Ms J's observations.

Police crash investigators and forensics officers attended the scene after the crash and a full investigation was conducted. As a result of that investigation I am satisfied that road and weather conditions were good and played no part in the crash. I am satisfied that both the truck and the car were roadworthy prior to the crash and there were no defects in the vehicles that contributed to its occurrence. I am also satisfied that Mr W was driving within his lane at an appropriate speed, in a prudent manner and was concentrating on the road.

I find that, tragically, Mr I took his own life by intentionally driving his vehicle into the path of the truck. Mr W did not have sufficient time to take action to avoid the crash in the circumstances of the sudden manoeuvre by Mr I. It is not possible to say exactly when Mr I formed the intention to end his life, although it is clear that he expressed that intention repeatedly and unequivocally to Ms Q and his loved ones in the 90 minutes before his death. He did not express in those calls the means by which he intended to do so. Concerted efforts were made to locate Mr I and help him, to no avail. In ending his own life, he also placed Mr W's life at risk. I also acknowledge the possibility of ongoing consequences to those witnessing Mr I's actions.

I have had regard to the review by police Professional Standards of the actions of Constable Dawkins and Constable Money in the minutes preceding Mr I's death. I accept the conclusions of the review that their actions in attempting to intercept Mr I were justified in the circumstances of the serious concerns held for his mental condition, even though they were not specifically aware of his intent to end his life by crashing into another vehicle. I am satisfied on all of the evidence in the investigation that Mr I was

intent on his actions. The presence of the police vehicle some distance behind him is unlikely to have influenced his decision.

It appears from the evidence that Mr I suffered from long standing and distressing mental health difficulties, perhaps from a young age. It seems that he was not able to rationally deal with relationship issues, even though he clearly loved Ms Q and she had expressed a desire to have a future with him. The medical evidence does not reveal that he discussed any mental health issues with his doctor. It is likely that he would have greatly benefited by treatment or assistance from mental health professionals.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Sven Mason for his investigation and report.

The circumstances of Mr DI's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr I.

Dated: 18 June 2019 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner