MAGISTRATES COURT TASMANIA

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 Jay Connell,

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

a) The identity of the deceased is Jay Connell;
b) Mr Connell died as a result of injuries sustained during a motor vehicle crash occurring in the circumstances described below;
c) The cause of death was multiple injuries; and
d) Mr Connell died on 31 August 2018 at Glengarry, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Connell's death. The evidence includes the Police Report of Death for the Coroner, an opinion of the forensic pathologist who conducted the autopsy, toxicological evidence, police and witness affidavits, medical records and reports, report of the crash investigator, meteorological and geographical evidence and forensic evidence.

Mr Jay Connell was born in Brisbane on 26 February 1962 and was 56 years of age at the time of his death. He was married at a young age and has three adult children from the marriage. He subsequently separated from his wife. At the time of his death, Mr Connell was in a relationship with his long-term partner, Ms Deborah Fabian. He lived in Ambleside, was employed as a captain at Tamar River Cruises and was also employed as a disability support worker at Glenhaven Disability Support Services. At the time of his death, Mr Connell's health was good and Ms Fabian described him as a very capable driver.

On Friday 31 August 2018, Mr Connell left his residence in the morning to travel to his place of employment at Tamar River Cruises in Launceston. He was driving a 2005 Citroen hatch, purchased by him and his partner. At 10.00am, when he was 52 kilometres into his journey travelling east on Frankford Road, he commenced to negotiate a downhill sweeping left hand bend. At this point he lost control of the vehicle. The Citroen crossed the centre double continuous white line and slid passenger side towards a Mitsubishi flat tray truck travelling in the opposite direction driven by Mr Brian McDonnell. The Citroen impacted the truck coming to rest under its cabin. Both vehicles caught fire and were extensively damaged. The point of

the crash was approximately 400 metres west of the junction of Frankford Road with Birralee Road.

The Citroen was being followed at the time by a witness, Ms Courtney Mathews. The Mitsubishi was being followed at the time by witness, Ms Patricia Archer. Both Ms Mathews and Ms Archer stated in their affidavits for the investigation that the road was wet due to rain. Both witnesses also stated that they saw no issues with the driving of either of the drivers involved in the crash before it occurred. Ms Archer said that the Mitsubishi was travelling under the speed limit, whilst Ms Mathews said that the Citroen was travelling at about the speed limit for the area, of 100km/h. She said that it had overtaken her just before the crash, when she was travelling at 80km/h. I accept that these estimates of speed are accurate.

Emergency services personnel arrived shortly after the occurrence of the crash but, due to the damage and position of the Citroen, it took some time for Mr Connell to be removed from the vehicle. He was deceased.

Ms Fabian, in her affidavit, said that Mr Connell was in good spirits before his journey and was a very experienced driver on the road in question. Further, the evidence indicates that, at the time of the crash, he was wearing his seat belt, had no alcohol or illicit drugs in his system, was licenced and had no medical condition that could have contributed to the crash. The Citroen was registered, and the transport inspector subsequently examining it located no defects that contributed to the crash.

Mr McDonnell, the driver of the Mitsubishi flat tray vehicle, was aged 43 years and resided in Winkleigh. He was driving from his residence to a worksite. Mr McDonnell, at the time of the crash, was also wearing his seatbelt, had no alcohol or illicit drugs in his system, was licenced, and had no medical condition that could have contributed to the crash. The Mitsubishi was registered, and the transport inspector located no defects that contributed to the crash. Mr McDonnell suffered no injuries in the crash.

Mr Connell was identified visually at the Hobart mortuary. He underwent autopsy, conducted by the then State Forensic Pathologist, Dr Christopher Lawrence, who concluded that the cause of his death was massive trauma injuries to the head, chest and abdomen, consistent with a motor vehicle crash and that death would have been almost instantaneous. I accept the opinion of Dr Lawrence.

A thorough investigation into the circumstances of the crash was conducted by Constable Kelly Hindle under the supervision of a qualified crash investigator, Constable Nigel Housego. They noted that the section of roadway where the crash occurred was on a wet downhill sweeping

bend where a vehicle travelling at a speed of 97km/h would cause the vehicle to slide out of its lane (critical curve speed). The speed limit in the area, however, is sign posted as 100km/h. On the approach to the bend no advisory sign was present. The crash investigators, upon examination of the scene, formed the opinion that the Citroen slid in the wet conditions, and that Mr Connell attempted but was unable to regain control of it. The scene markings further indicated that Mr McDonnell, driving the Mitsubishi, had attempted to move his vehicle to his left and partially off the roadway when the collision occurred. Mr McDonnell did all he could in the circumstances to avoid the crash.

Comments and Recommendations

The crash investigators reviewed the crash data for the area and located several other crashes on the bend in similar wet conditions. The Department of State Growth was alerted to the issue and the roadway was re-sealed in January 2019, with the re-sealing intended to mitigate the issue of the previous poor skid resistance in wet conditions. The general roadway delineations were also improved in the works, with new centre line markings and supplementary raised "cats-eye" pavement markers put in place. The Department of State Growth advised that, with the new works, advisory signage on the approach to the bend was not required. I have no reason not to accept this remedial action as an appropriate response to the issues associated with this section of roadway.

The death of Mr Connell represents a tragic loss of life. The poor skid resistance of the wet roadway contributed to the crash and Mr Connell was travelling marginally too fast in the wet conditions to retain control of his vehicle. The Citroen was not fitted with an electronic stability control system that may have assisted him in the circumstances.

Mr Connell's death is a reminder to motorists of the critical importance of driving to the conditions, which may mean travelling at a speed well under the posted speed limit.

I extend my appreciation to investigating officers, Constable Kelly Hindle, and Crash Investigator, Senior Constable Nigel Housego for their investigation.

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

Dated: 15 April 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner