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, Simon Cooper, Coroner, having investigated the death of Russell Rodney Tonks

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

a) The identity of the deceased is Russell Rodney Tonks;
b) Mr Tonks died as a result of injuries sustained in a motor vehicle accident;
c) The cause of Mr Tonks' death was pneumonia; and
d) Mr Tonks died on 10 April 2011 at the Royal Hobart Hospital, Hobart, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the investigation into Mr Tonks' death. The evidence includes:

- Police Report of Death for the Coroner;
- Death Report to Coroner – Royal Hobart Hospital;
- Medical Certificate of Cause of Death – Royal Hobart Hospital;
- Tasmania Police Incident Sheet – 31 May 2010;
- Report from Tasmania Police Accident Investigation Service;
- Affidavit of Matthew Paul Taylor, sworn 31 May 2010;
- Affidavit of Sgt Rodney Harold Carrick, sworn 27 June 2010;
- Reports of a Transport Inspector, 9 July 2010;
- Medical Records – Royal Hobart Hospital; and
- Material submitted by Kathleen and Michael Tonks, Russell's parents.

Background

On Monday, 31 May 2010 just after 4.00pm in the afternoon, Mr Tonks was terribly injured in a car accident. The accident occurred at the intersection of Old Beach Road and the East Derwent Highway at Old Beach. Mr Tonks was alone in his unroadworthy 1991 Daihatsu charade. In an apparent breach of a restriction on his driver's licence, he was on his way to pick up his girlfriend.[1]

[1] Mr Tonks was licensed only to drive a motor vehicle to, from and for employment purposes.

As he travelled west on Old Beach Road, and approached the junction of the East Derwent Highway, Mr Tonks failed to obey a give-way sign and line at the junction and commenced a right turn onto the Highway.

As he did so, an unroadworthy 1979 Ford 150 utility was being driven by Matthew Paul Taylor south on the East Derwent Highway. Mr Taylor's speed was subsequently determined by crash investigators to have been within the posted speed limit. He attempted to take evasive action by braking heavily, but had insufficient perception reaction time and collided with Mr Tonks' Daihatsu.

Mr Tonks was taken by ambulance to the Royal Hobart Hospital having suffered significant and permanent head injuries in the crash.

The circumstances of the crash were comprehensively investigated by a very experienced crash investigator, Sgt Rodney Carrick. Sgt Carrick's report of 27 June 2010 satisfies me that drugs, alcohol and speed were not factors in the crash. It also satisfies me that while the angle of the sun may have impeded Mr Tonks' ability to see clearly, nothing else about the weather conditions caused or contributed to the happening of the crash. It also satisfies me that no deficiency on the part of the road or the signs and markings caused or contributed to the happening of the crash.

Both vehicles involved in the crash were subsequently examined by a Transport Inspector. I have had regard to the contents of the reports provided by the Transport Inspector. Both vehicles were unroadworthy because of various deficiencies. However, I am satisfied that the deficiencies identified by the Transport Inspector did not cause or contribute to the happening of the crash.

Subsequent Events

Mr Tonks was admitted to the Royal Hobart Hospital. An urgent CT scan of his brain was carried out which showed he had suffered global cerebral oedema and had sustained a left-sided subdural haematoma and an acute subarachnoid haemorrhage as well as multiple facial fractures. In addition, a further CT scan showed that both of his lung bases had collapsed and he had a fractured right scapula.

Mr Tonks spent 16 days in the RHH's intensive care unit, after which he was discharged to the neurosurgical ward. After a prolonged stay in the neurosurgical award, Mr Tonks was transferred St John's Hospital for rehabilitation.

At the time of his transfer, his medical records indicate that he was non-verbal and needed to be fed by means of a percutaneous endoscopic gastronomy (PEG) tube. He could sit out of bed, but with support, remained minimally responsive and was unable to follow commands.

In short, he made no real recovery from his injuries.

On 26 March 2011, Mr Tonks suffered a grand mal seizure, associated with fever and tachycardia. As a result, he was transferred back to the RHH where he continued to suffer seizures in the ICU. Sadly, Mr Tonks' situation worsened and, after discussions with family and medical consultants, a palliative care regime was instituted. Medical records indicate that he died in the RHH on 10 April 2011.

The fact of Mr Tonks' death was not reported in accordance with the requirements of the *Coroners Act* 1995 (the "Act") until 9 January 2019. I remind medical practitioners of their obligation to report deaths in accordance with that Act "as soon as possible"[2].

The fact that Mr Tonks' death was not reported means that many of the usual investigations, such as a post-mortem by a forensic pathologist, were unable to be carried out. It also meant that the medical records from his time at St John's were unavailable – having been destroyed after seven years. In short, the failure to report in accordance with the requirements of the *Coroners Act* 1995 hampered the investigation in relation to Mr Tonks' death.

The fact that Mr Tonks' death was not reported for the best part of eight years also undoubtedly caused additional grief to his already grieving family.

Discussion

A review of all the available material in relation to Mr Tonks' death satisfies me that although he died of pneumonia, the cause of his death was the injuries he sustained in the motor vehicle accident described above.

The available medical material was reviewed at my request by Dr Anthony J Bell MB BS MD FRACP FCICM, medical advisor to the Coroners Office. Dr Bell expressed the opinion that the medical care received by Mr Tonks was appropriate. I accept Dr Bell's opinion.

[2] See section 19 (1).

Comments and Recommendations

The circumstances of Mr Tonks' 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 Tonks.

Dated 5 May 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner