
**Findings of Coroner Simon Cooper following the
holding of an inquest under the Coroners Act
1995 into the death of:**

Gary John Hayes

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Gary John Hayes with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

7 July 2022 at Hobart in Tasmania

Representation

A Barnes – Counsel Assisting the Coroner

Introduction

1. Mr Hayes died in the early hours of New Year's Day 2019 when he was run down by a vehicle travelling north on the Midlands Highway, near Brighton. The driver of the vehicle, likely to have been a large truck, must have known that they hit Mr Hayes. But they did not stop and left Mr Hayes to die by the side of the highway.
2. Mr Hayes was 30 at the time of his death. He was the third and youngest child of Ms Jane Beck and Mr John Hayes. He grew up and went to school in the Northern suburbs of Hobart. Mr Hayes met his wife Danielle in 2005 or 2006. The couple began dating in 2008 and married in 2011.
3. It is evident that Mr Hayes had a history of mental illness. He was receiving treatment for depression at the time of his death.

What a coroner does

4. Before considering the circumstances of Mr Hayes' death it is necessary to say something about the role of the coroner. In Tasmania a coroner has jurisdiction to investigate any death that "occurs at, or as a result of an accident or injury that occurs at, the deceased person's place of work, and does not appear to be due to natural causes".¹ Mr Hayes' death meets this definition. Because of the element of mystery surrounding Mr Hayes' death an inquest was held. I note that an inquest is a public hearing.²

¹ *Coroners Act 1995*, section 3.

² *Supra*.

5. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. The coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act 1995* asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.³ The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.
6. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.
7. As was noted above, one matter that the *Coroners Act 1995* requires, is a finding (if possible) as to how the death occurred.⁴ 'How' has been determined to mean "by what means and in what circumstances",⁵ a phrase which involves the application of the ordinary concepts of legal causation.⁶ Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.
8. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.⁷

Evidence at the inquest

9. The only witness called to give evidence was Senior Constable Adam Hall.

³ *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

⁴ *Coroners Act 1995*, section 28(1) (b).

⁵ See *Atkinson v Morrow* [2005] QCA 353.

⁶ See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.

⁷ (1938) 60 CLR 336 (see in particular Dixon J at page 362).

10. In addition, numerous documentary exhibits were tendered by counsel assisting at the inquest. A full list of those exhibits appears at the conclusion of this finding as Annexure A.
11. In addition, my finding was informed by a site inspection of the area of the Midlands Highway where Mr Hayes lost his death. That inspection took place at night to help a better appreciation of lighting conditions.

Circumstances of death

12. Sometime after 10.00pm on Monday, 31 December 2018, Mr Hayes left his home at 97A Branscombe Road Claremont. Sometime between about 12.30 and 1.45am on Tuesday, 1 January 2019, he was seen by a number of witnesses walking near the edge of, and at times actually on, the carriageway of the north bound lane of the Brooker Highway between the Claremont Link Road off ramp and the Hilton Road turnoff.
13. Despite the efforts of investigators, no witness was identified who saw Mr Hayes any time between 1.45 and 2.15am. He was next seen on the Midlands Highway at Brighton, near the Weily Park Road intersection. Logically this seems to indicate that Mr Hayes received a lift from a passing motorist, although no such passing motorist has been able to be identified.
14. Several witnesses saw someone who can only have been Mr Hayes between 2.30 and 3.15am walking on the Midland Highway northbound.
15. At about 3:10am, a member of the public was driving north on the Midlands Highway to work at Kempton. That member of the public saw a large object on the road (which was ultimately proved to be Mr Hayes' body) and rang police.
16. The first police officers arrived from Bridgewater Uniform a few minutes later. Upon arrival the first responding police identified significant amount of blood and body tissue spread across the road surface. Located at the end of the blood stains and tissue was Mr Hayes' body. It was apparent he was dead and had sustained massive head and other injuries.
17. The evidence located at the scene indicated that after being struck, Mr Hayes had been thrown approximately 33 metres forward along the roadway. His body came to rest on the road surface approximately 1 metre inside the painted white fog line on the edge of the highway.

18. No debris from a vehicle was located at the scene. Senior Constable Hall explained in his evidence at the inquest the significance of this was it indicated, strongly, that the vehicle which struck Mr Hayes must have been a large truck. A smaller motor vehicle would have been damaged striking a human and left a significant amount of debris at the scene.
19. The evidence located at the scene satisfies me that when Mr Hayes was struck by a vehicle while walking in the centre of the left hand lane of the Highway. He was dressed in dark clothing.
20. The weather at the time of the crash was fine and the road conditions were dry. The road surface itself was in good condition. There was no artificial lighting in the general area. Perhaps obviously, given the date and time there was minimal traffic on the Midlands Highway. The speed limit is 110 kilometres an hour.

Investigation

21. After police and emergency services attended the scene and located Mr Hayes body, it was examined and photographed *in situ*. Following those initial investigations, his body was taken to the mortuary at the Royal Hobart Hospital. At the Royal Hobart Hospital, the following day, experienced Forensic Pathologist Dr Donald Ritchey carried out an autopsy. Dr Ritchey provided a report, which was tendered at the inquest.⁸ In that report he expressed the opinion that the cause of Mr Hayes' death was multiple traumatic injuries sustained when he was hit by a motor vehicle. Dr Ritchey found that Mr Hayes had suffered severe traumatic injuries including injuries of the head, skull, brain, neck, chest, abdomen, pelvis and extremities which had likely resulted in near instantaneous death.
22. Dr Ritchey said in his report that there was a pattern of the injuries to Mr Hayes body that included multiple horizontally oriented superficial linear lacerations of the skin of the proximal right side of the groin region as well as across the back. Dr Ritchey interpreted those observations to mean that the most likely scenario was that Mr Hayes was struck while upright with the major point of impact being the left side of his back and buttocks. In other words he was struck from behind whilst walking.
23. I accept Dr Ritchey's opinion.
24. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. The results of that toxicological analysis were tendered at

⁸ Exhibit C5.

the inquest.⁹ In summary, no alcohol or illicit drugs were identified as having been present in Mr Hayes' body at the time of his death. The tricyclic antidepressant agent nortriptyline was found to have been present at a therapeutic level.

25. Mr Hayes' body was formally identified by fingerprint comparison.¹⁰
26. Thereafter, an extensive investigation was carried out by Tasmania Police Crash Investigation Services and Criminal Investigation Branch detectives to attempt to identify the driver of the vehicle which struck and killed Mr Hayes. It is unnecessary for me to set out in any detail the nature and extent of that investigation other than to say that I consider every reasonable and available avenue of enquiry was followed. Unless and until someone with some knowledge of the circumstances of Mr Hayes death comes forward, I do not consider any further investigation is likely to uncover any evidence bearing upon his death.
27. Notably, the Crash Investigation Service investigations at the scene having regard to the road surface, speed limit, lighting, position of Mr Hayes on the roadway and clothing Mr Hayes was wearing satisfy me that a reasonably prudent driver driving a vehicle with headlights on and at about the speed limit would not have had sufficient time to react to and respond so as to avoid hitting Mr Hayes. I do not consider a reasonably prudent driver would have expected a person to be walking in the middle of a lane then or at any time.
28. Despite Mr Hayes' documented history of mental illness there is no evidence that supports a conclusion that the actions which caused his death were voluntary and intentional acts on his part. To put it another way I do not consider there is sufficient evidence to reach a conclusion that Mr Hayes' death was due to suicide.
29. Finally, I cannot, on the evidence, determine why Mr Hayes was where he was when he was struck by a vehicle.

Formal Findings

30. On the basis the evidence at the inquest to make the following formal findings pursuant to section 28 (1) of the *Coroners Act 1995*:
 - a) The identity of the deceased is Gary John Hayes;
 - b) Mr Hayes died in the circumstances set out in this finding;

⁹ Exhibit C6.

¹⁰ Exhibit C3.

- c) The cause of Mr Hayes' death was multiple injuries; and
- d) Mr Hayes died on 1 January 2019 on the Midlands Highway near Brighton in Tasmania.

Comments and Recommendations

- 31. I urge anyone with any information about the circumstances of Mr Hayes' death to make contact with the Coronial division or Tasmania police.
- 32. I acknowledge in particular the extremely thorough and professional investigation carried out by officers of Tasmania Police Crash Investigation Services, and in particular Senior Constable Hall.
- 33. I thank Senior Constable Barnes for the professional manner in which she presented the evidence at the inquest.
- 34. The circumstances of Mr Hayes' death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*.
- 35. I convey my sincere condolences to the family and loved ones of Mr Hayes.

Dated 22 July 2022 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

Annexure A

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	POLICE REPORT OF DEATH	Snr Cst Kelly Ann Cordwell
C2	AFFIDAVIT OF IDENTIFICATION	Anthony Cordwell (Mortuary Ambulance)
C3	AFFIDAVIT OF IDENTIFICATION	Ian Fleming (Tasmania Police Fingerprint Bureau)
C4	AFFIDAVIT OF LIFE EXTINGUISHED	Dr Eiliam Hedges
C5	POST-MORTEM REPORT	Dr Donald Ritchey
C6	TOXICOLOGY REPORT	Neil McLachlan-Troup
C7	STATUTORY DECLARATION	Stephen Pestrucchi
C8	AFFIDAVIT	Philippa Frances Rice
C9	AFFIDAVIT	Brendan Arnold Roberts
C10	AFFIDAVIT	Anne Salt
C11	AFFIDAVIT	David John McCormack
C12	AFFIDAVIT	Laura Meaghan Gunn
C13	AFFIDAVIT	Jocelyn Tatnell
C14	AFFIDAVIT (12.01.2019) AND DASH CAM FOOTAGE	Tait Aaron Fraser
C14A	AFFIDAVIT (5.06.2020)	Tait Aaron Fraser
C15	AFFIDAVIT	Alison Mary Norris
C16	AFFIDAVIT	Tania Lee Tennant
C17	AFFIDAVIT	Daniel Jeffrey Andrew White
C18	AFFIDAVIT	Sgt Kelly Taylor
C19	AFFIDAVIT	Cst Hailey Sinclair
C20	AFFIDAVIT	Csr Adrian Woodhead
C21	AFFIDAVIT	Cst Shaun Pedder
C22	AFFIDAVIT, RUNNING SHEET, AND SUBJECT REPORT	Cst Kelly Anne Cordwell
C22A	DIAGRAM AND NOTES	Cst Kelly Anne Cordwell
C23	AFFIDAVIT	Sgt Luke Walker
C23A	DIAGRAM	Sgt Luke Walker
C24	AFFIDAVIT	Snr Cst Adam Hall
C24A	VISIBILITY TESTING REPORT AND USB XI	Snr Cst Adam Hall
C25	AFFIDAVIT	Snr Cst Richard Keygan
C26	AFFIDAVIT	Cst Jared Gowen

C27	AFFIDAVIT	Cst Nicholas Monk
C28	AFFIDAVIT	Sgt Scott Poke
C29	AFFIDAVIT	Snr Cst Rance Swinton
C30	AFFIDAVIT (11.01.2019)	Danielle Emma Hayes
C30A	AFFIDAVIT (5.05.2019)	Danielle Emma Hayes
C31	AFFIDAVIT	Jane Elizabeth Beck
C32	AFFIDAVIT	Timothy Ikin
C33	AFFIDAVIT	Cst Shane Leek
C34	STATUTORY DECLARATION	Hannah Johnson
C35	STATUTORY DECLARATION	Gareth Delaney
C36	STATUTORY DECLARATION	Shane Denny
C37	AFFIDAVIT	Stuart Roberts
C38	AFFIDAVIT	Gayelene Bannister
C39	AFFIDAVIT	Matthew John Berry
C40	AFFIDAVIT	Noel Quinn
C40A	REGISTRATION HISTORY OF QUINN TRANSPORT AND SPREADING SERVICE	DPFEM
C40B	ACTIVITY REPORT BY VEHICLE	Quinn Transport and Spreading Service
C41	AFFIDAVIT	Andrew Treloar
C42	AFFIDAVIT	Troy Williams
C43	AFFIDAVIT	Roger Stone
C44	AFFIDAVIT	Paul Palmer
C45	AFFIDAVIT	Nathan McGann
C46	AFFIDAVIT	Kerry Scott
C47	AFFIDAVIT	David Kamprad
C47A	SUPPORTING DOCUMENTS	Bennett's Petroleum
C47B	PHOTOGRAPHS	Bennett's Petroleum
C48	AFFIDAVIT	Cst Jessica Lewis-Shaw
C49	AFFIDAVIT	Matthew Probin
C50	AFFIDAVIT	Darren Clarke
C51	AFFIDAVIT	Lee Bedelph
C52	AFFIDAVIT	Peter Griggs
C53	AFFIDAVIT	Jamie Burden
C54	AFFIDAVIT	Stephen Ryan

C55	AFFIDAVIT	Wayne Goss
C56	AFFIDAVIT	Michael Edwards
C57	AFFIDAVIT	Natasha Petrascu
C58	AFFIDAVIT	Andrew Clark
C59	AFFIDAVIT	Stephen Cooley
C60	AFFIDAVIT	Steve McNamara
C61	AFFIDAVIT	Dale Smith
C62	AFFIDAVIT	Carla Wilby
C63	AFFIDAVIT	Robert Fahey
C64	AFFIDAVIT	Gary Reidd
C65	AFFIDAVIT	Joanna Diakodimitriou
C66	TIMELINE OF MOVEMENTS	Tasmania Police
C66A	TRAFFIC CRASH REPORT	Tasmania Police
C66B	INCIDENT DETAILS (1.01.2019)	Tasmania Police
C67	CRASH REPORT	Department of State Growth
C68	LOCATION CRASH HISTORY	Department of Infrastructure, Energy and Resources
C69	WEATHER REPORT	Bureau of Meteorology
C70	PRIOR CRIMINAL HISTORY	Tasmania Police
C70A	INTELLIGENCE SUBMISSION REPORT	Tasmania Police
C71	MEDICAL RECORDS (DISCS X2)	Royal Hobart Hospital
C71A	MEDICAL RECORDS	Royal Hobart Hospital and Tasmania Ambulance Service
C72	MEDICAL REPORT FOR THE CORONER	Dr Anthony Bell
C73	INCIDENT DETAILS (17.11.2018)	Tasmania Police
C74	INVESTIGATIVE MATERIALS IN RELATION TO PETER CURRWOOD	Tasmania Police
C74A	PHONE RECORDS (DISC X1)	Tasmania Police
C75	INJURY SCALE AND PHOTOS	Tasmania Police Forensic Services
C76	ROAD WORKS REPORT	Department of State Growth
C77	FORENSIC PHOTOGRAPHS OF SCENE	Cst Nicholas Monk
C78	FORENSIC PHOTOGRAPHS OF INJURIES	Cst Nicholas Monk
C79	OTHER FORENSIC PHOTOGRAPHS	Cst Rance Swinton

C80	EXAMINATION OF COMPUTER REPORT AND USB X1	Tasmania Police
C81	BRIDGEWATER BRIDGE SURVEILLANCE FOOTAGE	Tasmania Police
C82	SURVEILLANCE FOOTAGE (USB x1)	Mood Food Pty Ltd (Kempton)
C83	SURVEILLANCE FOOTAGE (BUS 327) (DISC x1)	Metro Tasmania Pty Ltd
C83A	SURVEILLANCE FOOTAGE (BUS 329) (DISC x1)	Metro Tasmania Pty Ltd
C83B	SURVEILLANCE FOOTAGE (BUS 806) (DISC x1)	Metro Tasmania Pty Ltd
C84	TT- LINE SAILING MANIFEST	TT- Line Pty Ltd (Spirit of Tasmania)
C85	MESSENGER SCREENSHOT	Jonothan Millhouse
C86	STARTRACK EXPRESS EMAILS	Dean Marshall
C87	TRUCKERS TOY STORE EMAILS	Tash Renault
C88	CONSTRUCTION LOGS (31.12.2018 – 18.01.2019)	TasWater
C89	TRUCK INSPECTION SHEETS X2	Tasmania Police
C90	TRUCK INSPECTIONS – HOBART DIVISION	Tasmania Police
C91	TRUCK INSPECTIONS – GLENORCHY DIVISION	Tasmania Police
C92	TRUCK INSPECTIONS – BRIDGEWATER DIVISION	Tasmania Police
C93	TRUCK INSPECTIONS – NEW NORFOLK DIVISION	Tasmania Police
C94	TRUCK INSPECTIONS – OATLANDS DIVISION	Tasmania Police
C95	TRUCK INSPECTIONS – BELLERIVE DIVISION	Tasmania Police
C96	TRUCK INSPECTIONS – SORELL DIVISION	Tasmania Police
C97	TRUCK INSPECTIONS – SWANSEA DIVISION	Tasmania Police
C98	TRUCK INSPECTIONS – DUNALLEY DIVISION	Tasmania Police
C99	TRUCK INSPECTIONS – KINGSTON DIVISION	Tasmania Police
C100	TRUCK INSPECTIONS – HUONVILLE DIVISION	Tasmania Police
C101	MEDIA RELEASES X2	Tasmania Police