



# 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 Kevin Alexander Brooks

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

- a) The identity of the deceased is Kevin Alexander Brooks, date of birth 29 December 1957;
- b) Mr Brooks died in a motorcycle crash in the circumstances set out in this finding;
- c) The cause of death was multiple injuries; and
- d) Mr Brooks died on 25 March 2022 at Carrick, Tasmania.

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

- Police Report of Death for the Coroner;
- Crash Investigation Report by Constable Matthew O'Neil;
- Report of the State Forensic Pathologist regarding cause of death;
- Affidavit of Jackie Brooks, daughter of the deceased and senior-next-of-kin;
- Affidavit of Deirdre Batley, partner of the deceased;
- Affidavit of Sergeant Aleena Crack, witness to both crashes;
- Affidavit of Peter Candy, driver of the Mitsubishi Triton involved in both crashes;
- Affidavit of Peter Tree, driver of the Toyota Hilux involved in both crashes;
- Affidavit of Annegret Lackmann, passenger in the Toyota Hilux involved in both crashes;
- Affidavit of Gus Edmondson, witness to the second crash;
- Affidavits of Seth McGregor and Bryce Heazlewood, witnesses who rendered assistance after the second crash;
- Statutory declaration of Michael Hyland, driver of the rear pilot car assisting with the escort of the OSOM load;

- Affidavits of Barry Spencer and Casey Perkins, Transport Safety and Investigation Officers; and
- Vehicle Inspection report by Transport Inspector Ben Hunt.

## Background

Mr Brooks was born in Ilfracombe, Devon, United Kingdom on the 29th of December 1957 and was aged 64 years old at the time of his death.<sup>1</sup> Mr Brooks lived in Invermay, Launceston.<sup>2</sup> In a previous marriage, Mr Brooks had two children, Sally Brooks (deceased) and Jackie Marina Brooks.<sup>3</sup> At the time of his death, he was in a relationship with Deirdre Batley. In his early life, Mr Brooks was involved in a tractor accident which resulted in his legs being crushed, requiring pins to be inserted.<sup>4</sup> On a different occasion, he had his back broken in a tree falling accident.<sup>5</sup> Despite sustaining these significant injuries, Ms Batley stated that Mr Brooks was in excellent health, and rarely saw a doctor.<sup>6</sup>

Mr Brooks was the holder of a Tasmanian Heavy Combination driver licence with a motorcycle extension.<sup>7</sup> Mr Brooks was passionate about cars and motorcycles.<sup>8</sup> At the time of his death, Mr Brooks was employed full time at Timber World in Deloraine. He rode his green Triumph motorcycle to and from work every day.<sup>9</sup> He had 17 prior traffic infringements recorded in Tasmania since 1999, with the most recent being in December 2021 for speeding between 15-22km/h over the speed limit.<sup>10</sup>

At 5.00am on 25 March 2022, an Over Size Over Mass load ('OSOM') was being transported from Newstead to East Devonport.<sup>11</sup> A permit was issued by the National Heavy Vehicle Regulator on 23 March 2022 approving the transport of the OSOM.<sup>12</sup> This was a convoy consisting of a 3-axle Prime Mover, a 2x8 dolly, an 8x8 platform trailer (laden with a locomotive) and a 3-axle push retarder truck.<sup>13</sup> It was being escorted by Transport Safety and Investigation officers from the Department of State Growth.<sup>14</sup> This consisted of two escort vehicles and two pilot vehicles.

---

<sup>1</sup> Northern Crash Investigations Report at page 8; C1 Report of Death to Coroner at page 1.

<sup>2</sup> C1 - Report of Death to Coroner 1.

<sup>3</sup> C10 – affidavit of Jackie Brooks at page 2.

<sup>4</sup> C10 Jackie Brooks Affidavit 3.

<sup>5</sup> C10 Jackie Brooks Affidavit 3.

<sup>6</sup> C11 Batley Affidavit 2.

<sup>7</sup> Northern Crash Investigations Report 8.

<sup>8</sup> C10 Jackie Brooks Affidavit 2.

<sup>9</sup> C10 Jackie Brooks Affidavit 2.

<sup>10</sup> Northern Crash Investigation Report 8.

<sup>11</sup> C20: Spencer Affidavit 2; C21 Perkins Affidavit 1-2; C35 WorkSafe Report 5.

<sup>12</sup> C32 NHVR permit.

<sup>13</sup> Northern Crash Investigation Report 4; C32 NHVR Permit.

<sup>14</sup> Northern Crash Investigations Report 4.

At around 6.20am the OSOM was required to travel west over the Illawarra Road overpass on the Bass Highway.<sup>15</sup> The OSOM was required by its permit to travel on the centreline of the overpass at no more than 10km/h and to stop all other traffic on the highway at that location.<sup>16</sup> All traffic was stopped while the OSOM travelled on the overpass. This caused a build-up of stationary traffic on both sides of the overpass.<sup>17</sup> Once it cleared the overpass, the OSOM pulled onto the verge to allow traffic to clear.<sup>18</sup> This was when two multi-vehicle crashes occurred, with the second crash resulting in Mr Brooks' death.

### **First crash**

The first crash involved the Triumph motorcycle driven by Mr Brooks (registration number A872E), a Mitsubishi Triton Ute driven by Peter Candy (registration number E94DY) and a Toyota Hilux driven by Peter Tree with his partner Ms Annegret Lackmann in the passenger seat (registration WZE760).<sup>19</sup> The Toyota Hilux was hit by a Volkswagen Amarok driven by Mitchell Harvey (registration number F32UJ). The facts of the first crash are set out in the following paragraphs.

At 6.24am on 25 March 2022, Mr Harvey was driving his Volkswagen Amarok at approximately 100km/h along the Bass Highway towards Deloraine to his workplace at the Ashley Youth Detention Centre.<sup>20</sup> Immediately before the crash, Mr Harvey diverted his attention from the road for about two seconds when he attempted to pick something out of his eye.<sup>21</sup> When Mr Harvey's attention returned to the road, he saw the taillights of the Toyota Hilux in front of him but was unable to stop his vehicle.<sup>22</sup> Mr Harvey struck the rear of the stationary Toyota Hilux. This caused the Toyota Hilux to hit the back of the Mitsubishi Triton, which in turn hit the Triumph motorbike causing Mr Brooks to fall off it.<sup>23</sup>

After the crash, Mr Harvey moved his vehicle onto the off-ramp at Illawarra Road. The Toyota Hilux and the Mitsubishi Triton remained on the roadway, along with the Triumph motorcycle. The impact damaged the rear lights of the Toyota Hilux and Mitsubishi Triton, causing them to stop working.<sup>24</sup> Mr Brooks was observed taking off his helmet and moving towards Mr

---

<sup>15</sup> C35 WorkSafe Report 5.

<sup>16</sup> C32 NHVR Permit condition 5.

<sup>17</sup> See Affidavits of drivers involved in crash from C13-15.

<sup>18</sup> C20 Spencer Affidavit 3.

<sup>19</sup> Northern Crash Investigations 6-12 (description of vehicles).

<sup>20</sup> C25 Harvey Interview Transcript 12.

<sup>21</sup> C25 Harvey Interview Transcript 23.

<sup>22</sup> C25 Harvey Interview Transcript 21.

<sup>23</sup> C13 Candy Affidavit 2; see C14: Tree Affidavit 2.

<sup>24</sup> Northern Crash Investigations 7; C25 Hunt Affidavit 16, 22.

Candy.<sup>25</sup> Mr Brooks began yelling at Mr Candy, thinking that he was the one who caused the crash.<sup>26</sup>

At the time of the crash, Sergeant Aleena Crack was driving an unmarked Rav4 police vehicle on her way to work. She had stopped in the vehicle line in front of the Triumph motorcycle due to the slow-moving OSOM.<sup>27</sup>

After observing the crash, Sergeant Crack turned on her emergency lights, and called for an ambulance and additional police to attend the scene.<sup>28</sup> The emergency lights on Sergeant Crack's vehicle were located on the top of the rear windscreen, and were not ideal for highway use.<sup>29</sup> Sergeant Crack walked over to Mr Brooks to calm him down, and checked up on the other people involved in the crash. Mr Candy observed that Mr Brooks was limping and had blood on his face following the crash, but otherwise did not appear badly injured. I am satisfied that he was not significantly injured. At this point, Mr Brooks was observed wandering off from the left side of the Mr Candy's vehicle.<sup>30</sup>

## **Second crash**

The second crash occurred approximately two minutes after the first crash. The crash involved a UD Rigid Truck (registration number F27GZ) driven by Mr Padman, the Mitsubishi Triton, the Toyota Hilux and Mr Brooks as a pedestrian.

The UD truck was travelling at approximately 90-100km/h when it approached the Illawarra overpass and crashed into the back of the Toyota Hilux.<sup>31</sup> Just before the impact, Sergeant Crack noticed the headlights of the UD Truck approximately 10 seconds before the crash. She attempted to stop the truck by flagging it down.<sup>32</sup> However, the truck did not stop or slow down. Mr Padman did not see Sergeant Crack as she was wearing dark clothing and did not have access to lights or road safety equipment.<sup>33</sup>

The impact caused the Toyota Hilux to crash into the back of the Mitsubishi Triton. The Toyota Hilux turned 180 degrees and the Mitsubishi Triton turned 90 degrees.<sup>34</sup> Mr Candy described the impact from the crash as causing "*everything to fly everywhere*".<sup>35</sup>

---

<sup>25</sup> C13 Candy Affidavit 2.

<sup>26</sup> C13 Candy Affidavit 2.

<sup>27</sup> C12 Crack Affidavit 1

<sup>28</sup> C12 Crack Affidavit 2.

<sup>29</sup> C12 Crack Affidavit 2.

<sup>30</sup> C13 Candy Affidavit 2.

<sup>31</sup> C26 Padman Interview 33; Northern Crash Investigation Services 24.

<sup>32</sup> C12 Crack Affidavit 3.

<sup>33</sup> C12 Crack Affidavit 3.

<sup>34</sup> C12 Crack Affidavit 3-4.

<sup>35</sup> C13 Candy Affidavit 2.

It is unknown where exactly Mr Brooks was standing at the time of the second crash, but he was struck by one of the vehicles involved in the crash. He was found lying on his back on the road in the westbound lane after it had occurred.<sup>36</sup> Mr Brooks appeared unconscious, his breathing was laboured, and his legs appeared to be crushed as if he was run over.<sup>37</sup>

Mr Brooks' condition deteriorated at the scene, and his breath became shallower, but he still had a pulse.<sup>38</sup> An Ambulance Tasmania paramedic arrived to perform first aid on him and began a soft bag resuscitation. Despite medical intervention Mr Brooks died from the injuries he suffered.

### **Subsequent investigations**

#### *Report of the forensic pathologist*

A post-mortem CT scan revealed that Mr Brooks suffered head, chest, spine and limb injuries.<sup>39</sup> The State Forensic Pathologist reported that these injuries were consistent with those that sustained by a pedestrian being hit by a motor vehicle.<sup>40</sup> He further concluded that Mr Brooks died as a result of the injuries suffered from the second crash.<sup>41</sup>

#### *Toxicology of the drivers<sup>42</sup>*

An analysis of blood samples of the drivers involved in the crashes was conducted by Forensic Science Service Tasmania. The reports concluded that it was unlikely that the drivers involved in both crashes were impaired by intoxicating substances or medications they had taken. Specifically, Mr Harvey's and Mr Padman's toxicology results did not reveal any intoxicating substances present in their body.

#### *Condition of the Vehicles*

An inspection of the UD Truck was conducted by Inspector Paul Buckley from the National Heavy Vehicle Regulator. He concluded that there were no defects in the truck that contributed to the crash.<sup>43</sup>

---

<sup>36</sup> C12 Crack Affidavit 4; C13 Candy Affidavit 2.

<sup>37</sup> C12 Crack Affidavit 4; C13 Candy Affidavit 2.

<sup>38</sup> C12 Crack Affidavit 2.

<sup>39</sup> C5 Post-mortem report 10.

<sup>40</sup> Ibid.

<sup>41</sup> Ibid.

<sup>42</sup> C6-C9 Toxicology Reports.

<sup>43</sup> C23 Buckley Affidavit 6.

Inspection of all the other vehicles involved in the crashes was conducted by Mr Ben Hunt, a transport inspector from the Department of State Growth. He concluded that there were no material defects in the other vehicles that contributed to the crashes.<sup>44</sup>

#### *Road Conditions*

At the time of the crashes, it was dark, and the road was dry.<sup>45</sup> Mr Harvey claimed that there was fog which limited visibility of the road.<sup>46</sup> However, other drivers on the day did not consider that there was fog.<sup>47</sup> It is unlikely that there was fog at the time of the crashes.

#### *Cause of the crashes*

Constable Matthew O'Neil of the Northern Crash Investigation Service conducted an investigation into the crashes. He concluded that the first crash was caused by the inattention of Mr Harvey who failed to observe the stationary line of traffic in front of him.<sup>48</sup> Mr Harvey's failure to stop caused damage to the rear taillights of the Toyota Hilux, a factor that contributed to the second crash.<sup>49</sup> Subsequently, Mr Harvey was charged with driving without due care and attention, and pleaded guilty to that offence on 3 March 2023.<sup>50</sup>

Constable O'Neil concluded that the second crash was caused by the damaged and inoperative taillights of the vehicles hit by Mr Harvey.<sup>51</sup> He concluded that Mr Padman did not breach the standards of a reasonable driver. Due to the dark conditions, and likely headlights of oncoming vehicles, it was not possible to see that there were stationary vehicles on the road. Dashcam footage from the UD Truck showed that the vehicles were only visible to Mr Padman approximately 1-2 seconds before the collision.<sup>52</sup> Dashcam footage of Mr Padman showed that he was not distracted and had attempted to avoid the vehicles as soon as he saw the vehicles.<sup>53</sup> Because of this, Mr Padman was not charged with any offence in relation to the crash.<sup>54</sup>

Despite specialist scene analysis, it was not possible for investigators to determine which vehicle or vehicles involved in the second crash struck Mr Brooks or his location on the road beforehand.

#### *Over Size Over Mass Convoy (OSOM)*

---

<sup>44</sup> C24 Hunt Affidavit 2, 7, 12, 18.

<sup>45</sup> See C16 Edmonson Affidavit, 1; C17 McGregor Affidavit, 1; C18 Heazlewood Affidavit, 3.

<sup>46</sup> C25 Harvey Interview 13.

<sup>47</sup> See C16 Edmonson Affidavit, 1; C17 McGregor Affidavit, 1; C18 Heazlewood Affidavit, 3.

<sup>48</sup> Northern Crash Investigations 28.

<sup>49</sup> Northern Crash Investigations 28.

<sup>50</sup> See after Northern Crash Investigation, Record of Prior Convictions for Mr Harvey.

<sup>51</sup> Northern Crash Investigations 28.

<sup>52</sup> Northern Crash Investigations 20-24.

<sup>53</sup> Northern Crash Investigations 20-24.

<sup>54</sup> See DPP Brief 4-5.

The OSOM load was permitted to travel on the day of the crash.<sup>55</sup> The permit included several conditions including:

- That the OSOM could not travel over 10km/h while on the Illawarra overpass (condition 5);
- That there were 2 escort vehicles and 2 pilot vehicles<sup>56</sup> (condition 13);
- That it could not travel in certain areas between 7.00am and 9.00am (condition 18); and
- The OSOM must cease travel if weather conditions prevented vehicles approaching from seeing the OSOM within 250 metres (condition 23).<sup>57</sup>

The operating procedures for the OSOM also set out the requirements for the positioning and visibility in respect of the escort and pilot vehicles.<sup>58</sup> The warning lights on pilot vehicles were required to be visible for a distance of 500 metres in all directions.<sup>59</sup> These must be illuminated while the OSOM is travelling and when it is stationary.<sup>60</sup> It also required that one of the pilot vehicles was to be positioned 300 metres behind the OSOM.<sup>61</sup>

Before the OSOM began travelling, officers from the Department of State Growth inspected the OSOM and considered that it complied with the conditions of the permit.<sup>62</sup> Inspector Casey Perkins, who escorted the OSOM, confirmed that visibility of the OSOM did not fall below 200 metres.<sup>63</sup> Michael Hyland, the driver of the pilot vehicle behind the OSOM, confirmed that he was 300 metres behind the OSOM and that he would have been visible to westbound traffic at the Illawarra overpass.<sup>64</sup>

Despite this, Sergeant Crack and drivers involved in the crashes state that they did not see any warning lights from the location of the crash and that traffic appeared to have stopped abruptly.<sup>65</sup> Sergeant Crack said that she was taken by surprise that traffic had stopped and she needed to brake heavily to come to a stop.<sup>66</sup> In contrast, drivers who were driving towards the OSOM, in the opposite lane, were able to see the warning lights.<sup>67</sup>

---

<sup>55</sup> C32 NHVR Permit.

<sup>56</sup> Pilot Vehicles are designed to warn other road users of the OSOM, see C33 Operating Procedure 11.

<sup>57</sup> C32 NHVR Permit condition (5), (13), (18), (23),

<sup>58</sup> C33 Operating Procedures 13-4.

<sup>59</sup> C33 Operating Procedures 4.

<sup>60</sup> C33 Operating Procedures 4.

<sup>61</sup> C33 Operating Procedures 13.

<sup>62</sup> C20 Spencer Affidavit 1; C21 Perkins Affidavit 1.

<sup>63</sup> C21 Perkins Affidavit 1.

<sup>64</sup> C19 Hyland Statutory Declaration.

<sup>65</sup> C13 Candy Affidavit 1-2 (no lights and sudden stop); C14 Tree Affidavit 2 (no lights); C15 Lackmann Affidavit 2 (no lights); C12 Crack Affidavit 1 (no lights).

<sup>66</sup> C12 Crack Affidavit 1.

<sup>67</sup> C16 Edmonson Affidavit 1; C17 McGregor Affidavit 1; C18 Heazlewood Affidavit 1.

At the time of the crashes, the OSOM had passed the Illawarra overpass and was parked on the side of the road, approximately 900-1000m away from the site of the crashes.<sup>68</sup> The pilot vehicle behind the OSOM would have been situated 600-700m away from the crash site. It would not have been a contravention of the permit or the operating procedures if the lights from the pilot vehicle were not visible from the location of the crashes. The warning lights from the pilot vehicle did not need to be visible from the crash site as it was in excess of 500 metres away.

A WorkSafe investigation was conducted by WorkSafe Inspector James Day. He considered that there were no reasonable measures that could have been undertaken by the Department of State Growth, Gradco Pty Ltd (the company transporting the OSOM) or Borgs Pty Ltd (Mr Padman's employer) to prevent the crashes occurring.

Inspector Day considered that there were no contraventions of the *Work Health and Safety Act 2012* and that those organisations implemented reasonable procedures to control the risk of their activities. Inspector Day considered that the cause of the crashes was due to Mr Harvey's inattention when driving.

#### *Comments*

Having considered the comprehensive evidence in this investigation, I am satisfied that the immediate cause of Mr Brooks' death was being struck by one or more of the vehicles in the second crash at a time when Mr Brooks had alighted from his motorcycle after the first crash and was standing on the roadway. I cannot further determine Mr Brooks' exact position on the roadway or which vehicles made contact with him.

I find that the major cause of the second crash was the fact that the rear lights of the vehicles involved in the first crash were damaged and non-operational. This situation resulted from the inattention of Mr Harvey in causing the first crash. The lack of tail lights, combined with oncoming headlights, caused Mr Padman not to see that the vehicles had stopped, even though he was paying sufficient attention to the road. This, in turn, led to the second crash and then to Mr Brooks' most unfortunate death.

Mr Harvey's inattention to the road also played a part in the circumstances of Mr Brooks death.

I am satisfied that the weather, road conditions, alcohol and drugs played no part in the crashes.

---

<sup>68</sup> C35 WorkSafe Report 4. C20 Spencer Affidavit 3; C21 Perkins 2.

I am satisfied that the Department of State Growth and the operators of the OSOM complied with the permit and their operating procedures.

#### *Senior Next of Kin Concerns*

During the investigation, the Senior-Next-of-Kin, Jackie Marina Brooks, made representations that she would like an inquest to be held. She raised a number of concerns which I summarise as follows:

1. That the investigation was not thorough, that there is more evidence available and that she has not been provided with all the information supplied;
2. That there were inadequacies with the OSOM transport which have not been investigated which contributed to Mr Brooks' death;
3. Sergeant Crack did not have the appropriate equipment in her vehicle to prevent the second crash;
4. Mr Harvey failed to follow Sergeant Crack's advice to turn on his hazard lights after the first crash and that he was charged with an offence that was insufficiently serious; and
5. Mr Padman should have been able to stop before causing the second crash.

After providing Ms Brooks with full disclosure of the evidence in the investigation and having had regard to her comprehensive written submissions dated 28 September 2023, I decided in accordance with section 26(1) of the *Coroners Act* 1995 that it was not desirable to hold an inquest. I gave the following reasons for my decision:

- The death is not one referred to in section 24 of the *Coroners Act*;
- The investigation revealed that there are no suspicious circumstances surrounding the death;
- An inquest is not necessary or desirable in the interests of justice;
- An inquest is unlikely to reveal any additional, significant information about the death; and
- I had sufficient information to make findings about the matters required by section 28 of the *Coroners Act*.<sup>69</sup>

Following my above written decision, Ms Brooks did not apply to the Supreme Court within 14 days as specified by section 26(2) of the *Coroners Act*.

It is appropriate, however, to deal with the issues raised by Ms Brooks and I do so below in the same order as listed above.

---

<sup>69</sup> Written decision dated 28 March 2024 pursuant to Section 26 of the *Coroners Act*.

*Issue 1*

Ms Brooks was provided with access to all the evidence that is available to me. I consider that the investigations conducted were appropriately thorough. I do not consider that any further avenues of investigation would lead to additional material evidence.

*Issue 2*

I have dealt with this issue above. The OSOM complied with the permit and the operating procedures during its travel. I accept the conclusion from the WorkSafe Report and the evidence from the Department of State Growth Officers that the OSOM was compliant in its travel.

*Issue 3*

Sergeant Crack was in an unmarked vehicle on her way to work. She did not carry, and was not required to carry, equipment for management of a multi-vehicle crash on a major highway.

Having reviewed the recording of the 000 call by Sergeant Crack,<sup>70</sup> which recorded her discussions and actions at the scene, it is clear that she managed the incident in a highly competent manner. She maintained excellent communication with the operator and was able control the situation effectively. Sergeant Crack could not have done anything more to prevent the second crash from occurring. She was, in fact, responsible for instigating a timely emergency response.

*Issues 4 and 5*

In the 000 call by Sergeant Crack, the only mention of activating hazard lights was after the occurrence of the second crash.<sup>71</sup> It is unclear why Mr Harvey did not turn on his hazard lights after the first crash of his own initiative. During Mr Harvey's interview, he said that he thought his lights were not working.<sup>72</sup> Despite this, an inspection of Mr Harvey's vehicle found that his rear indicators were still working.<sup>73</sup> It would have been prudent for Mr Harvey to activate his hazard lights following the first crash.

It is unclear, in any event, whether the second crash would have been prevented even if Mr Harvey had activated his hazard lights. Relevantly, the police lights from Sergeant Crack's vehicle were not visible from the dashcam footage of Mr Padman's truck.

---

<sup>70</sup> C34 000 Call Crack.

<sup>71</sup> C34 000 Call Crack.

<sup>72</sup> C25 Harvey Interview 43.

<sup>73</sup> C24 Hunt Affidavit 5.

It is not the function of the coroner to comment in relation to the laying of criminal charges against persons involved in the circumstances surrounding death. Further, a coroner is specifically prohibited from including in a finding or comment any statement that a person is or may be guilty of an offence.<sup>74</sup>

The Director of Public Prosecutions has the sole discretion to bring charges and it is not for me to make any further comment in this regard.

### **Conclusion**

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

I extend my appreciation to investigating officer Constable Matthew O'Neil for his thorough investigation and report.

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

**Dated:** 15 July 2024 at Hobart, in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**

---

<sup>74</sup> Section 28(4) of the *Coroners Act*.