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 Macy Jayne Edwards

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

a) The identity of the deceased is Macy Jayne Edwards;

b) Ms Edwards died as a result of injuries sustained as the driver in a two vehicle collision on Frankford Road on 28 March 2023;

c) The cause of Ms Edwards's death was traumatic (diffuse axonal and intracranial haemorrhagic) brain injuries; and

d) Ms Edwards died, aged 22 years, on 8 June 2023 at the Royal Hobart Hospital, Hobart, Tasmania.

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

- Police Report of Death for the Coroner;
- Tasmanian Health Service – Death Report to Coroner;
- Affidavit confirming identity;
- Report – Dr Andrew Reid, Forensic Pathologist;
- Report – Forensic Science Service Tasmania (Edwards);
- Report – Forensic Science Service Tasmania (*Road Safety (Alcohol and Drugs) Act* 1970) (Holloway);
- Records – Ambulance Tasmania;
- Medical Records – Royal Hobart Hospital;
- Affidavit – Celisa Edwards, sworn 13 July 2023;
- Affidavit – Liam Smith, sworn 13 June 2023;
- Affidavit – Adam Beattie, sworn 24 July 2023;

- Affidavit – Amanda Holloway, sworn 4 April 2023;
- Affidavit – Constable Gregory Johnson, sworn 27 June 2023;
- Affidavit – Constable Sven Mason, Western District Crash Investigation, sworn 25 July 2023;
- Affidavit – Constable Lindsay Needham, Forensic Services, sworn 7 April 2023 (and photographs);
- Affidavit – First Class Constable Dean Wotherspoon, sworn 24 May 2023 (and photographs);
- Statutory Declaration – Craig Shepherd, Transport Safety and Investigation Officer, made 14 April 2023; and
- Crash Data Retrieval report.

Introduction

Ms Edwards was born on 22 January 2001 in Burnie Tasmania. She was the second oldest child of Celisa and Stephen Edwards.

Ms Edwards was educated on Tasmania's North-West coast.

At the time of her death, she was living with her parents in Wynyard while she undertook a course in relation to tour guiding. Some of that course was in Launceston but some was completed online from home.

Circumstances of death

On Tuesday 28 March 2023, Ms Edwards was driving her 2007 Mazda Tribute Wagon in a general westerly direction on the Frankford Highway. She was alone in the vehicle wearing her seatbelt.

At the same time, Ms Amanda Holloway was driving her Toyota HiLux 4WD utility in a general easterly direction. Ms Holloway was also alone in her vehicle wearing her seatbelt.

The posted speed limit for the area of road was 100 km an hour. It comprised of a single lane travelling in each direction separated by continuous double white centre lines. The road had no edge lines.

The road surface was wet (the evidence is that there had been rain for most of the day) and there was light drizzle at the time. The road surface was slippery. A witness said there was fuel on the road surface, although the crash investigator did not find any evidence of fluids or contaminants on the surface at the scene.

At a point approximately 2 km east of Saxon Creek Bridge, Ms Edwards' vehicle moved into the wrong lane and collided with the vehicle driven by Ms Holloway.

Both vehicles came to rest in contact with each other on the northern side of the road (the correct side for Ms Holloway) on a level dirt area. Ms Holloway's Toyota was facing in an easterly direction and Ms Edwards' Mazda facing west.

Passers-by stopped to assist. One of them, Mr Liam Smith, called 000 although he had to drive some distance away from the crash site to do so as there was no mobile phone reception at the point of the collision.

Police and emergency service personnel from the Tasmania Fire Service and Ambulance Tasmania were quickly on the scene.

Ms Holloway managed to extricate herself from her vehicle and, fortunately, only suffered minor injuries. The airbags in her vehicle deployed.

Ms Edwards was terribly injured. The airbags in her vehicle also deployed. She was extracted from her vehicle and taken by ambulance to the Launceston General Hospital before being transferred to the Royal Hobart Hospital.

Ms Edwards underwent by frontal craniectomy and the insertion of ICP monitor in the hospital's ICU before being transferred to the hospital's neurosurgical ward. Unfortunately, she did not make any neurological recovery and remained in the Royal Hobart Hospital until her death on 8 June 2023.

Investigation

An investigation was commenced at the scene. The scene and the vehicles involved in the crash were photographed. Both vehicles were impounded for subsequent examination. The scene itself was examined by a Police Crash Investigation Officer. That officer provided a comprehensive report which has informed theses findings. Specifically, the surface of the road where the crash occurred was found to be wet and quite slippery. No evidence of any fluids or contaminants was located on the surface.

The road surface where the crash occurred lacked edge lines, but otherwise was free of defects.

After Ms Edwards died her body was formally identified and then examined by the State Forensic Pathologist, Dr Andrew Reid. Dr Reid provided a report in which he expressed the opinion that the cause of Ms Edwards' death was traumatic brain injuries along with multiple

fractures of the skull and spine as well as chest splenic and pelvic injuries. I accept Dr Reid's opinion.

Toxicological examination of samples taken upon Ms Edwards' admission to hospital revealed no anomalies. Specifically, no alcohol or illicit drugs were detected in those samples.

Similarly, samples were taken from Ms Holloway and no alcohol or illicit drugs were identified as having been present either.

Both vehicles involved in the crash were inspected by a Transport Safety and Investigation Officer. Ms Edwards' Mazda was found to have considerable body damage to its left side and both left doors, left B pillar, the floor pan and roof structure all consistent with major impact. It also had significant damage to steering, braking and rear suspension systems.

Ms Holloway's vehicle also displayed considerable damage to its front end with all frontal lighting and bodywork destroyed. All airbags, along with both front seatbelt pre-tensioners were found to have deployed, again consistent with major impact.

The damage to both vehicles demonstrated that the left front of Ms Edwards' vehicle collided with the front of Ms Holloway's vehicle.

Nothing about either vehicle was identified by the Transport Safety and Investigation Officer as having caused or contributed to the happening of the crash.

Ms Edwards mobile phone was located in her vehicle with a flat battery and there is no evidence that it was in use at the time of the crash. I am positively satisfied that Ms Holloway was not using her mobile phone at the time of, or in the lead up to, the crash.

I have already mentioned the road and weather conditions – that is it was drizzling, and as a result the road surface was wet and slippery.

Conclusion

The evidence satisfies me that the crash which claimed Ms Edward's life occurred when her vehicle strayed into the incorrect lane.

The other driver involved was not in any way at fault.

Comments and Recommendations

Section 28 (2) of the *Coroners Act* 1995 provides that "a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate".

On 28 January 2016, Mr Lindsay Forbes Wright was killed in a motor vehicle crash which occurred at the same location as the one which claimed Ms Edwards life. That crash happened when the other driver involved, like Ms Edwards, also strayed into the wrong lane.

It is apparent to me that the section of road where both crashes occurred requires attention so as to minimise the risk of future fatalities.

Thus, circumstances of Ms Edwards's death require me to make the following recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I therefore **recommend** that the curve where the collision be examined by the appropriate authority potentially with a view to if appropriate undertaking some or all of the following actions:

- Resealing the curve with nonslip asphalt;
- Placing a "slippery when wet" advisory sign near the start of the curve warning westbound traffic;
- Placing a speed advisory sign of 35 km an hour at the start of the curve; and
- Installing audible painted edge lines throughout the length of the curve.

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

Dated: 23 October 2024 at Hobart, in the State of Tasmania.

Simon Cooper

Coroner