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

**Jari Elliot Ernest Wise**

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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 Jari Elliott Ernest Wise with an inquest held at Hobart in Tasmania, make the following findings:

## Hearing Dates

6 and 7 February 2024

## Representation

E Bill – Counsel Assisting the Coroner

P Morgan – M Oates

F Cangelosi - F Tkalac, Senior Next of Kin

## Introduction

1. In the early hours of 29 February 2020, Jari Wise was killed when he was struck by a vehicle driven by Melissa Oates at Huonville. The fact of his death was reported to me in accordance with the requirements of the *Coroners Act 1995* (“the Act”). I commenced an investigation under the Act.
2. Eventually, I reached the view that there would be no purpose served in holding an inquest. I was satisfied an inquest would not unearth any additional information that would help answer any of the questions I was required to answer about Mr Wise’s death. I conveyed my decision to Mr Wise’s senior next of kin, Ms Faith Tkalac. Unhappy with that decision, Ms Tkalac, as was her right, applied to the Supreme Court for an order that I hold an inquest.
3. At the hearing of that application before Justice Brett, the then Attorney General Ms Archer, was represented by counsel and argued in support of my decision not to hold an inquest.
4. Justice Brett upheld my decision and dismissed Ms Tkalac’s application.<sup>1</sup> Less than three hours after the judgment was delivered, Ms Archer announced to the media that

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<sup>1</sup> *Tkalac v Cooper* [2023] TASSC 7

she intended to exercise the power reposed in her by section 24(1)(g) of the Act, to direct me to hold an inquest.

5. In my view, this was an extraordinary decision to make.
6. The Attorney General had given no hint of her intention to exercise such a power in her argument in the hearing before Justice Brett. His honour's judgment, in fact, vindicated the position for which she argued.
7. I consider, in such circumstances, that a careful exercise of the power under section 24(1)(g) would involve the Attorney General engaging carefully in various actions – reading the judgment, forming a view that she disagreed with the outcome and the reasons why, taking legal advice, considering that legal advice and formulating adequate reasons for exercising the power.
8. I suppose it is possible that the Attorney General did undertake some of these steps by 12.45pm when her announcement was made to the media.
9. However, the written decision conveyed to the Coronial Division several days after her public announcement, disclosed only brief, generic reasons. She asserted for example, without explaining why, that she considered that “holding an inquest [would] assist the Coroner to make findings about how Mr Wise's death occurred and the cause of his death” and that in some way the “evidence gathering powers attached [sic] to an inquest [would] have a practical benefit [sic] in terms of understanding the circumstances of Mr Wise's death”.
10. It is not my role to comment upon whether such reasons were adequate or otherwise capable of legal challenge. In any event, the decision was not challenged and, as coroner investigating this matter, I proceeded to prepare for and hear the inquest as directed.
11. Apart from the concerning issue of the Attorney General's decision having the immediate effect of practically overruling the judgment of Justice Brett, I observe that the hearing before him took place on 12 August 2022. His Honour delivered his detailed reasons on 4 May 2023. If the Attorney General had intended exercising the power at any time in the 10 months following the hearing, nothing prevented that occurring. By delaying the decision, His Honour was required to write a judgment unnecessarily and the inquest process was actually delayed.
12. I should say when I made the decision not to hold an inquest, I gave careful consideration to the evidence gained in the comprehensive investigation into Mr

Wise's death. I assume, when she decided to direct me to hold an inquest, Ms Archer did as well. The evidence I considered was:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Post-mortem report – Dr Donald Ritchey;
- Report – Forensic Science Service Tasmania;
- Ambulance Tasmania records;
- Statutory Declaration – Jessica Hosking;
- Statutory Declaration – Toni Hosking;
- Statutory Declaration – Brodie Scott;
- Statutory Declaration – Katie Shead;
- Statutory Declaration (and copy of text messages) – Daniel Hyde;
- Statutory Declarations (2) – Jack Willing;
- Statutory Declaration – Jake Phillips;
- Statutory Declaration – Luke Gerlach;
- Statutory Declaration – Benjamin McGee;
- Statutory Declaration – Jessica Nelson;
- Statutory Declaration – Lockie Bond;
- Statutory Declaration – Max Cowen;
- Statutory Declaration – Garry Henricks;
- Statutory Declaration – Sally Roberts;
- Statutory Declaration – Tegan Hill;
- Statutory Declaration – Colin Morgan;
- Affidavit – Lena Direen;
- Statutory Declaration – Krystal Kelly;
- Statutory Declaration – Jemma Dance;
- Statutory Declaration – Amber Lovell;
- Statutory Declaration – Darren Lovell;
- Statutory Declaration – Tamsyn Rich;
- CCTV footage – Huon Library; Huonville Trade Centre; Huonville Caltex Service Station; Huonville High School; Stihl Shop, Huonville; and Huon Medical Centre;
- Police body worn camera footage - scene;
- Statutory Declaration – Senior Constable Richard Pascoe;
- Statutory Declaration – Senior Constable Justin Caswell;
- Affidavit – Detective First Class Constable Matthew Burleigh;

- Statutory Declaration – Constable Leah Hicks;
  - Statutory Declaration – Detective Senior Constable Nicolette Munro;
  - Statutory Declaration – Constable Samuel Storer;
  - Statutory Declaration – Detective Sergeant Kim Norton;
  - Statutory Declaration – Detective Senior Constable Sally Swifte;
  - Statutory Declaration – Detective Senior Constable Martin Ritson;
  - Statutory Declaration – Detective Senior Constable Michael Manning;
  - Affidavit (and photographs) – First Class Constable Dean Walker;
  - Statutory Declaration – Senior Sergeant Andrew O’Dwyer;
  - Affidavit (and photographs) – Melissa Bartulovic, police officer (rank not stated);
  - Statutory Declaration (and photographs) – Senior Constable Rance Swinton;
  - Forensic Biology Report – Forensic Science Service Tasmania;
  - Interim Laboratory Report – Forensic Science Service Tasmania;
  - Affidavit (and photographs) – Constable Carly Medhurst;
  - Affidavit (including *curriculum vitae*, sketch maps, scene diagrams and speed calculations) – Senior Constable Kelly Cordwell APM;
  - Drive-through footage and speed comparison - Crash Investigation Services;
  - Drone Footage of scene and markings;
  - Affidavit – Senior Constable Richard Keygan;
  - Blood Analysis Result – Melissa Oates;
  - Video Record of Interview – Melissa Oates;
  - Affidavit – Jason Hardy, Transport Inspector;
  - SMS downloads – Jari Wise, Melissa Oates;
  - Material provided to the Coronial Division by Ms Faith Tkalac (who was provided with access to various requested documents from the file); and
  - Miscellaneous court and Tasmania Police records.
13. Finally, before I made my decision not to hold an inquest, I had also inspected the scene of Mr Wise’s death with Senior Constable Kelly Cordwell, Crash Investigation Services, Tasmania Police.

### **Evidence at the inquest**

14. At the inquest evidence was given by:
- Ms Amber Lovell;
  - Ms Katie Shead;
  - Sergeant Megan Williams;

- Dr Donald Ritchey;
- Senior Constable Kelly Cordwell APM; and
- Ms Melissa Oates.

15. I will discuss the evidence of each witness in due course.
16. I note that Ms Tkalac did not give evidence. She did not call any witnesses to give evidence or present any new or fresh evidence.

### **The role of a coroner**

17. Before I discuss the evidence at the inquest, something should be said about what a coroner does. It is worth noting that a coroner in Tasmania is an independent judicial officer. She or he has jurisdiction to investigate any death which appears to have been unexpected or unnatural. Obviously, the circumstances of Mr Wise's death meets this test. When investigating a death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to look at the circumstances surrounding a death and answer the questions (if possible) that section 28(1) of the *Act* asks. These questions include who the deceased was, how he or she 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.
18. In excess of 900 deaths are reported to coroners in this state every year. Routinely, coroners make decisions about whether or not to hold an inquest. They do that by having regard to any submissions from interested parties and by independently applying the law.
19. It is important to understand 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. I note that by the time of these findings, all criminal proceedings arising out of Mr Wise's death were complete.
20. As was noted above, one matter that the *Act* requires, is a finding (if possible) as to how the death occurred. This phrase involves the application of the ordinary concepts of legal causation. Any coronial investigation 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.

21. The standard of proof in a coronial investigation 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 investigation 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, the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.<sup>2</sup>
22. A coroner may not enquire in relation to any decisions made by prosecution authorities such as the DPP. Nor is an investigation (with or without an inquest) an opportunity to revisit the outcome of criminal proceedings. A coroner is forbidden, by law, from making findings that are inconsistent with the determination of any criminal proceedings that arose out of the death.<sup>3</sup>
23. Coroners are permitted to make “recommendations with respect to ways of preventing further deaths and on any matter that the coroner considers appropriate”.<sup>4</sup> Any recommendations made by coroners must be sufficiently connected with the particular death. So for example, in the past, coroners have made recommendations about the safe use of chainsaws, the use of PFDs in boats and safe sleeping practices for parents and infants.
24. Finally, a coroner may comment “on any matter connected with the death including ... the administration of justice.”<sup>5</sup> Any comment must avoid “philosophical self-indulgence”.<sup>6</sup>

### **Circumstances of death**

25. Mr Wise had been in the relationship with Ms Oates for about four years before his death. They had a young daughter.
26. It is not unfair to describe the relationship as volatile. At the time of his death, both Mr Wise and Ms Oates were the subject of police family violence orders made on 17 January 2020, forbidding each to have contact with the other.<sup>7</sup> Despite those orders, they were living together.

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<sup>2</sup> [1938] 60 CLR 336.

<sup>3</sup> Section 25 (4) of the *Coroners Act 1995*.

<sup>4</sup> Section 28 (2) of the *Coroners Act 1995*.

<sup>5</sup> Section 28(3) of the *Coroners Act 1995*.

<sup>6</sup> *Chief Commissioner of Police v Hallenstein* [1996] 2VR 1 at 7.

<sup>7</sup> Exhibit C 65.

27. At about 7.00pm on Friday 28 February 2020, Mr Wise and Ms Oates went together to Jessica Hosking's house at Tutton Avenue, in Huonville. There they consumed alcohol together – mainly beer, although Ms Oates also was drinking pre-mix vodka.<sup>8</sup> Shortly before midnight, after having argued with Ms Oates, Mr Wise left, smashing a stubby of beer on Ms Oates' car as he did.
28. Mr Wise left on foot. Several people saw him and he visited a friend, Brodie Scott<sup>9</sup> before 1.00am (it was by now, of course, 29 February 2020). When he left Mr Scott's residence, Mr Wise said he was going to walk home. Several people saw him walking along Wilmot Road.
29. At about the same time as Mr Wise was walking along Wilmot Road (probably about 1.10am), Ms Oates drove to a service station in Huonville, apparently with a view to purchase a sausage in batter.<sup>10</sup> CCTV footage<sup>11</sup> shows her entering the Caltex Service Station, Main Road, Huonville just before 1.00am. When asked by the attendant she denied she had been drinking. The CCTV footage shows she was clearly affected by alcohol – giggling, slurring her words and unsteady on her feet.
30. Meanwhile, Mr Wise sent a text message to a friend Daniel Hyde at basically the same time asking for cigarette papers.
31. Subsequent analysis of mobile phone records<sup>12</sup> indicated a number of calls and messages between Ms Oates and Mr Wise after 1.00am.
32. Ms Oates was alone in her vehicle, a Toyota Estima (similar in appearance to a Toyota Tarago). She drove up Wilmot Road in the direction of Ranelagh. Ms Oates turned at Ranelagh and drove back along Wilmot Road towards the centre of Huonville.
33. She was travelling at a speed of approximately 110km an hour (the speed limit in the area was 50km an hour). Just outside the Huonville High School, at 1.12am, the vehicle driven by Ms Oates struck Mr Wise. He suffered massive injuries and died.
34. Several witnesses heard the sound of the collision and saw Ms Oates' vehicle, with significant damage to its front end heading away from where Mr Wise had been hit.

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<sup>8</sup> Exhibit C 8.

<sup>9</sup> Exhibit C 10.

<sup>10</sup> Exhibit C 8.

<sup>11</sup> Exhibit C 31.

<sup>12</sup> Exhibit C 60.

35. After hitting Mr Wise, Ms Oates kept driving. She went back to Jessica Hosking's house (about 1.6km away). When she got there, Ms Hosking's evidence is that Ms Oates said "you've got to help me I think I've hit something or someone and I hope it's not Jari".<sup>13</sup>
36. Ms Hosking's mother Toni said in her statutory declaration<sup>14</sup> that Ms Oates said that she did not know what she had hit.
37. Ms Hosking's neighbour, Mr Garry Hendricks, witnessed Ms Oates' arrival back at Tutton Avenue after she had run over Mr Wise. In his statutory declaration tendered at the inquest,<sup>15</sup> Mr Hendricks described hearing Ms Oates tell Ms Hosking's that she had "hit the cunt".<sup>16</sup> Contextually, that can only have been a reference to Mr Wise.
38. Ms Oates then returned to Wilmot Road with Ms Hosking's, Ms Hosking's was driving. On the way, Ms Hosking's said that Ms Oates repeated that she did not know what she had hit and kept repeating: "I hope it's not Jari".<sup>17</sup>
39. At the time of the crash, Mr Wise was wearing dark blue trousers, a dark blue 'hoody', with the hood covering his head and over a black cap.
40. The first call to 000 was made at 1.23am. The first police officers – Senior Constable Caswell and Senior Constable Pascoe arrived four minutes later. Upon arrival, they found Ms Oates hugging Mr Wise (who was lying on the ground in the car park of Huonville High School). She was intoxicated and extremely emotional. Police arrested her at the scene. Her interactions with police at the scene were captured on body worn camera.<sup>18</sup> Ms Oates said words to the effect 'why did he jump out in front of me?' to Senior Constable Pascoe at the scene.<sup>19</sup>

### **Forensic pathology and crash investigation evidence**

41. An investigation was commenced at the scene. The scene was secured and specialist officers from Criminal Investigation Branch, Forensic Services and Crash Investigation Services all attended to conduct enquiries. Mr Wise's body was examined and photographed. The scene was examined and marked and then re-examined in daylight.

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<sup>13</sup> Exhibit C 8.

<sup>14</sup> Exhibit C 9.

<sup>15</sup> Exhibit C 20

<sup>16</sup> *Supra*.

<sup>17</sup> Exhibit C 8.

<sup>18</sup> Exhibit C 36.

<sup>19</sup> Exhibit C 36.

42. Mr Wise's body was formally identified at the scene by Senior Constable Pascoe.<sup>20</sup> He was then taken by mortuary ambulance to the Royal Hobart Hospital (RHH). At the RHH an autopsy was performed by a senior and experienced Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey provided a report that was tendered at the inquest.<sup>21</sup> He also gave evidence. His evidence was impressive and logical.
43. Dr Ritchey's opinion was that the cause of Mr Wise's death was severe traumatic injuries of his head and neck. Those injuries included multiple abraded contusions and lacerations of the chin that overlay comminuted fractures of the mandible. Dr Ritchey also found extensive basal skull fractures and associated injury of the upper brainstem that would have resulted in near instantaneous death. There was also a transverse fracture of the anterior body of the seventh cervical vertebra to the level of the underlying spinal cord. In addition, Mr Wise had severe blunt traumatic injuries of the chest and abdomen, right arm and lower left leg.
44. He said Mr Wise was upright and facing in the direction of the vehicle when he was struck by Ms Oates. Dr Ritchey also said that the toxicological evidence<sup>22</sup> indicated Mr Wise was intoxicated at the time of his death.
45. I accept Dr Ritchey's opinion as to the cause of Mr Wise's death. I note there was no evidence to the contrary nor was his opinion challenged. Nothing I heard at the inquest changed my conclusion as to the cause of Mr Wise's death.
46. Toxicological analysis of samples taken at autopsy showed that at the time of his death Mr Wise had alcohol (0.220g per 100mL of blood) and THC (the active constituent of cannabis) in his body.<sup>23</sup>
47. Senior Constable Cordwell said in her evidence that she arrived at 2.42am at the scene. She gave detailed and comprehensive evidence at the inquest of her observations of the scene, investigations and conclusions. Her extremely detailed analysis of the scene was included in both her affidavit and crash analysis report (both tendered at the inquest). In summary, Senior Constable Cordwell's evidence was that the location of debris, blood spatter on a road sign, where Mr Wise's body came to rest and the damage to Ms Oates' vehicle was all consistent with Mr Wise standing in the centre of the lane Ms Oates was travelling in, facing towards her oncoming car. I

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<sup>20</sup> Exhibit C 3. Senior Constable Pascoe knew Mr Wise from previous police dealings.

<sup>21</sup> Exhibit C 5.

<sup>22</sup> Exhibit C 6.

<sup>23</sup> *Supra*.

am also satisfied on the basis of Senior Constable Cordwell's evidence that the windscreen of Ms Oates' car struck Mr Wise's head.

48. Senior Constable Cordwell was unable to identify any evidence at the scene that Ms Oates had taken any evasive action (such as braking or swerving) prior to or immediately after the collision. I accept her evidence on this point. It leads me to conclude that Ms Oates did not take any evasive action immediately prior to running Mr Wise over.
49. Senior Constable Cordwell calculated that Ms Oates was driving at approximately 110km/h in the seconds prior to the collision. That conclusion was based on a reliable comparison of CCTV which I accept.
50. Senior Constable Cordwell also gave evidence about a re-creation or re-enactment of the scene being conducted with a similar vehicle and a police officer dressed in dark clothing located adjacent the approximate point of impact. She said, and I accept, that the re-creation indicated that due to a combination of poor lighting and dark clothing a sober driver travelling within the speed limit would have had insufficient perception/reaction time to avoid a collision with a pedestrian positioned where Mr Wise was.
51. In summary, I accept all of Senior Constable Cordwell's evidence about the circumstances associated with the crash. Like the evidence of Dr Ritchey, it was not challenged.
52. I am completely satisfied that Mr Wise died when he was facing north and positioned more or less in the centre of the south bound lane of Wilmot Street. That was the conclusion I had reached when I decided not to hold an inquest. Nothing that I heard at the inquest changed that conclusion.

### **Ms Oates' evidence**

53. In the immediate aftermath of the crash which claimed Mr Wise's life, Ms Oates refused to answer questions in a formal police interview.<sup>24</sup> Relevantly, concerning the circumstances of the crash, Ms Oates' evidence at the inquest was that she left Tutton Avenue to go to Caltex Mood Food to buy something to eat and that her intention was then to pick up Mr Wise and go home to Lucaston. I note that her and Mr Wise's original plan, according to her, was to stay at Tutton Avenue with the children.

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<sup>24</sup> Exhibit C 57.

54. Ms Oates was unable to recall when she spoke with Mr Wise to arrange to pick him up.
55. She did not deny she drove at speed on Wilmot Road. She said she had not seen Mr Wise which was why she turned around near Ranelagh and drove back along Wilmot Road towards Huonville. She said she decided to do that so she could drive along the highway towards Lucaston. Ms Oates said she made that decision because that was the way Mr Wise had walked home two weeks earlier.
56. Ms Oates said that as she drove back towards Huonville she heard a bang and felt something hard hit her car. She said she did not know what it was and that she drove immediately back to Tutton Avenue. She said she did not know if Mr Wise had been there and thrown something at the car or if she had hit an animal. She was unable to give any coherent explanation as to why she did not stop.
57. She was cross-examined by counsel for the Senior Next of Kin and repeatedly denied that she had seen Mr Wise before she hit him. She also denied being angry with him by the time she reached Mood Food, although admitted to having been angry with him before that.
58. Ms Oates was also questioned about her history of family violence towards Mr Wise.
59. Ms Oates said that she had spoken to Mr Wise by mobile telephone after she left the Caltex Service Station. She said she did not think she asked where he was, or if he told her where he was. I confess to finding her evidence in that regard to be difficult to understand. It seems to me that if arrangements are made to pick someone up, a basic precondition to carrying that out would be to determine from where the person is to be picked up.
60. Having seen and heard Ms Oates give evidence, I considered her to be a poor witness. I formed the view that she was evasive and vague in relation to the detail of the events of the night in question. Nonetheless, that presentation may well be due to the fact that, in my assessment, she was grossly intoxicated at the time of the accident and her recollection of what occurred was affected accordingly.
61. That having been said and having regard to the need to direct myself in accordance with the ratio of *Briginshaw*,<sup>25</sup> there is not sufficient evidence to support a conclusion that Ms Oates saw Mr Wise before she turned the car around near Ranelagh.

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<sup>25</sup> *Supra*.

### Other witnesses

62. Ms Amber Lovell gave evidence at the inquest. In summary, her evidence was that Mr Wise had a supposed tendency to jump into the path of moving vehicles. I do not accept her evidence.
63. I have to say that she was a most unimpressive witness. Initially, Ms Lovell gave evidence from the protected witness room. However, her conduct was so very poor that I required her to be brought to court for her evidence to continue there.
64. While I accept that Ms Lovell may well have been in a highly emotional state, that fact does not excuse her behaviour in any way at all. She was argumentative, rude and erratic. Her evidence was internally contradictory and affected, as counsel for Ms Tkalac submitted, by unconvincing failures of memory. An example of this was her claim when she was brought to court to continue her evidence that the statement she had with her in the protected witness room was not the same statement tendered in evidence and which she was provided in court. The evidence from Sergeant Megan Williams, who was present with Ms Lovell in the protected witness room, proves beyond any argument that she was wrong in this regard.
65. I also consider her evidence is likely to be tainted by the closeness of her relationship to Ms Oates. I think it necessary to approach her evidence with a high degree of caution. In summary, she described an incident earlier in February 2020, in which she said Mr Wise had stepped out in front of Ms Oates' van which Ms Lovell was driving (Ms Oates was apparently a passenger).<sup>26</sup> I reject her account. Her evidence was, I thought, implausible as well as confusing and singularly unpersuasive.
66. Ms Lovell also gave evidence about Ms Oates' behaviour in the immediate aftermath of Mr Wise's death. She said that Ms Oates had told her *'when something did impact with the car she thought it might have been Jari throwing something at the car'*.<sup>27</sup>
67. Ms Katie Shead was also called to give evidence. She had also been present at Tutton Avenue on the night of Mr Wise's death. In addition, she said in her statutory declaration made on the day of the crash *"I know that years ago Jari jumped out in front of Melissa while she was driving. They both told me about it soon after it happened. They had been arguing in the car and Jari jumped out when Melissa told him to get out. Melissa went up the road, turned around and came back and as she got near him he jumped out at her."*

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<sup>26</sup> Exhibit C 27.

<sup>27</sup> *Supra*.

*She swerved but she clipped him with the mirror. I saw a bruise on Jari's leg after this incident. This was probably three or four years ago.*"<sup>28</sup>

68. However, her evidence at the inquest was materially different to this account. At the inquest she said that in fact, Mr Wise had had to jump clear to avoid being struck by the vehicle driven by Ms Oates.<sup>29</sup> Her explanation for the change in evidence was that when she made her statutory declaration, she had been tired and had not read the statement properly. In short, I was left with evidence from Ms Shead which was fundamentally inconsistent. I consider it was evidence upon which I should not rely.

### **Criminal proceedings**

69. At the conclusion of the police investigation, and following advice from the Director of Public Prosecutions, Ms Oates was charged with dangerous driving, driving a motor vehicle while exceeding the prescribed alcohol limit (namely 0.152g of alcohol in one hundred millilitres of blood)<sup>30</sup> and failing to stop and assist in the case of an accident.
70. On 22 April 2021, after a plea of guilty to a charge of dangerous driving contrary to section 172A of the *Criminal Code*, Justice Geason sentenced Ms Oates to 14 months imprisonment, 6 months of which was suspended on condition that she commit no offence punishable by a term of imprisonment for a period of 3 years.
71. Other summary offences committed by Ms Oates in respect of breaches of the *Road Safety (Alcohol and Drugs) Act 1971* and the *Traffic Act 1925* were also dealt with before the inquest.

### **Conclusion**

72. I am satisfied that Mr Wise died as a result of massive, unsurvivable injuries sustained by him when he was struck by a motor vehicle driven by Melissa Oates. I am satisfied there was nothing about the weather, road conditions or mechanical condition of Ms Oates' vehicle which caused or contributed to her running into Mr Wise.
73. I am also satisfied that at the relevant time Ms Oates was travelling at an excessive speed with a blood alcohol content more than three times the legal limit for driving on Tasmanian roads. She was plainly very intoxicated. She should never have been driving. In addition, although required as a condition of her licence to wear glasses, Ms

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<sup>28</sup> Exhibit C 11.

<sup>29</sup> Transcript.

<sup>30</sup> Exhibit C54 – Blood Analysis Results – Oates.

Oates was not wearing those glasses at the time. I am satisfied her vision for driving was impaired without them.

74. There is a complete absence of any reliable evidence that supports a conclusion that Mr Wise jumped into her path. I specifically reject the evidence of Amber Lovell in that regard (to the extent that it might be thought to support such a conclusion). The evidence from Ms Shead was as I have already said, at best equivocal.
75. As I have also already said, there is insufficient evidence to support a conclusion that Ms Oates saw Mr Wise before she turned the car around on Wilmot Road. The most that can be said is that whilst it is beyond argument Mr Wise was on Wilmot Road, there is no certainty as to where he was when Ms Oates drove past him (as she must have). All that can be said with a degree of confidence is that Mr Wise was in the middle (or near the middle) of the south bound lane when Ms Oates travelled in that direction (having turned near Ranelagh).
76. There is no evidence that supports a conclusion Ms Oates deliberately ran Mr Wise over. Although I am satisfied she said that she had 'hit the cunt' and this was a reference to Mr Wise, it does not support a conclusion she hit him deliberately.
77. There is no evidence that Ms Oates took any evasive action immediately prior to hitting Mr Wise.
78. I specifically reject Ms Oates' evidence that she did not know that she had hit Mr Wise.
79. I find that Mr Wise was wearing dark clothing and was standing upright facing the direction from which Ms Oates was driving on the carriageway of Wilmot Road when the vehicle driven by Ms Oates struck him. He was intoxicated (by reason of having consumed alcohol and cannabis).
80. All these conclusions were conclusions I had reached when I decided not to have an inquest. The holding of the inquest did not change any of them.

#### **Formal Findings pursuant to Section 28(1) of the Coroners Act 1995**

81. On the basis of the evidence at the inquest I make the following findings pursuant to section 28(1) of the *Coroners Act 1995*:
  - a) The identity of the deceased is Jari Elliott Ernest Wise;

- b) Mr Wise died as a result of injuries sustained by him as a pedestrian when he was struck by a motor vehicle;
- c) The cause of Mr Wise's death was multiple injuries; and
- d) Mr Wise died on 29 February 2020 at Wilmot Road, Huonville, Tasmania.

### **Comments and recommendations**

- 82. The circumstances of Mr Wise's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*.
- 83. However, as I have already pointed out, a coroner is empowered to comment on "any matter connected with the death including... the administration of justice". This case calls for comment about the administration of justice in Tasmania, so far as it is connected with Mr Wise's death.
- 84. I have already made comment regarding the particularly concerning aspects of the Attorney General's exercise of the power under section 24(1)(g) of the *Act*. Ultimately, the exercise of the power resulted in no positive outcome for the administration of justice by the holding of this inquest. Further, it had the effect of publicly undermining the role of the Supreme Court.
- 85. In exercising the power, the Attorney General was obviously motivated by the strident advocacy of the Senior Next of Kin, Ms Tkalic who embarked upon a campaign to change the *Act* so that coroners must hold inquests into every death where a coroner suspects that family violence contributed.
- 86. The proposed amendment to the *Act*, termed "*Jari's Law*" was recently passed by both Houses of Parliament. I understand it is yet to be proclaimed.
- 87. Early estimates indicate that Tasmanian coroners will, as a result of the amendment, be required to hold at least double the number of public inquests. The effect of this upon an already strained coronial system will be to significantly delay all inquests, thereby increasing the grief and trauma of many families in our community.
- 88. It will also mean that coroners will be required to hold public inquests into many deaths where no additional evidence is to be gained and not appropriate for recommendations to improve the safety of members of the community – such as this case. Further, in many cases, many families would not wish for a public inquest, which

will necessarily result in a prolonged process and the ventilation of sensitive information about the deceased and their family members – for no good reason at all.

89. Coroners in this state are well accustomed by reason of training and experience to determine when matters should or should not be the subject of an inquest. On a not infrequent basis, coroners determine that particular deaths involving family violence issues should be the subject of public inquest.
90. In the cases where a coroner decides against the holding of an inquest, consideration is given to the wishes of the senior next of kin and other persons with a sufficient interest. In such cases, a right exists to have the coroner's decision reviewed by the Supreme Court. As a matter of course, the senior next of kin is advised of their rights in this regard.
91. I urge the appropriate authorities to consider taking steps to reverse this most unfortunate exercise in 'law reform'.

**Dated** 13 May 2024 at Hobart in the State of Tasmania.

**Simon Cooper**

**Coroner**

**Annexure A****LIST OF EXHIBITS****Record of investigation into the death of JARI ELLIOT WISE**

<b>No.</b>	<b>TYPE OF EXHIBIT</b>	<b>NAME OF WITNESS</b>
<b>C1</b>	<b>REPORT OF DEATH</b>	<b>SEN/CONST R PASCOE</b>
<b>C2</b>	<b>LIFE EXTINCT AFFIDAVIT</b>	<b>DR JILLIAN NEVE</b>
<b>C3</b>	<b>AFFIDAVIT OF IDENTIFICATION</b>	<b>CONST J O'NEILL</b>
<b>C4</b>	<b>AFFIDAVIT OF IDENTIFICATION</b>	<b>ANTHONY CORDWELL</b>
<b>C5</b>	<b>POST MORTEM AFFIDAVIT</b>	<b>DR RITCHEY</b>
<b>C6</b>	<b>TOXICOLOGY REPORT</b>	<b>NEIL MCLACHLAN-TROUP</b>
<b>C7</b>	<b>MEDICAL REPORT</b>	<b>AMBULANCE TASMANIA</b>
<b>C8</b>	<b>STATUTORY DECLARATION</b>	<b>JESSICA HOSKING</b>
<b>C9</b>	<b>STATUTORY DECLARATION</b>	<b>TONI HOSKING</b>
<b>C10</b>	<b>STATUTORY DECLARATION</b>	<b>BRODIE SCOTT</b>
<b>C11</b>	<b>STATUTORY DECLARATION</b>	<b>KATIE SHEAD</b>
<b>C12</b>	<b>STATUTORY DECLARATION</b>	<b>DANIEL HYDE</b>
<b>C13</b>	<b>STATUTORY DECLARATION</b>	<b>JACK WILLING</b>
<b>C14</b>	<b>STATUTORY DECLARATION</b>	<b>JAKE PHILLIPS</b>
<b>C15</b>	<b>STATUTORY DECLARATION</b>	<b>LUKE GERLACH</b>
<b>C16</b>	<b>STATUTORY DECLARATION</b>	<b>BENJAMIN MCGEE</b>
<b>C17</b>	<b>STATUTORY DECLARATION</b>	<b>JESSICA NELSON</b>
<b>C18</b>	<b>STATUTORY DECLARATION</b>	<b>LOCKIE BOND</b>
<b>C19</b>	<b>STATUTORY DECLARATION</b>	<b>MAX COWEN</b>
<b>C20</b>	<b>STATUTORY DECLARATION</b>	<b>GARRY HENRICKS</b>

<b>C21</b>	<b>STATUTORY DECLARATION</b>	<b>SALLY ROBERTS</b>
<b>C22</b>	<b>STATUTORY DECLARATION</b>	<b>TEGAN HILL</b>
<b>C23</b>	<b>STATUTORY DECLARATION</b>	<b>COLIN MORGAN</b>
<b>C24</b>	<b>STATUTORY DECLARATION</b>	<b>LENA DIREEN</b>
<b>C25</b>	<b>STATUTORY DECLARATION</b>	<b>KRYSTAL KELLY</b>