



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 John Anthony Curtis

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

- a) The identity of the deceased is John Anthony Curtis date of birth 9 March 1988.
- b) Mr Curtis was aged 36 years, and lived in West Hobart. He has two children born in 2007 and 2008 with a former partner, Beverley Banfield. Mr Curtis grew up in the Kingston area attending Blackmans Bay Primary School and Kingston High School. He was employed casually in labouring, landscaping and at the Royal Hobart Show. When Mr Curtis was about 22 years of age, he was involved in a serious car accident and rolled his car several times. He was in a coma for about three months and did not recover until nine months after the accident. Following this incident, Mr Curtis was unable to work and received funding and support from the NDIS.

Mr Curtis was known to use illicit drugs and had been incarcerated for drug offences and drug-related driving offences. His only mode of transport was a Suzuki GXS – R1000 R1 motorcycle that he had owned for about 12 months prior to his death.

At the time of his death, Mr Curtis was subject to a court-imposed driving disqualification as part of a sentence for driving charges involving driving with methylamphetamine in his system. Further, Mr Curtis had been arrested on 4 December 2023 for one count of driving whilst disqualified and was granted police bail with a condition he must not be found behind the controls of a motor vehicle. The crash resulting in his death occurred six days prior to this court appearance.

On Tuesday, 16 January 2024, Mr Curtis' NDIS worker took him to a doctor's appointment. Later that day, Mr Curtis contacted his father, Tony Curtis, to ask if he would be coming to his apartment as had been

discussed earlier that day. Tony Curtis told his son that he would not be coming that day but would visit the following morning. Tony Curtis was of the belief that his son was intending to spend the remainder of the day in his apartment.

Just prior to 8.15pm that evening, Mr Curtis was riding his motorcycle and was travelling to a destination that cannot be ascertained. The evidence does not allow me to find where he had travelled from or what time he had left his apartment. However, he was witnessed to travel in a westerly direction on Liverpool Street around the Railway Roundabout, coming to a stop at a red light on the Brooker Avenue at its junction with Bathurst Street.

In his affidavit for the investigation, witness Matthew Pace said of the motorcycle rider (Mr Curtis): *"His manner of riding caught my attention... The light at the Bathurst Street intersection was red... When the light went green I accelerated normally and the bike took off at speed. He got about 20 metres ahead of me"*. Other witnesses at the scene described the motorbike as travelling between 100km/h and 110km/h. The speed limit in that location is 70km/h.

Raymond Harvey was travelling in his Holden Captiva southbound along the highway to collect his wife from work at the Royal Hobart Hospital. He entered the required slip lane prior to executing a right hand turn to enter Brisbane Street.

Mr Curtis likely observed the Captiva in front of him and heavily applied the brakes, losing control of his motorcycle. He crashed into the rear passenger side of the Captiva as it crossed the highway into Bathurst Street. As a result of the impact, Mr Curtis suffered catastrophic internal injuries. He was taken by ambulance to the Royal Hobart Hospital.

In hospital, his substantial injuries were treated intensively over eight weeks. After discussions with family, it was determined that ongoing treatment was futile. On 16 March 2024 his life support systems were turned off and Mr Curtis died later that day.

A comprehensive investigation was conducted into the crash by specialist crash investigators. I am satisfied upon the crash investigation analysis, including CCTV footage, that Mr Curtis was travelling at or close to

120km/h at the time of the crash. Mr Harvey was travelling slowly, at about 13km/h, just prior to the crash.

Both drivers were toxicologically tested, neither having alcohol detected or any other substances that would have impaired their driving. There were also no mechanical faults in either vehicle which contributed to the crash.

I accept the opinion of the crash investigator, Constable Mandy Ladson, that if Mr Curtis had been travelling at the speed limit of 70km/h, as he should have been, the crash would not have occurred. Unfortunately, Mr Curtis lost his life primarily because of his own deliberate act of irresponsible driving.

At the beginning of his turn, Mr Harvey had visibility to the left of 123 metres and had an opportunity to see Mr Curtis travelling at speed on the highway towards his vehicle. However, Mr Harvey told police that he did not see Mr Curtis' motorcycle at all prior to the crash.

Whilst the driving of Mr Curtis was clearly the predominant cause of the crash, Mr Harvey was required lawfully to give way to all traffic before crossing over the highway. The footage shows that he did not slow to a stop before making the turn but proceeded straight from the slip lane onto the highway. He was familiar with the turn in question and the requirement to give way. A higher degree of vigilance would have allowed him to see the motorcycle and to stop moving forward to avoid a crash.

- c) Mr Curtis died as a result of traumatic brain injury, spinal cord infarction at level T6-conus and recurrent pneumonia. His traumatic rib fractures, pulmonary contusions, transected thoracic aorta and ruptured diaphragm also contributed to his death.
- d) Mr Curtis died on 16 March 2024 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Government Death Report to Coroner;
- Affidavit confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Toxicology report of Mr Curtis;

- Medical records of Mr Curtis;
- Crash Investigation Report;
- Affidavit of Tony Curtis, father of Mr Curtis;
- Affidavit of Mr Curtis' NDIS community worker;
- Police video interview with Raymond Harvey, driver involved in the crash;
- Certificate of blood analysis of Mr Harvey;
- Affidavits of three eyewitnesses at the scene;
- Affidavits and statutory declaration of five police officers, including a specialist crash investigator, together with photographs;
- Tasmania Police information, including Mr Curtis' criminal history; and
- Information from the Department of State Growth.

Comments and Recommendations

I have received for this investigation a report from the Manager Traffic Engineering, Department of State Growth, regarding the crash history for the intersection in question, including for the right-hand turn from the Brooker Avenue slip lane into Brisbane Street. The report indicates that there have been no previous fatalities at the intersection and insufficient numbers of crashes to warrant any changes. I note, however, that the Department will continue to monitor the safety performance of the intersection.

I accept the contents of the report and do not consider that it is appropriate to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I extend my appreciation to investigating officer Constable Mandy Ladson for her very thorough and helpful investigation and report.

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

Dated: 27 October 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner