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

David John McIntosh

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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 David John McIntosh with an inquest held at Launceston in Tasmania, make the following findings:

Hearing Dates

19-20 May 2025 at Launceston, Tasmania

Representation

J Harrison, W Wu – Counsel Assisting the Coroner

A Dickens – Suncoast Express

Introduction

1. Mr McIntosh died as a result of injuries sustained by him as the driver in a single vehicle truck and trailer crash which occurred at or around 8.15 am on 15 November 2022 at Semmens Road, north of St Mary's.
2. Mr McIntosh was a truck driver by occupation. At the time of his death, he was 65 years old and married to Louise. Mr and Mrs McIntosh had been married for over 30 years and had three children from that marriage as well as three others from previous marriages. All the children are no longer dependent on their parents. At the inquest, Mrs McIntosh spoke movingly of the loss of her husband.
3. After a varied working career, Mr McIntosh started driving trucks in about 1992. There is no evidence at all of him having had any mishaps or accidents whilst working as a truck driver.¹ He had a very good driving record. On 15 November 2022, he was driving for Suncoast Express, a transport company based in St Leonards. His normal day involved delivering cardboard packaging in and around Launceston, with occasional trips to Scottsdale and the North West Coast.

¹ Exhibit C7 – Affidavit of Louise McIntosh, page 2 of 2.

The role of a coroner

4. Before considering the circumstances of Mr McIntosh's death in further detail, it is necessary to explain the general role of the coroner. In Tasmania, a coroner is an independent judicial officer. A coroner has jurisdiction to investigate any death, and hold an inquest, in relation to that death if it appears that "*the deceased died at, or as a result of an accident or injury that occurred at, his or her place of work and the coroner is not satisfied that the death was due to natural causes*".² The circumstances of Mr McIntosh's death meet this definition.
5. The requirement to hold an inquest (which is a public hearing) is subject to section 26A of the *Coroners Act 1995* (the "Act"). That section provides that if the senior next of kin requests the coroner not to hold an inquest and the coroner is satisfied that it would not be contrary to the public interest or the interests of justice not to hold an inquest, then no inquest need be held. In this case Mr McIntosh's widow, the senior next of kin under the Act, did not make such a request and as such it was necessary to hold an inquest.
6. When conducting an inquest, a coroner performs a role different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. In an inquest, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the Act asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.
7. A coroner is required 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.³
8. It is important to recognise that a coroner does not punish or award compensation to anyone.⁴ Punishment and/or 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.

² Section 24(1)(ea) of the *Coroners Act 1995*.

³ Section 28(2) of the *Coroners Act 1995*.

⁴ Section 45(3) of the *Coroners Act 1995*.

9. As was noted above, one matter that the Act requires, is a finding (if possible) as to how the death occurred.⁵ 'How' has been determined to mean 'by what means and in what circumstances',⁶ a phrase which involves the application of the ordinary concepts of legal causation.⁷ Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.
10. 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.⁸
11. A coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner she or he reasonably thinks fit. To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) of the Act or, in appropriate circumstances, to assist in making a comment or recommendation. A coroner has significant latitude in receiving evidence. The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.
12. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.⁹ A coroner must ensure that any person (any person can include a legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

Evidence at the inquest

13. A number of witnesses gave evidence and were questioned at the inquest. In order, they were:

⁵ Section 28 (1)(b) of the *Coroners Act 1995*.

⁶ *Atkinson v Morrow* [2005] QCA 353.

⁷ See *March v MH Stramare Pty Ltd and Another* [1990 – 1991] 171 CLR 506.

⁸ (1938) 60 CLR 336.

⁹ See *Annetts v McCann* (1990) 170 CLR 596, *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASFC.

- a) Mr Timothy Woodward – witness to the crash;
 - b) Mr Preet Singh – colleague of Mr McIntosh;
 - c) Ms Bridie Larby – witness to the crash;
 - d) Mr James Harper – former Operations Manager - Suncoast Express;
 - e) Mr Paul Buckley – National Heavy Vehicle Regulator, Vehicle Inspector;
 - f) Mr Nicholas Webb – former owner of Suncoast Express; and
 - g) Senior Constable Michal Rybka – Tasmania Police, Crash Investigator.¹⁰
14. I formed a favourable view of all the witnesses who gave evidence at the inquest. I considered all were honest and forthright and provided assistance to me in carrying out my function under the Act. I will discuss the evidence of the witnesses later in this finding.
15. In addition to the verbal evidence from the witnesses set out in the list above, a substantial amount of documentary material was tendered at the inquest. The complete list of that material is annexed to this finding and marked with the letter 'A'.

Circumstances of Death

16. On the day of his death, Mr McIntosh was driving a truck ordinarily driven by Mr Preet Singh. Mr Singh had called in sick that morning,¹¹ and so Mr McIntosh was required to use his truck to make deliveries to Fingal, St Helens, and Scamander. The truck (registration number C84PK) was a four-cylinder diesel Hino rigid truck with three axles. It was manufactured in 2013. Mr McIntosh had driven the truck on many occasions in the past, including on the section of road where the fatality occurred.¹²
17. The evidence was that the truck had an air leak the week or so before. That leak was repaired. The leak only affected low range gear selection.
18. On the day in question, the truck was loaded with a substantial quantity of building material. There is no evidence at all that it was either overloaded or unsafely loaded.
19. After making a delivery at the Blackwood Coal Mine site in the Fingal Valley, Mr McIntosh headed towards St Helens, using Semmens Road rather than the more usual

¹⁰ Senior Constable Rybka attended the inquest and gave evidence on a rostered day off.

¹¹ Exhibit C10 – Affidavit of Preet Singh, page 1 of 2.

¹² Exhibit C18 – Affidavit of James Harper, page 2 of 3.

Esk Highway/St Mary's Pass route, because the Pass was closed. It is clear on the evidence that there was a mechanical issue with the truck, which was losing air. The air loss affected Mr McIntosh's ability to engage low-range gears one and two. However, it had no impact on the truck's braking system.

20. Mr McIntosh made several calls to Mr Harper that morning about the air leak. Mr Harper gave evidence at the inquest. In addition to being a very experienced truck driver, at the relevant time he was the Operations Manager for Suncoast Express, where he had worked for 23 years. It was normal for any driver with a mechanical issue to contact him.
21. The first call was made at 7.15 am when Mr McIntosh was at the Blackwood Coal mine site, Cornwall, northwest of St Marys. In that conversation, Mr McIntosh told Mr Harper that "*the truck was losing air and that he couldn't get low gears in the truck*".¹³ He told him that he was unloading at the mine and would call him back.
22. The second call was made at 7.47 am. When Mr McIntosh made the call, he was heading north on German Town Road, towards Semmens Road and beyond that to Upper Scamander. Mr Harper said that Mr McIntosh "*didn't say anything about the truck at that point, only that it was still losing air*".¹⁴
23. The third call was at 7.56 am when Mr Harper called Mr McIntosh "*to make sure he was ok*".¹⁵ Mr Harper said that Mr McIntosh told him that he had pulled over to let a truck go past him. Mr Harper told Mr McIntosh to "*stop and pull off the road as far as he could get... put the truck in reverse and turn it off. Let the handbrake off and then jump out to see if he could hear where the air was escaping*".¹⁶ Doing as Mr Harper suggested would build up pressure in the air cylinder. Mr McIntosh told Mr Harper that he would do that and would call back.
24. The final call was at 8.07 am when Mr McIntosh called Mr Harper. In that call Mr McIntosh told Mr Harper that he could hear air leaking from the same area as before – a reference that, contextually, can only mean the area that was repaired a week or so prior.
25. Mr Woodward and his partner Ms Larby saw and heard the crash happen. They were travelling to Launceston in their Volkswagen Amarok Ute with their daughter (who was a passenger in the rear passenger side seat). About one kilometre south of a

¹³ *Supra*, page 2 of 3.

¹⁴ *Supra*, page 2 of 3.

¹⁵ *Supra*, page 2 of 3.

¹⁶ *Supra*, page 2 of 3.

quarry on Semmens Road, Mr Woodward said that as he steered through the 'S' section of the steepest part of Semmens Road, he saw a heavy rigid truck heading towards them. Mr Woodward said he could see that the driver was fighting the steering and had the steering wheel in a "*full left-hand down motion*". He said he had to accelerate to avoid being hit by the truck as it passed his vehicle. Mr Woodward described watching the truck which he said was "*totally out of control*" in his rear vision and side mirrors, seeing a large dust cloud and then losing sight of it. He stopped his car, made his vehicle safe and told his partner to ring 000 as he ran down the road to where he saw the dust cloud.¹⁷

26. Mr Woodward found Mr McIntosh trapped in the driver's seat but with the door open. He said that he could see Mr McIntosh had his seatbelt on and his left hand was shaking. Mr McIntosh was unable to speak although he was still breathing. Other people stopped to assist. Ms Larby's evidence was to the same effect. Mr McIntosh's mobile phone was 'live' at the time of the crash, as a call was in progress to Mr Singh's phone. Although the call was not answered, it went to voicemail, during which Mr Woodward's voice can be heard.
27. Mr Woodward said that the weather was clear and visibility was good; however, the road surface was wet. The surface of the road was packed clay with a loose layer of gravel.

Investigation

28. The investigation in relation to Mr McIntosh's death commenced at the scene. His body was removed from the cabin of the truck and taken to the Launceston General Hospital where his son, Drew McIntosh, carried out the formal identification.¹⁸ Following identification, Mr McIntosh's body was taken to the Royal Hobart Hospital by mortuary ambulance.
29. At the Royal Hobart Hospital, highly experienced forensic pathologist Dr Donald Ritchey performed an autopsy upon Mr McIntosh's body. Following the autopsy, Dr Ritchey provided a report which was tendered at the inquest.¹⁹ In his report, Dr Ritchey said that he found extensive blunt trauma of the head, neck, chest, abdomen, pelvis arms and legs. Dr Ritchey said, and I accept, that the severity of the traumatic injuries suffered by Mr McIntosh particularly in relation to his neck and brainstem almost certainly resulted in near instantaneous death.

¹⁷ Exhibit C8 – Affidavit of Timothy Woodward.

¹⁸ Exhibit C2 – ID Affidavit.

¹⁹ Exhibit C4 – Post-mortem.

30. Dr Ritchey did not find any significant natural disease at autopsy. He is well qualified to express the opinions that he did, and I accept those opinions.
31. Samples taken from Mr McIntosh's body at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. The results of that analysis did not reveal any anomalies.²⁰ No alcohol or drugs of any type were detected as having been present in Mr McIntosh's body at the time of the happening of the crash.

Vehicle inspection

32. The truck was inspected by Mr Paul Buckley, a Safety and Compliance Officer with the National Heavy Vehicle Regulator. Mr Buckley is a qualified automotive mechanic with 32 years of experience in the heavy vehicle and motor industry. I accept that Mr Buckley has the necessary qualifications and experience to express the opinions that he did in his evidence at the inquest.
33. In summary, Mr Buckley concluded that prior to and at the time of impact, the truck "*would have been classed as mechanically sound and roadworthy*".²¹ Mr Buckley said that his inspection did not reveal any failure that may have caused or contributed to the happening of the crash which claimed Mr McIntosh's life. Specifically, Mr Buckley found no defects with the brakes, suspension, or steering. There was no evidence at all of any failure of the brakes or a pre-impact blowout of any of the tyres.
34. Mr Buckley confirmed the substance of Mr Harper's evidence that any air leak, as described by Mr McIntosh, would only affect the selection of low range gears. He said, as did Mr Harper, that the air leak would not have made any difference to Mr McIntosh's ability to drive the vehicle safely, and in particular, bring it to a safe halt.

Crash Inspection – Tasmania Police

35. Senior Constable Rybka carried out a comprehensive crash investigation at my direction pursuant to the provisions of the Act. Senior Constable Rybka is an experienced and qualified crash investigator with 25 years of experience. He has attended over 100 fatal motor vehicle crashes and a similar number of serious crashes in his time with Tasmania Police. He has successfully completed a number of courses relevant to the discipline of crash investigation. I am satisfied that he possesses the necessary expertise to carry out a thorough investigation and express the opinions that he did.

²⁰ Exhibit C5 – Toxicology Report.

²¹ Exhibit C13 – Affidavit and Transport Inspection by Paul Buckley, page 7 of 8.

36. Senior Constable Rybka arrived at the scene at 12.06 pm where, after being briefed by First Class Constable Michael Harley (the scene controller), he carried out an inspection. The entry of several emergency vehicles had contaminated the scene, something unavoidable in the circumstances. In addition, it was raining by the time Senior Constable Rybka arrived and water was washing across parts of the roadway which also made his job difficult. He made a number of measurements and produced a sketch map; the latter being tendered at the inquest.²²
37. Using a combination of physical evidence obtained at the scene and witness evidence (from Mr Woodward in particular), Senior Constable Rybka expressed the opinion that Mr McIntosh, whilst travelling at an excessive speed for the road conditions (a gravel surface), lost control of the truck while travelling downhill. The truck then impacted with a steep clay bank on the western edge of the roadway before rotating, travelling a further distance, and impacting with a steep rock wall on the same side of the roadway. After that impact, the truck travelled a further 33.8 metres before coming to rest. As it careered down the road, the truck's load was ejected onto the roadway, its tray torn from the chassis and the cabin of the truck crushed, causing massive intrusion and the subsequent injuries which killed Mr McIntosh.
38. I accept Senior Constable Rybka's opinion as to the cause and circumstances of the crash.
39. Mr McIntosh's Apple iPhone was recovered from the crash site. A subsequent forensic download of the phone establishes that the phone was in use at the time of the collision. That download shows an outgoing call to Mr Singh at 8.13am. Mr Singh did not answer. It seems reasonable to conclude that the crash occurred whilst Mr McIntosh was in the process of calling Mr Singh.

Formal findings pursuant to Section 28(1) of the Coroners Act 1995

- a) The identity of the deceased is David John McIntosh;
- b) Mr McIntosh died in the circumstances set out in this finding;
- c) The cause of Mr McIntosh's death was multiple blunt injuries; and
- d) Mr McIntosh died on 15 November 2022 at Semmens Road, north of St Mary's, Tasmania.

²² Exhibit C17a – Scene Sketch Plan by Senior Constable Rybka.

Conclusion

40. I am satisfied on the evidence at the inquest that neither alcohol nor drugs played any role in the happening of the crash. There is no evidence to suggest the involvement of any other person in the happening of the crash. Weather and road conditions were not, in my view, contributing factors. There is no evidence that would support a conclusion that the truck which Mr McIntosh was driving suffered from any mechanical defect or deficiency which was capable of having caused or contributed to the happening of the crash.
41. There is no evidence that Mr McIntosh suffered any medical event which could have caused or contributed to the happening of the crash.
42. Although I am satisfied that Mr McIntosh's mobile phone was in use when the crash happened, the evidence does not enable a conclusion on the balance of probabilities as to whether it was being used in a 'hands free' manner or not.
43. The evidence satisfies me to the requisite legal standard that the crash was the result of an accident. The accident occurred when Mr McIntosh lost control of his vehicle. He was, in my view on the evidence, travelling at a speed which was excessive for the circumstances.
44. The circumstances of Mr McIntosh's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.
45. I convey my sincere condolences to the family and loved ones of Mr McIntosh.

Dated: 26 June 2025 at Hobart, in the State of Tasmania.

Simon Cooper
Coroner

Annexure 'A'

LIST OF EXHIBITS

Record of investigation into the death of David John McINTOSH

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	POLICE REPORT OF DEATH	Cst C JACKSON
C2	AFFIDAVIT OF IDENTIFICATION	CST C JACKSON
C3	AFFIDAVIT OF IDENTIFICATION	MORTUARY AMBULANCE
C4	POST MORTEM	Dr DONALD RITCHEY
C4a	IPM	DR DONALD RITCHEY
C5	TOXICOLOGY REPORT	N McLAUGHLAN-TROUP
C6	MEDICAL RECORDS	LGH
C7	AFFIDAVIT - SNOK	LOUISE M McINTOSH
C8	AFFIDAVIT – WITNESS 1	TIMOTHY J WOODWARD
C9	AFFIDAVIT – WITNESS 2	BIRDIE L LARBY
C10	AFFIDAVIT – WITNESS 3	PREET P SINGH
C10a	MOBILE PHONE MESSAGE	PREET P SINGH
C11	AFFIDAVIT	M SPILSBURY
C11a	CCTV	M SPILSBURY
C12	MOBILE PHONE RECORDS	TASMANIA POLICE
C13	AFFIDAVIT AND INSPECTION REQUEST	P BUCKLEY (NHVR)
C13a	PHOTOGRAPHS	P BUCKLEY (NHVR)
C14	AFFIDAVIT	Cst BRETT G TYSON
C14a	PHOTOGRAPHS	Cst BRETT G TYSON
C15	AFFIDAVIT – FIRST ON SCENE	Cst MICHAEL J HARLEY
C15a	BWC	Cst MICHAEL J HARLEY
C16	AFFIDAVIT	Sgt SCOTT D McKINNELL
C16a	3D MODEL (DVD)	Sgt SCOTT D McKINNELL
C17	AFFIDAVIT - CRASH ANALYST	Cst MICHAL RYBKA

C17a	SCENE SKETCH PLAN	Cst MICHAL RYBKA
C18	AFFIDAVIT	JAMES S HARPER
C19	TRUCK RUN SHEET & NHVR PROCEDURE	VARIOUS
C20	TRAFFIC CRASH REPORT	TASMANIA POLICE
C21	WEATHER REPORT – ST HELENS	BOM
C22	INCIDENT REPORT	TASMANIA POLICE
C23	PROPERTY RECEIPTS	TASMANIA POLICE AND LGH
C24	MISCELLANEOUS PAPERWORK	VARIOUS
C25	TRIPLE ZERO CALL – (Nurse calls initially, male voice takes over part way through)	Cst BARRY SCHRADER
C26	FURTHER TRIPLE ZERO CALLS FROM MULTIPLE DIFFERENT PEOPLE (4 FILES)	Cst BARRY SCHRADER
C27	BUNDLE OF DOCUMENTS – REGISTRATION AND INSURANCE OF VEHICLE RELATED	N. WEBB