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

**Danielle Kate Walker**

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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 Danielle Kate Walker with an inquest held at Hobart in Tasmania, make the following findings:

## **Hearing date**

6 December 2024

## **Representation**

A Godleman – Counsel Assisting the Coroner

C Graves – Graham John Freeman

## **Introduction**

1. Ms Walker, daughter of Wayne and Maxine and sister of Charlotte and Nicole, died on the Boyer Road just before 9am on 3 June 2023 when a vehicle driven by Graham John Freeman collided with her Suzuki Swift. Mr Freeman was driving on the wrong side of the road, under the influence of methylamphetamine and having had little sleep. Despite those unarguable facts, a decision was made by the office of the Director of Public Prosecutions not to charge Freeman with any crime or offence.
2. Ms Walker lived at home with her parents at Gretna. She was an experienced and careful driver very familiar with the Boyer Road. Her health was good and so was her life.
3. On Saturday, 3 June 2023 she was on her way to her first full day at work in her new business as a beautician at Brighton. Ms Walker did not get to work.

## **Evidence at the inquest**

4. At the inquest evidence was given by:
  - Mr Graeme Freeman;
  - Mr Patrick Johnson;
  - Mr Neil McLachlan-Troup; and
  - Senior Constable Jimi Morris.

5. I will discuss the evidence of each witness in due course.
6. In addition to the evidence from the witnesses set out above, the documents in the list annexed to this finding (and marked A) were tendered at the inquest. I also inspected the scene of Ms Walker's death. All of this evidence informed this finding.
7. At the conclusion of the inquest, I made directions for the delivery of submissions by counsel. Counsel assisting complied with those directions and delivered helpful and comprehensive written submissions. Submissions were received on behalf of Mr Freeman and I have had specific regard to the content of them.

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

8. 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 the result of an accident, unexpected or unnatural. The circumstances of Ms Walker's death meets this test.
9. 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 *Coroners Act 1995* (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.
10. 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.
11. 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.
12. 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>1</sup> I am particularly conscious of this requirement in the context of this case.

13. It is not the role of a coroner to consider any decisions made by prosecution authorities such as the DPP.

### **Circumstances of Ms Walker's death**

14. The evidence at the inquest (none of which was in dispute) leads me to conclude as follows. On the day before Ms Walker's death, Friday 2 June 2023, Mr Freeman, after finishing work as a truck driver went to a shack owned by his parents in the Great Lakes area. He was the passenger, along with another man Mr Ryan Hodge, in a vehicle driven by a friend, Mr Patrick Johnson. The men arrived at the shack at about 5pm. They were joined by two other men. During the evening, Mr Freeman and his companions hunted at the property and Mr Freeman used the illicit drug methylamphetamine.
15. Mr Freeman said in his evidence at the inquest that he took "*a little bit less than*" 0.5g of what he believed to be "*speed*" to the Great Lake property. He said he had bought the substance approximately two weeks earlier.
16. He said that on the evening of 2 June 2023 he used approximately 0.1g (otherwise known as a "point") at approximately 6pm after arriving at the shack and unpacking. He had another point sometime between 7 and 8pm and another point at around midnight. In summary, Mr Freeman's own evidence was that he had consumed at least 0.3g of methylamphetamine between 6pm and midnight. He said he had ingested the substance by snorting it.
17. Mr Freeman said that he did not take MDMA or cocaine at the Great Lake and could offer no explanation as to how the substances were later detected in his blood sample<sup>2</sup>. He said that he regularly used methylamphetamine, seeming to suggest that it was used by him as a substitute for alcohol and that, in some way, that made that use acceptable. He was well aware of the effects of methylamphetamine including both their stimulant and withdrawal effects, in particular the latter causing fatigue, feeling rundown and less alert and experiencing difficulties concentrating.

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<sup>1</sup> [1938] 60 CLR 336

<sup>2</sup> Exhibit C6a

18. The evidence was that Mr Freeman went to bed no earlier than 1am on 3 June 2023 and woke sometime between 5 and 6am that day. I observe that I consider it likely that having regard to the stimulant effect of methylamphetamine it is unlikely that Mr Freeman went to sleep immediately.
19. In any event he travelled back to his parents' address at Brighton with Mr Johnson and the evidence was that Mr Freeman laid in the back of that vehicle for at least some of that journey. He could not say whether he slept at all during the trip, although Mr Johnson said that he did.
20. Mr Johnson dropped Mr Freeman at his parents' home in Brighton at about 8am. Mr Freeman then borrowed his mother's vehicle, a gold Toyota Camry placing his firearms in the back of the vehicle and leaving the property. The evidence is he travelled through Bridgewater and on to Boyer Road in the direction of New Norfolk. He was unable to explain why he was driving to New Norfolk.
21. At approximately 8:39am after passing the Coomera Court turnoff Mr Freeman reached an area of the road with a slight left-hand bend and dip in the road followed by a more pronounced left-hand bend. He was seen by witnesses to begin to slowly drift to his right into the incorrect lane and into the path of oncoming traffic.
22. Mr Adam Barnett was driving on Boyer Road in the opposite direction to Mr Freeman and saw him drift into the wrong lane. Mr Barnett had to take evasive action to avoid a collision with Mr Freeman. He said in his evidence that he considered that Freeman had missed his vehicle by less than 50 cm.<sup>3</sup>
23. Ms Walker was travelling behind Mr Barnett. Mr Freeman did not correct his course and continued in the wrong lane colliding head-on with Ms Walker's vehicle. Mr Barnett saw the collision in his rear vision mirror. He stopped his vehicle and his passenger, Mr Thomas Scattergood contacted emergency services<sup>4</sup> while Mr Barnett ran to the cars involved in the collision. He went to Mr Freeman's vehicle first and saw an "iPad or something [playing] a TikTok video" on the passenger's side floor of the vehicle.<sup>5</sup> Mr Barnett then went to Ms Walker's vehicle. She was still alive, but barely. Police and emergency services were in attendance within 10 minutes by which time Ms Walker was unresponsive.<sup>6</sup> Despite the best efforts of paramedics who arrived at

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<sup>3</sup> Exhibit C11

<sup>4</sup> Exhibit C12

<sup>5</sup> Exhibit C11

<sup>6</sup> Exhibit C28

8:52am Ms Walker was unable to be resuscitated and she was pronounced deceased at the scene at 9:55am.<sup>7</sup>

### Investigation

24. Ms Walker's body was removed from her vehicle and taken to the mortuary at the Royal Hobart Hospital. Her body was formally identified and an autopsy performed by the Tasmanian State Forensic Pathologist Dr Andrew Reid. Dr Reid provided a report which was tendered at the inquest<sup>8</sup> in which he expressed the view that the cause of her death was multiple head, chest and limb injuries. I accept Dr Reid's opinion. Toxicological analysis of samples taken from Ms Walker's body did not show the presence of any alcohol or illicit drugs.
25. On the other hand, samples taken from Mr Freeman's body showed he had been driving with methylamphetamine, MDMA and cocaine in his body.<sup>9</sup> I have already commented earlier in this finding upon the source of those drugs. The effect of those drugs (and in particular methylamphetamine) was the subject of careful evidence from forensic scientist Mr Neil McLachlan-Troup at the inquest. In summary he said that methylamphetamine had a significant impact on driving causing, as it did, in the withdrawal stage feelings of disorientation, lack of coordination, impaired reaction time, impaired ability to safely control a vehicle and drowsiness. I accept Mr McLachlan-Troup's evidence.
26. Senior Constable Jimi Morris, a Crash Investigator with Tasmania Police, commenced an investigation at the scene. He authored a comprehensive report which was tendered at the inquest<sup>10</sup> and also gave evidence at the inquest.
27. As a result of his investigations at the scene Senior Constable Morris concluded, and I accept, that Ms Walker was travelling at less than the posted speed limit for the area of 80 km/h, that Mr Freeman had ample line of sight from the left-hand bend prior to the point of collision (197 m) and that the crash had occurred at least 1.2 m from the centreline of the road and in Ms Walker's lane. Senior Constable Morris was unable to calculate Mr Freeman's speed due to the absence of tire marks and some issues surrounding the airbag control module in his vehicle.
28. Both vehicles were subsequently inspected by a Transport Inspector. No mechanical defects were identified in Ms Walker's vehicle; the vehicle driven by Mr Freeman was

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<sup>7</sup> Exhibit C8

<sup>8</sup> Exhibit C5

<sup>9</sup> Exhibit C6 a

<sup>10</sup> Exhibits C25 and C34

found to have one tyre with insufficient tread<sup>11</sup> although I do not think that caused or contributed to the happening of the crash.

29. Mr Freeman could not explain at the inquest why his vehicle ended up on the wrong side of the road. He said that he did not have any underlying medical conditions which could have caused or contributed to his evident loss of control of his vehicle.
30. He acknowledged that the tablet device recovered from his vehicle belonged to him and that he was the only person who would have used it. He acknowledged that the TikTok data retrieved as part of investigation from the tablet was consistent with his use. He also agreed, when asked by Mr Godleman, that he had used the tablet while driving on previous occasions.

### **Conclusion**

31. I am completely satisfied that the crash in which Ms Walker died was entirely due to the manner in which Mr Freeman drove his vehicle, that is to say on the wrong side of the road, under the influence of methylamphetamine, while fatigued and likely distracted by TikTok videos on his tablet.
32. I am satisfied that mechanical defects, road and weather conditions did not in any way cause or contribute to the happening of the crash. I am also satisfied that no other person, other than Mr Freeman, and in particular Ms Walker, was to blame for the happening of the crash.

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

33. On the basis of the evidence at the inquest I make the following formal findings pursuant to section 28(1) of the *Coroners Act 1995*:
  - a. The identity of the deceased is Danielle Kate Walker;
  - b. Ms Walker died as a result of injuries sustained by her as a driver involved in a two-vehicle motor vehicle crash;
  - c. The cause of Ms Walker's death was multiple head, chest and limb injuries; and
  - d. Ms Walker died, aged 26 years, on Boyer Road, between Coomera Court and Pegasus Drive, on Saturday, 3 June 2023.

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<sup>11</sup> Exhibit C22

**Comments and recommendations**

34. The circumstances of Danielle Kate Walker's tragic death do not require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act 1995*.
35. I express my sincere and respectful condolences to Ms Walker's family on their tragic loss.

**Dated:** 14 February 2025 at Hobart in the State of Tasmania

**Simon Cooper**

**Coroner**