MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Leigh Mackey, Coroner, having investigated the death of FI

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

a) The identity of the deceased is FI (date of birth 22 March 1972).

b) FI was born in Melbourne, Victoria, and relocated to Tasmania in 1974. She never married and had two children, PQ and CE from a former relationship. FI worked in administrative roles, often for not-for-profit organisations throughout her working life. At the time of her death, she was employed at the Claremont Golf Club.

FI had a history of mental health illness. At 10 years of age, she was an inpatient for psychiatric care at the Children's Ward at the Royal Hobart Hospital. Later she was diagnosed with major depressive disorder and, in 2015, with bipolar disorder. She was prescribed Lithium for the management of her bipolar disorder and at times was under the care of a psychiatrist and psychologist. FI had a long-standing history of alcohol misuse but was considered by those who knew her to be "high functioning". At the time of the incident, she was seeking assessment for attention deficit hyperactivity disorder.

Shortly prior to her death FI experienced increased stress. She was unhappy at her work, suffered ongoing pain in her feet and at a consultation with her general practitioner on 31 August 2023, reported her mental health was "*all over the place...a bit hypomanic...sleep poor*".[1] She did not present

[1] Medical records Ochre IMedical.

with suicidal ideation at that time and was prescribed Seroquel.[2] Neither Lithium nor antidepressants were identified in her blood by toxicological testing after FI's death.

FI's medical records were reviewed by Dr Anthony Bell, who concluded that whilst there was a history of noncompliance with medication by FI and the likelihood that her use of Lithium had ceased, the failure to take medication for her bipolar disorder and her depression was less likely to have contributed to the circumstances of her death than her use of alcohol.[3]

On Monday 9 October 2023, at approximately 9pm, FI drove her green Mazda 2 motor vehicle (Mazda) along the Brooker Highway heading south. She entered the highway from the western side of the Risdon Road intersection. She had been stopped at the intersection on Risdon Road by a red light. She was on the front row of the vehicles stopped at the light; there were no vehicles in front of her. Her right indicator was activated signalling her intention to turn right into the south bound lanes of the highway. Upon the lights facing her turning green she accelerated but instead of turning right onto the south bound lanes she veered into the north bound lanes of the Highway still heading south. The intersection is well lit and signage on the centre island required vehicles to "*keep left*" of the centre of the highway and enter the left hand, south bound side when heading south.

At the same time Natasha Strong was driving her Tiguan motor vehicle (Tiguan), with her daughter, Chanelle French as a front seated passenger, entered the highway, south from the Risdon Road intersection at Federal Street and travelled north bound on the Highway, appropriately in the north bound lanes, heading toward the Risdon Road intersection.

Brooker Highway is, between the Risdon Road intersection and Federal Street entry, a four-lane highway with two south bound and two north bound lanes separated by a concrete barrier. The speed limit applicable in this part of the highway is 80km/h.

[2] An antipsychotic prescribed used in the treatment of schizophrenia, bipolar disorder and major depressive disorder.
[3] Report of Dr Bell dated 14 October 2024.

As the Mazda was driven south in the north bound lane of the highway by FI its movements were captured on dashcam footage of a vehicle travelling behind it heading south in the south bound lane. The footage shows the movement of the Mazda part of the way as it entered the north bound lane from the intersection at Risdon Road and travelled south along the north bound lane. The headlights on the Mazda are illuminated and as it is driven along the incorrect side of the highway FI performs manoeuvres on two occasions to avoid collision with oncoming vehicles. She brakes and moves between the east and west side lanes of the highway. A total of six vehicles travelling north along the highway in this section avoided colliding with her vehicle. At no time does FI attempt to stop her vehicle, activate hazard lights, maintain a slow speed, or turn her vehicle around. The north bound lanes of the highway have a total width of 19 metres and provide sufficient space to enable a u turn to be undertaken.

As FI drove the Mazda to a point on the highway proximate to the exit and entry to the Domain Highway she collided with Ms Strong's vehicle. The accident was attended and investigated by Senior Constable Kelly Cordwell of Southern Crash Investigation Services of Tasmania Police Senior Constable Cordwell concluded that the collision between the Mazda and the Tiguan occurred in the eastern side lane of the north bound lanes. This conclusion was based on the gouge marks evident in that lane which occurred as the vehicles collided, the positioning of the vehicles and debris.

Ms Strong's driving of her Tiguan was not in a manner or at a speed that caused or contributed to the accident. Whilst toxicological analysis of her blood revealed the presence of cannabis there is no evidence that this slowed her reaction time to the extent that it reduced her ability to avoid the collision. She was, whilst driving at an appropriate speed, at night, faced unexpectedly with the Mazda travelling at high speed toward her in her lane of travel.

FI drove the Mazda at an excessive speed. The speedometer on the Mazda was stuck at a reading of 115km/h after the collision. Dashcam footage of the Mazda in the moments before the collision shows it being driven at high speed. Witnesses also recall that the Mazda was being driven at high speed; Matthew Chalk who was driving north along Brooker Highway and avoided collision with FI estimated the speed of the Mazda

as 120km/h[4]; Rachel Ford who was a passenger in a south bound vehicle on the highway described the Mazda as "*flying*".[5]

Inspection of both vehicles after the accident by Mr Benjamin Holmes, a Transport Safety and Investigation Officer with the Department of State Growth, whilst limited by the extent of damage resulting from the collision, concluded that both the Mazda and the Tiguan were in non-compliant condition prior to the collision, primarily due to tyre tread depth however the nature of the noncompliance of either vehicle did not cause nor contribute to the accident.

FI died in the driver's seat of the Mazda after the collision. She was restrained by a seatbelt. Airbags had deployed within the Mazda. She sustained extensive injuries from the collision including subarachnoid haemorrhage, multiple bilateral rib fractures, fracture of the lower thoracic spine, pelvic and appendicular fractures consistent with the collision and intrusion of the vehicle chassis. Postmortem examination did not reveal evidence of a medical event that may explain the manner of her driving immediately prior to the collision.[6]

Toxicological analysis of a sample of FI's post-mortem blood revealed a blood alcohol concentration of 0.217 g/100ml.[7] The presence of alcohol in the blood at this concentration can significantly impair driving performance by causing a loss of judgement, incoordination, reduced perception and awareness, sedation and reduced responsiveness.[8]

I find FI drove the Mazda on the incorrect side of the Brooker Highway having entered the highway from Risdon Road and driven south on the north bound lanes. She drove at a speed considerably more than the applicable speed limit of 80km/h. Having entered the north bound lanes of the highway, FI was prevented by the presence of a concrete barrier dividing the north and south bound lanes, from recorrecting and returning to the south bound lanes. FI entered the north bound lanes contrary to signage requiring her to keep left at the Risdon Road intersection. Having entered the incorrect side of the highway there remained options available

[4] Affidavit of Mathew Chalk sworn 17 October 2023.
[5] Affidavit of Rachel Ford sworn 11 October 2023.
[6] Report of Dr Andrew Reid, State Forensic Pathologist dated 20 December 2023.
[7] Affidavit of Mr Neil McLachlan-Troup sworn 5 December 2023 Page 1.
[8] Affidavit of Mr Neil McLachlan-Troup sworn 5 December 2023 Page 1-2.

to her of slowing her speed, effecting a u turn, pulling to the far western side of the highway where there were, in areas, room for a vehicle to pull off the road to the side or over the kerb, to avoid a collision. Other than effecting evasive lane changes and some braking, FI did not take any other action to avoid a collision and increased the likelihood of a collision occurring by driving at considerable speed. As a result of her driving FI collided with Ms Strong's Tiguan resulting in a high-speed collision between the two vehicles and injuries to Ms Strong and her daughter and the death of FI.

c) FI's cause of death was multiple (head, chest, pelvic and limb) injuries.

d) FI died on 9 October 2023 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Affidavit of PQ, sworn on 8 November 2023;
- Dashcam footage and affidavit of Samrah Khan, sworn on 17 October 2023;
- Police Investigation and corresponding affidavits;
- Ambulance Tasmania, THS, Hobart Pathology and GP records;
- Medical review by Dr Anthony Bell MD FRACP FCICM, Coronial Medical Consultant; and
- Crash investigation reports and corresponding affidavits.

Did FI deliberately enter the wrong side of the highway?

Interrogation of her phone following her death revealed that FI applied for employment the day before the collision and had flights arranged for an upcoming holiday to Bali. She spoke with her daughter, PQ, on 9 October 2023 between 3.56pm and 6.25pm. There was no indication made during that call that FI intended to end her life. She was described as "*very upbeat and chatty*" and there were plans for FI to visit her daughter in Melbourne.[9]

[9] Affidavit of PQ sworn 8 November 2023.

FI's driving leading up to the collision included instances of her actively avoiding collision with other vehicles by braking and changing lanes, once she had entered onto the wrong side of the highway. She had her headlights on and was wearing a seatbelt. Whilst FI experienced difficulties with her mental health and had complained to her general practitioner of mental health issues eight weeks prior to the collision there were no signs at that examination of any suicidal intent and she had made no arrangements in contemplation of ending of her life.

I find that FI's conduct driving her Mazda onto the incorrect side of the highway, continuing on without attempting to turn her vehicle, stop or leave the highway and driving at speed was not undertaken deliberately by her with an intent to end her life but was caused or at least contributed to by her intoxication.

I extend my appreciation to investigating officer Constable Kelly Cordwell for her investigation and report.

The circumstances of FI's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

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

Dated: 19 May 2026 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner

Addendum
At the request of family, an amendment has been made to the findings to remove the reference to "at a psychiatric institute" and replace with "for psychiatric care at the Children's Ward at the Royal Hobart Hospital".