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, Olivia McTaggart, Coroner, having investigated the death of TP

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

a) The identity of the deceased is TP, date of birth 12 September 1991.

b) TP was 32 years of age, was single and lived in Chigwell. He had significant qualifications and experience in a wide range of manual work areas. At the time of his death, he was working as a subcontractor for a concreting business. TP's medical records indicate that he had struggled with his mental health for some years before his death, suffered suicidal ideation and used some illicit drugs. However, from 2021, records indicate that he was using methamphetamine regularly and heavily. His use of this substance caused ongoing episodes of psychosis, paranoia, hallucinations and dyskinesia (uncontrollable, erratic movements). He attempted suicide on two or more occasions whilst he was experiencing drug-induced psychosis, which included distressing auditory hallucinations. TP received hospital treatment at the Royal Hobart Hospital following episodes of severe psychosis, culminating in a five-day inpatient stay in August 2023. Following that hospitalisation, he appeared to improve. Although he was under the regular care of his general practitioner, he did not engage adequately with the recommended services to overcome his drug addiction and the associated mental illness. The evidence indicates that he was still using methamphetamine up until his death. In the week before his death, he barely slept and was hearing voices.

In the afternoon of 6 January 2024, TP's friend (and housemate) observed that he was particularly upset about the voices in his head and she feared that he may have had thoughts of suicide. Just after 3.25pm, TP left his

residence in his Toyota Hilux utility. At 3.57pm he was driving north on the Midland Highway travelling at a speed of at least 121 km/h as he drove onto an offramp leading to Hove Way, Brighton. The advisory speed was 35 km/h and the offramp took the form of a left-hand curve. TP was the sole occupant of the vehicle and he was not wearing a seatbelt. He failed to negotiate the left-hand bend from the Midland Highway as he entered the offramp and, instead, travelled straight through the Armco railing on the right-hand side of the road. In the crash with the Armco rail, the vehicle rolled and, in this process, TP was ejected from the closed driver's side window. Witnesses from the nearby service station heard the crash and arrived quickly to provide assistance. Ambulance paramedics also arrived quickly and attempted resuscitation until determining that TP was deceased.

I am satisfied that a very thorough investigation has taken place into TP's death. I find, based upon the opinion of the qualified crash investigator, that TP made no attempt to use the brakes on his vehicle before the crash or to steer around the curve of the offramp. Inspection of his vehicle determined that the driver's seat belt was faulty and therefore TP may not have been able to use it correctly. If he had been wearing a seatbelt, he may well have survived. There were no issues with the road, visibility or weather conditions that contributed to TP's death. At the time, he had a high level of methamphetamine in his system. Methamphetamine has a profound effect on thought processes, judgement and the psychomotor skills required for driving. Erratic driving and high-speed collisions may result with its use.

c) TP died of multiple injuries caused by a single vehicle crash.

I am not able to determine upon all of the evidence whether TP intended to end his life. I am satisfied that he was experiencing symptoms of drug-induced psychosis which may well have caused him to crash his vehicle at high speed as a means of suicide. However, it is also plausible that he was so affected by methamphetamine and his mental illness that he lost control of the vehicle unintentionally as he proceeded on to the offramp.

d) TP died on 6 January 2024 at Brighton, Tasmania.

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

- The Police Report of Death for the Coroner.
- Affidavits confirming identity;
- Report of the forensic pathologist regarding cause of death;
- Report of Forensic Science Service Tasmania;
- Affidavit of TP's parents;
- Affidavit of TP's housemate;
- Affidavits of witnesses at the scene;
- Medical records of TP;
- Report of specialist crash investigator;
- CCTV footage of United Petroleum premises, capturing the crash;
- Tasmania Police documents and information; and
- Mobile phone data.

Comments and Recommendations

The death of TP, tragically, represents another life lost as a result of the terrible effects of methamphetamine addiction.

I extend my appreciation to investigating officer Constable Nicholas Dennis and Constable Mandy Ladson for their investigation and respective reports.

The circumstances of 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 TP.

Dated: 27 April 2026 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner