MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Investigation into the death of David Stanley Bailey

Ruling

Introduction

1. This ruling concerns the question of whether it is desirable to hold a public inquest into the death of David Stanley Bailey pursuant to the section 24(2) of the *Coroners Act* 1995 (the Act). Mr Bailey died on 17 August 2024 as a result of injuries sustained as a pedestrian when he was struck by a car driven by an on-duty police officer on Flinders Island.

2. The function of a coroner, by section 28 of the Act, is to establish, if possible, the identity of the deceased, the cause of death and how, when, and where the death occurred. In holding a public inquest, a coroner is not bound by the rules of evidence and may be informed and conduct an inquest in any matter the coroner reasonably thinks fit.[1] An inquest is not a forum for determining civil or criminal liability, but rather a fact-finding inquiry. A public inquest involves, in addition to the documentary evidence gathered in the investigation, the calling of witnesses to give sworn oral evidence. It is a court hearing in the Magistrates Court Coronial Division, in which the presiding coroner exercises a judicial function.

3. In determining whether the holding of a public inquest is desirable, the coroner has a broad discretion. There are no provisions in the Act specifically guiding the exercise of the discretion. However, relevant considerations may include, but are not limited to the following; where there is uncertainty in the apparent cause or manner of death; whether calling witnesses in a public hearing will provide important additional evidence or test the strength of the existing evidence; whether a public inquest can assist in resolving critical conflicting accounts regarding the circumstances of death; to explore the involvement of public agencies or authorities where there is a connection to death; and the extent of legitimate public interest in the circumstances of the death.

[1] Section 51 of the Act.

4. In Tasmania, the vast majority of cases reported to the coroner and subsequently investigated, do not proceed to public inquest. This is because the necessary findings may be made by the coroner on the investigation evidence in a written "in-chambers" finding.[2]

5. In this case, the wife and senior next of kin of Mr Bailey, Mrs Bailey, has made application for a public inquest into the death of her husband, submitting that it is desirable that an inquest be held.

6. Pursuant to s24 of the Act, a coroner must hold an inquest in certain defined circumstances. However, this is not a case where an inquest is mandatory and it was not submitted otherwise by Mrs Bailey's counsel.

7. Mr Bailey's death from accident or injury was properly reported to the coroner in accordance with statutory requirements.[3] Pursuant to s21(1) the coroner has jurisdiction to investigate and, if possible to make the necessary findings under s28(1). Further, the coroner is empowered to make recommendations with respect to ways of preventing further deaths and to comment on any matter connected with the death.[4]

The evidence in the investigation

8. Following Mr Bailey's death being reported to the coroner, an investigation was conducted. The investigation material included medical evidence, video interviews and statements from relevant witnesses and police officers, scene photographs and body worn camera footage, Tasmania Police records, and analysis and opinion from specialist police officers[5] and other experts.

9. Prior to making the submission that a public inquest should be held, Mrs Bailey and her counsel were provided with disclosure of the documentary evidence in the investigation.

10. A brief summary of the evidence concerning the circumstances surrounding Mr Bailey's death is as follows:

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[2] About 96% of reported cases are finalised without inquest.
[3] Section 3 of the Act, definition of *reportable death.*
[4] Section 28 (2) and (3) of the Act.
[5] Including from Forensic Services, Crash Investigation Services and Professional Standards.

11. At 2:53pm on 17 August 2024 Mr Bailey and family members arrived at the Furneaux Tavern for his sister-in-law's birthday function. In accordance with analysis of hotel CCTV, Mr Bailey consumed 18 handles of beer,[6] before leaving by himself on foot at 7:53pm without others noticing.

12. Shortly after he left the hotel, witnesses observed Mr Bailey jogging on Lady Barron Road, between the township of Lady Barron and the crash site. The bitumen road, comprising one lane in each direction, was dark, with no street lighting. The posted speed limit for vehicles was 100km/h.

13. At approximately 9:00pm a motorist, Fiona Stewart, observed Mr Bailey on the road near the "Sapphire" property, over three kilometres from the Furneaux Tavern. She said she suddenly saw a man on the road and was shocked because she saw him from only a short distance away. She braked and drove into the oncoming lane to go around him because he was running on the road itself, about a metre from the edge of the road. She said in her statement:

> *"Um, as I slowed down when passing I saw his black hoodie design and realised it was David Bailey. He'd jumped to the side of the road as I, as I passed. I, I pulled over in front of him and wound my window down and waited for him to get to the car and he said, "Who's that?" And then he saw me and, and he said, "Oh Fiona." I told him that I, I was in a bit of shock because I felt like I could have hit him and I told him um, that I could have hit him because he was in a black hoodie in the dark and it was really hard to see him and I said that it was dangerous and I told him to hop in with me and I'd drive him home."*

14. In the interview, she speculated that if someone was travelling at the actual speed limit it would be much harder to slow down, and they would probably have had to swerve. However, she was not going that fast and was able to brake. She further stated that Mr Bailey did not appear intoxicated and she spoke to him for around 5 minutes. He did not take up the offer of a lift.

15. At about 8.50pm another motorist, Joshua Donovan, left the township of Lady Barron. Sergeant Michael Preshaw was driving his marked police vehicle, a Toyota Prado, behind Mr Donovan. Mr Donovan stated he saw Mr Bailey near "Sapphire". He had lights on high beam and was traveling at 95 km/h.

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[6] A handle of beer is 285mls in volume.

16. He outlined that the police car travelling behind him had its lights on low beam. He said Mr Bailey "*was pretty hard to see"* because of his dark clothing. He also said that he only identified him from 10 metres away[7]. He said he had to swerve and move into the oncoming lane, crossing the centre line *"a little bit".* He then saw the police car behind him stop and assumed it had stopped to give Mr Bailey a lift.

17. In fact, the police vehicle driven by Sergeant Preshaw had collided with Mr Bailey. Sergeant Preshaw stopped the vehicle and looked for Mr Bailey. He activated his body worn camera ("BWC"). He commenced CPR but stopped shortly afterwards because he found no pulse and Mr Bailey was not breathing. He had died as a result of his severe injuries sustained in the impact. The aftermath of and response to this tragic event, involving the attendance of other police officers and emergency services personnel, was captured on body worn camera. The footage included Sergeant Preshaw, at 11:40pm, submitting to a roadside breath test. The result was negative for alcohol.

18. The evidence indicates that there were genuine logistical constraints preventing an approved breath analysis operator from attending Flinders Island within the prescribed five-hour period under the *Road Safety (Alcohol and Drugs) Act* 1970. At 4.25am on 18 August 2024, Sergeant Preshaw voluntarily consented to the taking of a blood sample at the Whitemark Hospital, notwithstanding that the statutory five-hour limit had expired. The sample was analysed, and no alcohol was detected. The negative alcohol tests are consistent with Sergeant Preshaw's statement that he had not consumed any alcohol in the three months whilst he had been stationed on Flinders Island due to on call requirements. Meloxicam (an anti-inflammatory prescription medication) was detected in his system at therapeutic levels, and paracetamol at sub-therapeutic levels. In the opinion of the toxicologist, neither drug would have affected driving performance.

19. Sergeant Preshaw provided Tasmania Police Professional Standards with a statement in which he detailed his recall of the accident. Sergeant Preshaw also spoke to a number of people either at the scene or on his phone giving his account, which was captured on his BWC. He consistently stated that he was

[7] This is likely to be an underestimation of distance given the crash investigators' opinions regarding visibility.

driving at approximately 100 km/h, and that he had his head lights on low beam because there was a vehicle travelling in front of him. He said that something came out of the dark on the front left-hand side and he realised it was a person who was stumbling or running. He said the person moved over the road in front of his vehicle to about the middle-of-the-road. He tried to swerve to the right but still struck the person.

20. His statement that he was driving at approximately 100km/h and had his lights on low beam is supported by the vehicle that was travelling in front of him and the speed data retrieved from the police vehicle.

21. The primary crash investigator, Senior Constable Michael Rybka, came to the following conclusions:

- The physical evidence at the scene suggested that the deceased was positioned near the centre of the roadway at the time of impact;
- There were scuff marks measuring some 82.5 metres, consistent with a "swerve to avoid" manoeuvre by Sergeant Preshaw;
- There was not sufficient information at the scene to calculate Sergeant Preshaw's speed at impact;
- Visibility testing indicated that, with the police vehicle lights on low beam Mr Bailey would have been visible from a distance of 16.4 metres. However, he qualified this by stating that in conducting the tests the object is at a known point, where on the night of the incident the driver did not know or expect a person on the roadway. Therefore, the distance at which the driver should have detected the object is likely to be further reduced;
- Testing revealed that at a speed of 100 km/h, Mr Bailey would have been visible to Sergeant Preshaw for 0.590 seconds; and
- At a speed of 100 km/h, Sergeant Preshaw would have needed a distance of 136 metres to stop the vehicle and avoid the accident. In other words, he would have had to commence stopping the vehicle 120 metres prior to Mr Bailey being visible.

22. Senior Constable Rybka concluded by stating:

"The physical evidence at the crash site supports that Sgt Preshaw has been extremely alert while driving. He has perceived the pedestrian Bailey in the low beam headlights of the Toyota Prado at a very early time. He has reacted and swerved into the oncoming traffic lane just prior to impact. He did not have enough distance in which to swerve and avoid the pedestrian at the speed being driven (refer to attached affidavit from S/Constable Sven Mason of Western CIS). His early actions prove that he had in fact been keeping a 'proper lookout' ahead and paying attention to his driving at the time. Travelling at the default speed limit of 100 km/h or 27 m/s, the pedestrian Bailey would have only been visible for a mere 0.590 of a second on the roadway at night time. Considering that the average complex perception/reaction time for a driver is 3 seconds (or more) under these circumstances, it is evident that Sgt Preshaw has displayed an exceptional perception/reaction time in this crash. In order to stop and avoid the collision, the Toyota Prado would have needed to be travelling at a speed slower than 55 km/h under the circumstances. From the physical evidence presented - the collision with the pedestrian David Stanley Bailey was imminent and unavoidable."

23. Senior Constable Rybka's investigation report was peer reviewed by Senior Constable Sven Mason, a qualified crash investigator of 21 years' experience. He conducted a further calculation in relation to perception/reaction, also concluding that Sergeant Preshaw would also have required a greater distance to swerve to avoid Mr Bailey than the distance at which he was actually visible.

DPP consideration and Professional Standards Review

24. Tasmania Police Professional Standards officers were called to the scene following the incident and oversaw the investigation. Acting Commander Taylor of Professional Standards evaluated the investigation and determined that there were no breaches of the code of conduct under the *Police Service Act* 2003 by Sergeant Preshaw in the incident. There is no other evidence in the investigation contrary to this conclusion.

25. On 23 August 2024 Professional Standards formally notified the Integrity Commission of the incident. There is no evidence that the Integrity Commission has, to date, sought to further investigate or activate its powers in respect of the matter.

26. On 11 September 2024, Professional Standards formally notified WorkSafe Tasmania of the incident. There is no evidence that WorkSafe has or will investigate the incident or activate its powers in respect of the matter.

27. Upon Professional Standards completing the investigation, it referred the evidence to the Director of Public Prosecutions for consideration as to whether or not Sergeant Preshaw ought to be charged with any offences arising from the accident. The Director of Public Prosecutions subsequently provided his opinion that Sergeant Preshaw had not committed any offences. There is no other evidence in the investigation contrary to this opinion.

Discussion and Conclusion

28. Upon the background set out above, I will now deal with the question of whether the holding of a public inquest is, in the opinion of the coroner, desirable.

29. I respectfully adopt the reasoning of Brett J In *Tkalac v Cooper [2023] TASSC 7* at paragraph 10, where His Honour stated:

> *"The desirability of holding an inquest is likely to be informed by its utility in advancing the investigation. Accordingly, in determining the desirability of an Inquest, consideration should be given to any benefit that may accrue from the public nature of the proceedings and further whether the conduct of the inquest itself, which includes the power to compel evidence from witnesses and the advantages and opportunities which arise from the public examination and cross examination of those witnesses, will assist the investigation and, in particular, make it more likely that it will be possible for the coroner to make the mandated finding."*

30. Both counsel assisting and counsel for the Commissioner of Police and Sergeant Preshaw submitted that the evidence allowed the requisite findings to be made by the coroner on the basis of the comprehensive investigation already conducted and that a public inquest would not place the coroner in any better position to make findings. Therefore, there is no utility in holding a public inquest.

31. Mrs Bailey and her counsel made a number of wide-ranging submissions regarding why a public inquest is desirable. I will make specific reference to the main submissions under the following headings:

Lack of transparency and independent scrutiny of the investigation, procedural failures in the investigation, potentially improper influence upon witnesses, lack of thoroughness and potential bias in the investigation.

32. I do not consider that, on the critical facts, these issues played any role that would cause me to decide to hold a public inquest. Where a police officer is involved in the circumstances of a particular death, the coroner should always be conscious of the fact that police officers usually "investigate their own" and form opinions of conduct or actions of other officers. Investigation by Professional Standards provides a degree of separation in investigation and is an established part of Tasmania Police specifically designated to deal with police conduct. Importantly, in a case such as this, a coroner has additionally available to them a considerable quantity of objective, specialised and scientific evidence to aid in accurate fact-finding.

33. Mrs Bailey, in her affidavit, pointed to witnesses being asked leading questions by the interviewing police officers. Some of the examples she referred to disclosed leading questions to witnesses regarding Mr Bailey's position on or on the verge of the roadway. This style of questioning on important issues should be avoided, if possible, but it was not the dominant form of questioning the witnesses. The witness interviews were comprehensive and there was no indication that any leading questions were asked inappropriately for the purpose of gaining specific answers in favour of Sergeant Preshaw. Even if there was a subconscious bias by the interviewer, the witnesses were firm and coherent in their evidence.

34. Overwhelmingly, the credible witness evidence indicates that Mr Bailey was running on or near the roadway, likely in different positions at different times over the approximately three kilometres of his foot travel. Sergeant Preshaw perceived that Mr Bailey had stumbled onto the road. It is possible that Mr Bailey was already on part of the road and stepped out further. Regardless, the comprehensive crash investigation based upon scene analysis indicates that Mr Bailey was actually on the road at impact and that Sergeant Preshaw had

limited available reaction time at the speed he was travelling and in the lighting conditions.

35. Counsel for Mrs Bailey questioned the integrity of the crash investigator's opinion, which was peer reviewed, but was unable to indicate any areas of deficit in the reasoning or expert opinion. As a coroner, I am aware that Sergeant Rybka is a highly competent and experienced crash investigator. I have no reason to consider his opinions are based upon anything other than application of his considerable expertise to the scene in question.

36. Further, there is no evidence of Sergeant Preshaw exceeding the speed limit, driving negligently or inattentively, breaching the rules of police conduct or engaging in any other wrongdoing that contributed to Mr Bailey's death. The crash analysis, in fact, demonstrates a very quick reaction time in the circumstances. The evidence also discloses that Sergeant Preshaw, an officer of 33 years at that time, had not previously been involved in any crash and had advanced driving qualifications.

The possibility of consumption of alcohol by Sergeant Preshaw

37. This issue was raised by counsel for Mrs Bailey as a possible matter to be explored at a public inquest. Sergeant Preshaw underwent a breath test at the scene at 11.40pm with negative result. As discussed in paragraph 18, reasons were advanced in the investigation regarding why breath analysis did not occur within the prescribed time. Given the location of the crash these reasons are plausible. There is no evidence at all in the investigation, nor could there be any further evidence obtained, that Sergeant Preshaw, an officer on duty, was driving with any alcohol in his body.

Consumption of alcohol by Mr Bailey

38. Mrs Bailey submitted that her husband's state of intoxication leading to and at the time of his death was a matter for further investigation at public inquest, suggesting that he was not as affected by alcohol as was portrayed by some witnesses.

39. Upon the scientific evidence, being a sample analysis by a forensic toxicologist, Mr Bailey's blood alcohol level was very high, likely between 0.171.g/100mL and 0.223g/100mL. This blood alcohol concentration is consistent with Mr

Bailey having consumed 18 beers between 3.00pm and 7.53pm as shown by the Furneaux Tavern CCTV footage. Sergeant Preshaw may have assumed that Mr Bailey was intoxicated as he was aware that he had been drinking prior to the accident, and also by virtue of his movements on the road. As discussed, he had only moments in which to make such observations. Some witnesses state that Mr Bailey did not appear intoxicated. His action of leaving the hotel and subsequent movements on the road suggest otherwise.

40. The forensic toxicologist stated in his affidavit that with alcohol in the system

> *"at higher concentrations there is a loss of critical judgement, incoordination, reduced perception and awareness, impaired balance, sedation, nausea and vomiting, reduced responsiveness and decreased intellectual performance."*

41. Regardless of Mr Bailey's apparent state of intoxication at any point in time before his death, a finding is inevitable that his judgment, perception, awareness and intellectual performance were compromised by the effects of alcohol. It is also clearly open to find that Mr Bailey's intoxicated state contributed to him placing himself in a dangerous position on the road and his unfortunate death.

42. Although not raised by Mrs Bailey's counsel, a wider coronial investigation might well have focussed upon the service of alcohol to Mr Bailey at the Furneaux Tavern. It could be said that this issue was part of the circumstances surrounding death and potentially appropriate for comment. This issue was touched upon in the investigation but not determined by Tasmania Police to be a case whereby the licensee of the hotel should face prosecution.

After the incident- emergency response, police procedures, public safety issues

43. Submissions were made by Mrs Bailey's counsel concerning various issues arising after Mr Bailey's death. These included ambulance response time, lack of emergency services resources, unavailability of body bags, Mr Bailey's body on the road for an extended period, and no doctor attending the scene. There may well have been deficits in respect to some or all these matters. However, tragically, Mr Bailey died instantly at the scene. He was not deprived of an opportunity to have survived because of a tardy emergency response. It therefore becomes less appropriate to investigate such issues because the

connection to death becomes increasingly tenuous. Such systemic issues, if they existed, might need to be explored in detail and this is not the appropriate case to do so.

44. Similarly, reducing the speed limit to 80km/h would not have prevented the crash nor most likely Mr Bailey's death. Counsel could not point to evidence regarding the desirability of a speed limit reduction on this road or roads of this type, even when given an opportunity for an adjournment. Again, it would be inappropriate to hold an inquest to embark upon an investigation of this matter when it was not a significant factor connected to death.

45. Finally, the continued posting of Sergeant Preshaw on Flinders Island after the crash is not a matter which, in the circumstances of this incident, should be investigated in a public inquest. There is no evidence of breach or wrongdoing such that the issue would arise for comment and Tasmania Police has its own processes for the placement of police officers in particular stations or locations.

The need to dispel rumours and misinformation on Flinders Island and the appearance of a "cover-up"

46. The Act does not mandate a public inquest because a police officer was involved in the circumstances of a death. But, of course, it is important for a coroner to consider carefully the particular aspects of such a case and to ensure that a rigorous and thorough investigation has occurred. If aspects of it are considered insufficient or not sufficiently objective, a coroner will have no hesitation in utilising the wide powers under the Act to obtain further evidence.

47. A coroner should also bear in mind the public value of an inquest where the investigation is one requiring particular scrutiny. This is not such a case. The publication of a finding on the website, as would routinely occur, will provide the public with the details of the investigation, the evidence gained and the findings.

48. Finally, I reject the submission by Ms Baumeler that an inquest should be held to counteract the possible perception that counsel assisting, from the Office of the DPP, is not sufficiently independent of Tasmania Police to perform the role. This submission fails to recognise that the coroner is, by the Act, bound to

make a request of the DPP for counsel assisting.[8] It also fails to give due recognition to the active and independent role of the coroner in an investigation.

Conclusion

49. For the above reasons, the evidence allows me to make the requisite findings under section 28 of the Act without holding a public inquest. They are able to be made upon robust, consistent and credible evidence. No further information of any significance would be gained by calling witnesses to give oral evidence and there is no reason to do so.

Dated 14 April 2026 in Hobart in the State of Tasmania

Olivia McTaggart
Coroner

[8] Section 53 of the Act.