



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Robert Webster, Coroner, having investigated the death of Joshua James Tyrrell

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

- a) The identity of the deceased is Joshua James Tyrrell;
- b) Mr Tyrrell died as a result of injuries sustained in a single vehicle motor bike crash;
- c) Mr Tyrrell's cause of death was multiple (head, facial and spinal) injuries sustained in the motor bike crash; and
- d) Mr Tyrrell died on 24 February 2022 at Berriedale, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Affidavit of the forensic pathologist Dr Andrew Reid;
- Affidavit of the forensic scientist Juliette Tria of Forensic Science Service Tasmania;
- Medical records obtained from the Grosvenor and Collins Street General Practices;
- Medical records obtained from Snug Medical Centre;
- Records obtained from Healthpoint Pharmacy Snug;
- Records obtained from Claremont Plaza Advantage Pharmacy;
- Medical records obtained from the Royal Hobart Hospital (RHH) and Mental Health Services including Community Mental Health;
- Report from the Chief Pharmacist Peter Boyles;
- Reports from the coronial medical consultant Dr Anthony Bell MB BS MD FRACP FCICM;
- Report from the general practitioner (GP) Dr Robert Hamilton;
- Affidavit of Bradley Tyrrell;

- Affidavit of Matthew Tyrrell;
- Affidavit of Emily Harrison;
- Affidavit of Mitchell Ehrlich;
- Affidavit of Timothy Noonan;
- Affidavit of Renee Hansen;
- Affidavit of Sarah Harriss, Tasmania police (rank not stated);
- Affidavit of Nikki Vasiljuk;
- Affidavit of Maureen Woods;
- Affidavit of Sergeant Darren Williams;
- Affidavit of First-Class Constable Caitlin Francis;
- Affidavit of First-Class Constable Tania Curtis;
- Affidavit of Senior Constable Richard Keygan and his collision analysis report;
- Affidavit of Craig Shepherd; and
- Body worn camera footage, photographs, CCTV footage and forensic evidence.

## **Introduction**

This investigation concerns a single motor bike crash which occurred in the northbound lanes of the Brooker Highway near Berriedale in Tasmania on 24 February 2022 at about 3:50pm. At that time, Mr Tyrrell was riding his 2015 Yamaha YZ FR3, registration number A086Z, when he lost control of his motorbike near the on-ramp from Berriedale Road, which mounted an embankment and left the road.

Mr Tyrrell and his motorbike then collided with a tree beside the highway, snapping the tree at its base. The motorbike and Mr Tyrrell continued to travel 30 m to 40 m before coming to rest. The motorbike sustained significant damage in the crash. Mr Tyrrell was wearing protective riding gloves, a jacket and a helmet.

The speed limit in the area where the motorbike left the roadway is 80 km/h. The roadway was constructed of bitumen and appeared to be in good condition. At the time of the crash the weather was fine, the road was dry and traffic flow was heavy at the time police attended after the crash.

## **Background**

Mr Tyrrell was 28 years of age (date of birth 20 October 1993), single and he resided with his father at the date of his death. He was the oldest of six children to his parents Bradley and Andrea Tyrrell (now Sent). One of the siblings is a step sister

and another two are half siblings. Mr Tyrrell did not marry and he did not have any children.

Mr Tyrrell resided with his parents and siblings at Seven Mile Beach up until the point his parents separated and his mother moved to Melbourne. Mr Tyrrell and his siblings also moved to Melbourne with her. At the age of 15, he returned to Tasmania to reside with his father, and a year later, two of his siblings returned to Tasmania. It appears from evidence on the file Mr Tyrrell had a very difficult relationship with his mother, he rebelled, and that his parents' separation was very difficult. Mr Tyrrell's relationship with his father was also strained for a number of years because of his anti-social behaviour.

Mr Tyrrell attended St Virgil's College for high school before moving onto Rosny College. He then worked at a pizza restaurant in Hobart, during which time he remained close to his brother Matthew. He worked his way up to managing the restaurant. Mr Tyrrell and his brother would socialise at the pizza restaurant and they would go to the gym together. It was during this time that Mr Tyrrell commenced taking illicit drugs. Mr Tyrrell's boss passed away and the business was bought by somebody else. As a result, Mr Tyrrell moved to the Derwent Park location of the restaurant where he commenced taking prescription medication and he also sold drugs for his boss. He lost that job after a period of time and his brother says he really struggled to find work from that point. He also had difficulties with his mental health. Mr Tyrrell's family attempted to intervene in relation to his drug use. They arranged for him to attend rehabilitation in January 2022, however that did not occur.

Mr Tyrrell's ex-partner, Ms Harrison, and his family say he displayed evidence of depression and voiced that he had suicidal thoughts. In January 2022, Ms Harrison recalls an evening where she received a generic video from Mr Tyrrell of somebody crashing their motorbike. He sent a caption with the video "*rest in peace those that have died in rest in peace those who will die*". His struggles with his mental health were present only a few weeks prior to his death when he left the house dressed in his motorbike riding gear, but before doing so, he kissed his family goodbye. The family thought this was out of character. At 2:30am the next morning, the police attended Mr Tyrrell's home after having been called by Ms Harrison, who advised that Mr Tyrrell had threatened to "*jump off the bridge*". She was concerned for his welfare. The next morning, he advised his father that he would never do something like that and then he finished by saying "*if he was ever to do that, it would be at high speed on his bike*". Over the years, Mr Tyrrell was encouraged to seek professional help with respect to his mental health difficulties, however this was not successful.

From a young age Mr Tyrrell had trouble sleeping, which was an ongoing issue and was thought to contribute to his mood and cause other difficulties such as fatigue.

At the beginning of 2022, Mr Tyrrell made some changes to his life. He commenced working as a bricklayer's assistant. That job was going well. He also was in the process of obtaining a second job working as a pizza restaurant manager. His brother believes his drug use had settled and he did not think he was taking as much by way of pain medication.

## **Health**

The medical records reveal that Mr Tyrrell was a smoker and that he suffered from anxiety. In late 2019, he was using steroid supplements and was bodybuilding. He gained 20 kg. On 11 March 2020, he tested positive for amphetamine, benzodiazepine and cocaine. The following are further references in the medical records that are of relevance:

- 4 May 2020: attendance at the RHH Emergency Department (ED), Bradley Tyrrell describes his son as paranoid, claiming people were surrounding the house and following him. He was also seeing people in trees and on the roof, and was walking around with a knife and wanting a gun. Mr Tyrrell admitted to using cocaine and amphetamine for 10 years intermittently but there was no evidence of a thought disorder and he was not treated. He was discharged.
- 16 June 2020: fractured jaw, surgery, infected fixation plate and screws.
- 25 July 2020: tonic-clonic seizure at home, lasting two minutes. This was followed by 60 minutes of post-ictal confusion and a further tonic-clonic seizure in the ED. Mr Tyrrell had taken two doses of 500 mg tramadol, one at 10:00 hours and one dose at 21:00 hours. Possible previous seizures were not investigated. A CT scan showed no acute intracranial pathology of the brain. Mr Tyrrell refused to be admitted and he departed.
- 20 November 2020: At 20:00 hours, Mr Tyrrell had a tonic-clonic seizure at home and had taken excessive tramadol. He was commenced on Keppra (levetiracetam), for electroencephalogram as outpatient and for a epilepsy clinic review.
- 1 February 2021: Dr K Dowd prescribed paracetamol 500 mg - codeine phosphate hemihydrate 15 mg for a strained knee and faxed a script to Chemist Warehouse Collins Street (telehealth appointment).

- 16 February 2021: Dr A Follett prescribed paracetamol 500 mg - codeine phosphate hemihydrate 15 mg for a strained knee and faxed a script to Chemist Warehouse Collins Street (telehealth appointment).
- 2 March 2021: Dr A Follett prescribed paracetamol 500 mg - codeine phosphate hemihydrate 15 mg for a strained knee and faxed a script to Chemist Warehouse Collins Street (telehealth appointment). His partner threw the script out. The doctor was reluctant to prescribe but did. A total of 120 tablets had been prescribed since 11 December 2020.
- 16 March 2021: Dr A Follett prescribed paracetamol 500 mg - codeine phosphate hemihydrate 15 mg for a strained knee and faxed a script to Chemist Warehouse Collins Street (telehealth appointment).
- 20 April 2021: Multiple outstanding accounts with GP.
- 21 April 2021: Dr A Follett has recorded Mr Tyrrell had experienced problems with anxiety for several months, problems with sleep, had not taken amitriptyline for more than a week, and he ran out of Keppra weeks ago. He had been taking his partner's benzodiazepine and he was also taking mirtazapine (the source was unknown). It was noted Mr Tyrrell was at high risk of drug misuse. He was prescribed venlafaxine and he was to continue with mirtazapine. Quetiapine was added and Keppra restarted. He was referred to a psychologist at Psychology Works (telehealth appointment).
- 27 April 2021: Dr A Follett recorded Mr Tyrrell had fallen and injured his right knee at work. He was prescribed paracetamol 500 mg - codeine phosphate hemihydrate 15 mg (telehealth appointment).
- 03 May 2021: Dr K Dowd provided Mr Tyrrell with a long counselling session regarding anxiety. He prescribed diazepam 5 mg twice daily as required. This medication was not for long term use. It was to be used only until other anti-anxiety drugs were working (venlafaxine, quetiapine) and then its use was to cease. If more diazepam was required, the GP will only prescribe it for seven days and it would need to be picked up at the pharmacy (telehealth appointment).
- 19 May 2021: Dr A Follett recorded Mr Tyrrell reported aggressive and agitated behaviour at work and towards his partner (but Mr Tyrrell was unable to give specific examples). It was noted Mr Tyrrell was a difficult historian. Dr Follett indicates Mr Tyrrell needs to go to Psychology Works for mental health treatment as he is too reliant on drugs and Dr Follett had concerns about drug seeking behaviour, perhaps diverting drugs. Dr Follett refused to provide a script for diazepam, and prescribed

paracetamol 500 mg - codeine phosphate hemihydrate 15 mg, to last 30 days at two per day, and quetiapine (telehealth appointment).

- 7 June 2021: Dr A Follett says Mr Tyrrell requested a letter of support to regain his driver's license which had been cancelled due to a positive test for amphetamine. Complained of sore shoulders and asked for paracetamol 500 mg - codeine phosphate hemihydrate 15 mg, which was refused (surgery consultation).
- 16 June 2021: Dr A Follett reports a urine drug screen was positive for codeine and diazepam. Scripts for venlafaxine, quetiapine and paracetamol 500 mg - codeine phosphate hemihydrate 15 mg provided which were to last for 30 days (telehealth appointment).
- 1 July 2021: Dr R Gangell (Snug GP) noted a history of substance abuse, anxiety and insomnia. A urine drug screen was positive for opiates (probably codeine). The plan was to prescribe 50 diazepam 5 mg tablets, however Mr Tyrrell was told he would only receive a maximum of one to two scripts yearly. He was prescribed paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets with no repeats.
- 5 July 2021: Letter to Driver Licensing Authority seeking to restore driver licence.
- 6 July 2021: Dr R Hamilton (Snug GP) prescribed diazepam 5mg 50 tablets and oxycodone 5 mg (no repeats).
- 8 July 2021: Dr R Hamilton (Snug GP) organised a plain ankle x-ray which showed no fracture. Mr Tyrrell was prescribed temazepam 10 mg 25 tablets, tramadol 200 mg slow release 20 tablets and paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets (no repeats).
- 12 July 2021: Dr R Hamilton (Snug GP), prescribed tramadol 200 mg slow release 20 tablets and paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets (no repeats).
- 14 July 2021: Dr R Hamilton (Snug GP), prescribed paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets and diazepam 5 mg 50 tablets (no repeats).
- 22 July 2021: Dr A Follett (surgery consultation), review of injured ankle, noting mild antalgic gait; CT scan of ankle organised, prescription for tramadol, notes transferred to Snug Medical Practice who have prescribed temazepam, diazepam, and Keppra. The request for diazepam was refused. The CT scan of the ankle showed an undisplaced fracture of the posterior aspect of the distal tibia (posterior malleolus).

- 23 July 2021: Dr R Gangell (Snug GP) referred Mr Tyrrell for a moonboot for ankle fracture, prescribed temazepam 10 mg 25 tablets (no repeats).
- 26 July 2021: Dr R Gangell (Snug GP) moonboot fitted, prescribed paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets, Stilnox 10 mg 28 tablets, and tramadol 200 mg 20 tablets (no repeats).
- 4 August 2021: Dr R Hamilton (Snug GP), lost second script for tramadol, lost job. Mr Tyrrell was prescribed paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets, tramadol 200 mg 20 tablets and temazepam 10 mg 25 tablets (no repeats).
- 6 August 2021: Dr R Hamilton (Snug GP), a letter was prepared to Driver Licensing Authority to restore driver licence.
- 12 August 2021: Dr R Gangell (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets, Stilnox slow release 12.5 mg 28 tablets and tramadol 200 mg 20 tablets (no repeats). The Snug pharmacy advised the pharmacist was not happy to dispense diazepam until four days had passed due to a recent self escalation in dose.
- 17 August 2021: Dr R Hamilton reports he was advised by Mr Tyrrell his partner had destroyed his postdated scripts which included those deferred for 12 and 18 August 2021. He was prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets and tramadol hydrochloride 200 mg 20 tablets (no repeats).
- 18 August 2021: Dr R Hamilton (Snug GP) was phoned by the Snug Pharmacy who reported Mr Tyrrell tried to use the two scripts written by Dr Gangell on that day - which he had told Dr Hamilton were destroyed by his partner. Dr Hamilton advised the pharmacy to destroy them and not to dispense anything further for him. Mr Tyrrell approached Dr Hamilton in the waiting room and Dr Hamilton advised Mr Tyrrell he had lost his trust. The pharmacist was advised to dispense medications strictly on the timeline of how they are prescribed.
- 23 August 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets and tramadol hydrochloride 200 mg 20 tablets (no repeats).

- 2 September 2021: Dr R Hamilton (Snug GP) noted Mr Tyrrell was looking for work and housing. He raised concerns of Mr Tyrrell overusing diazepam and requesting a script when he should have some left. These concerns were stressed. He was prescribed Stilnox CR 12.5 mg 28 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets and tramadol hydrochloride 200 mg 20 tablets (no repeats).
- 15 September 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets and tramadol hydrochloride 200 mg 20 tablets (no repeats). He was also prescribed Stilnox CR 12.5 mg 28 tablets and Venlafaxin 75 mg slow release 28 tablets.
- 24 September 2021: Dr R Hamilton (Snug GP) noted Mr Tyrrell was moving to Claremont. He was prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets, diazepam 5 mg 50 tablets and tramadol hydrochloride 200 mg 20 tablets (no repeats).
- 30 September 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, diazepam 5 mg 50 tablets and tramadol hydrochloride 200 mg 20 tablets (no repeats). Venlafaxin 75 mg slow release 28 tablets (five repeats) were also prescribed.
- 13 October 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, diazepam 5 mg 50 tablets, and tramadol hydrochloride 150 mg 20 tablets (no repeats).
- 26 October 2021: Dr R Gangell (Snug GP) attempted to discuss medications/need for/weaning with Mr Tyrrell but he was not willing to engage in meaningful conversation about this. After five minutes, Mr Tyrrell said he had a job interview now and could not continue the conversation. He just wanted the scripts. Dr Gangell was unwilling to prescribe diazepam. He prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, and tramadol hydrochloride 100 mg 20 tablets (no repeats). He sent the script Chemist Warehouse in Hobart (telephone consultation).
- 3 November 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30

mg 20 tablets, tramadol hydrochloride 150 mg 20 tablets and diazepam 5 mg 50 tablets (no repeats).

- 11 November 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets and paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets (no repeats). An additional script for paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 20 tablets and tramadol hydrochloride 150 mg 20 tablets were postdated until 15 November 2021, and diazepam 5 mg 50 tablets posted until 19 November 2021 (no repeats).
- 30 November 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30mg 20 tablets, tramadol hydrochloride 150 mg 20 tablets and diazepam 5 mg 50 tablets (no repeats).
- 13 December 2021: Dr R Hamilton (Snug GP), Mr Tyrrell had a motorbike accident and was prescribed temazepam 10 mg 25 tablets, tramadol hydrochloride 150 mg 20 tablets and diazepam 5 mg 50 tablets (no repeats). Paracetamol 500mg - codeine phosphate hemihydrate 30 mg either 20 or 40 tablets (no repeats) was also prescribed (notes are unclear on how much was prescribed but it is noted that dispensing records at Snug Pharmacy on 13 December 2024 show 40 tablets were dispensed).
- 23 December 2021: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, tramadol hydrochloride 150 mg 20 tablets and diazepam 5 mg 50 tablets (no repeats).
- 6 January 2022: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, tramadol hydrochloride 150 mg 20 tablets and diazepam 5 mg 50 tablets (no repeats).
- 19 January 2022: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, tramadol hydrochloride 150 mg 20 tablets and diazepam 5 mg 50 tablets (no repeats).
- 1 February 2022: Dr R Hamilton (Snug GP) prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, tramadol hydrochloride 150 mg 20 tablets and diazepam 5 mg 50 tablets.

- 07 February 2022: Dr R Hamilton (Snug GP) reports Mr Tyrrell had another motorbike accident and was prescribed oxycodone 5 mg 10 tablets (no repeats).
- 16 February 2022: Dr R Gangell noted Mr Tyrrell needs his medication regime reduced, polysubstance abuse was noted. He prescribed temazepam 10 mg 25 tablets, paracetamol 500 mg - codeine phosphate hemihydrate 30 mg 40 tablets, tramadol hydrochloride 150 mg 20 tablets, diazepam 5 mg 50 tablets, and oxycodone 5 mg 10 tablets (telephone consultation) (no repeats).
- 23 February 2022: Dr R Hamilton prescribed paracetamol 500 mg - codeine phosphate 30 mg 40 tablets and tramadol hydrochloride 150 mg 20 tablets (no repeats).

A summary of Snug Medical Centre prescribing between 1 July 2021 and 26 February 2022 is as follows:

- It is a period of 241 days;
- Paracetamol 500 mg and codeine 30 mg 840 tablets were prescribed. On the assumption all prescriptions were filled and consumed this amounts to 3.49 tablets per day;
- Tramadol (200 mg, 150 mg and 100 mg) 500 tablets were prescribed. On the assumption all prescriptions were filled and consumed this amounts to 2.07 tablets per day;
- Diazepam (5 mg) 1100 tablets were prescribed. On the assumption all prescriptions were filled and consumed this amounts to 4.56 tablets per day; and
- Temazepam (10 mg) 500 tablets were prescribed. Again on the assumption all prescriptions were filled and consumed this amounts to 2.07 tablets per day.

### **Circumstances leading to death**

In the afternoon of 24 February 2022, Mr Tyrrell was at home and told his father he had called in sick to work, but he was going to the shop to purchase some Panadol. He said he had a migraine headache.

Mr Noonan says at approximately 3:55pm on 24 February 2022, he was driving his vehicle north along the Brooker Highway. As he was approaching the intersection at Elwick Road, he observed a motorbike travelling at what he describes as a dangerously high speed. He was in the third vehicle back from the intersection and

he had first heard the bike approaching as he could hear the gears were shifting down as it approached the intersection. The motorbike weaved between his vehicle and the lane next to him which was also full of traffic. It came to a sudden halt at the line. Even before the light turned green, the rider was revving and preparing to drive away from the intersection. The lights turned green and he observed what he thinks was the front wheel of the motorbike coming off the ground as it drifted to the right. It disappeared quickly. He could hear it revving to high range and he could hear the gears changing quickly. A few minutes later, he was continuing on his journey north on the Brooker Highway when he observed debris, freshly disturbed soil and a damaged tree on the left-hand side of the road just after the Berriedale Road turnoff. He then noticed two males standing nearby further north and the motorbike which had been destroyed, which was laying on the nature strip to the left of the highway. He could also see the rider laying on the ground wrapped up in a tree trunk. He slammed on his brakes and pulled over, put his ambulance vest on and ran over to check on the rider. At that time, he started making a phone call directly to Ambulance Tasmania.

Ms Hansen was driving on the Brooker Highway at approximately 3:52pm in a southerly direction near Berriedale. She was driving down towards the bottom of the hill, at this point in the roadway, in the right-hand lane when she saw a motorbike riding on the outside of the left-hand lane on the opposite side of the road. She says there was a lot of dirt flying around. She then realised the motorbike had driven straight through the trees that were on the left-hand side of the road. She then observed the collision with the tree. She immediately called 000. She estimated the rider was travelling at over 100 km/h, perhaps even 150 km/h. She went over to the scene to see if she could assist in any way.

Ms Harriss is an off duty police officer who was driving south on the Brooker Highway from Claremont to Glenorchy with her three children at 3:45pm. She was travelling in the right-hand lane in the 100 km/h zone and as she proceeded down the hill at Berriedale towards the 80 km/h zone, she observed a cloud of dust in the northbound lane which attracted her attention. She immediately realised the cloud of dust was a motorbike leaving the Brooker Highway and crossing the median strip between the north bound left-hand lane and the on-ramp leading from Berriedale Road. The motorcycle continued across the on-ramp and out of sight momentarily before appearing to jump up through a culvert where it hit a small tree. She did not notice any other vehicles travelling in the same direction, or in the vicinity of the motorbike. She rang 000 as she was off duty and had her three children with her in her car. She

says there did not seem to be any speed variations the moment the motorbike left the Brooker Highway until it hit the tree and came to rest.

Ms Vasiljuk was driving home on the Brooker Highway near the Berriedale offramp at 3:52pm. She was about to turn off toward Berriedale, in order to go home to Collinsvale, and she had just turned onto the offramp when she observed the motorbike continuing north. Her attention was drawn to it because she could hear the engine screaming. She estimates the speed of the motorbike to be at least 120 km/h as it passed her. She observed the bike speed up and dangerously weave between traffic from the left lane to the right. It squeezed through a space between a four-wheel-drive and another car and thereafter it accelerated away. She continued on her journey home.

Ms Woods' home backs onto the Brooker Highway. At about 3:50pm, she was sitting on her outside porch when she heard the motorbike approaching. The sound got louder. She then heard a loud sound and the engine went silent. She then saw traffic slowing down. She says she ran to her back fence and saw the motorbike on its side on the grass embankment. She reported the crash at 3:54pm.

### **Investigation**

The Department of Health's (the Department) Pharmaceutical Services Branch (PSB) is responsible for administering the *Poisons Act 1971* (the 'Act') and *Poisons Regulations 2018* (the 'Regulations'). The records of the supply to patients of all narcotic (Schedule 8) substances and Schedule 4 opioids are sent to PSB by Tasmanian pharmacies. These are known as relevant substances under Regulation 124. Records of relevant substances are kept on the PSB database. These records show who received, who prescribed, as well as where and when these substances were dispensed. Schedule 4 opioids (codeine, tramadol and dextropropoxyphene) were included as relevant substances in Regulation 124 from February 2018.

Mr Tyrrell was known to PSB with concerns noted on the Department's database which included:

- Use of illicitly obtained prescribed high-risk substances, including alprazolam, diazepam, codeine and oxycodone;
- Use of illicit substances, such as cocaine and anabolic steroids;
- Reports from pharmacies of Mr Tyrrell pharmacy shopping for the over-the-counter product, Rikodeine® (contains dihydrocodeine tartrate); and

- Self-escalation of tramadol usage suspected to be triggering seizures in Mr Tyrrell.

The information on the Department's database in relation to Mr Tyrrell is limited as the high-risk substances prescribed by Dr Hamilton and his practice colleagues at Snug Medical Centre were mainly Schedule 4 or declared restricted substances, which do not require authority under section 59E of the *Poisons Act* 1971 to be sought from the Secretary of Health. The absence of a need for a section 59E authority limits PSB's clinical regulatory actions.

Mr Tyrrell's documented history of high-risk behaviours, as set out above, placed him at increased risk of harm from high-risk substances, including drug poisoning events and death. The Chief Pharmacist, Mr Boyles, says in his report these:

*"high-risk behaviours need to be considered by prescribers when initiating and continuing to prescribe high-risk substances including documenting appropriate risk-benefit assessments, and the implementation of appropriate risk mitigation strategies".*

It is noted Dr Hamilton commenced prescribing on or about 8 July 2021 for Mr Tyrrell. PSB contacted Dr Hamilton in relation to Mr Tyrrell on 6 July 2021 following Dr Hamilton prescribing 20 oxycodone immediate release 5mg tablets (Endone®) to Mr Tyrrell. The prescription of this medication triggered an alert on the Departmental database as Mr Tyrrell was noted to be taking benzodiazepines and opiates which were not prescribed to him, together with documented cocaine use and reports of pharmacy shopping for Rikodeine. Dr Hamilton advised Mr Tyrrell was a new patient to the practice with a suspected broken ankle but a few red flags which Dr Hamilton advised PSB included:

- Mr Tyrrell requested Targin as he had had it in the past;
- Mr Tyrrell claimed the Valium he had been prescribed and supplied the previous Friday was lost as it had been in his girlfriend's car which had gone to the wreckers;
- The urine drug screen results for Mr Tyrrell from the last visit with another doctor at the practice was positive for opioids (PSB advised Dr Hamilton Mr Tyrrell had recently been supplied with codeine/paracetamol which could be the reason for this result); and
- Mr Tyrrell had disclosed past cocaine use.

The supply of Endone to Mr Tyrrell at this appointment occurred but PSB advised Dr Hamilton to contact PSB prior to any further supplies of Schedule 8 substances, as this would require the submission of an application for authorisation under section 59E and a staged supply to be implemented.

Dr Hamilton's colleague at the Snug Medical Centre, Dr Gangell, prescribed paracetamol 500 mg - codeine phosphate hemihydrate 30 mg (quantity 20 tablets) to Mr Tyrrell on 1 July 2021. This is the first supply of high-risk substances to Mr Tyrrell from the Snug Medical Centre noted on the Departmental database, again aligning closely with the estimated date this practice took over Mr Tyrrell's care. From 1 July 2021 until the time of his death, Mr Tyrrell was prescribed relevant substances mainly by prescribers at Snug Medical Centre, except on the following occasions:

- Dr Haider Tanny from the Hello Home Doctor Service on 5 July 2021 prescribed paracetamol 500 mg - codeine phosphate hemihydrate 30 mg (quantity six tablets); and
- The prescription of 20 tramadol sustained release 200mg tablets on 22 July 2021 by Dr Follett. The PBS does not know if this was an old prescription by Dr Follett as Departmental records had her at Collins Street General Practice where Mr Tyrrell had previously attended.

Dr Hamilton and his practice colleagues prescribed paracetamol 500 mg - codeine phosphate hemihydrate 30 mg and tramadol sustained release tablets (of various strengths) regularly to Mr Tyrrell until the time of his death. There was limited prescribing of Schedule 8 substances to Mr Tyrrell by the prescribers at Snug Medical Centre, with only a handful of prescribing events for oxycodone immediate release (Endone) 5 mg tablets for Mr Tyrrell as follows:

- 16 February 2022, 10 Endone 5 mg tablets by Dr Gangell;
- 7 February 2022, 10 Endone 5 mg tablets by Dr Hamilton; and
- 6 July 2021, 20 Endone 5 mg tablets by Dr Hamilton.

In order to respond to my request for advice, the PSB sought information in relation to the prescribing of all high-risk substances to Mr Tyrrell. This was obtained from the Claremont Plaza Advantage Pharmacy and the Healthpoint Pharmacy at Snug. The dispensing history from the latter could not be accessed due to a change in dispensing software. The dispensing history obtained from Claremont Plaza Advantage Pharmacy, confirms Mr Tyrrell was also prescribed the following additional high-risk substances by prescribers at Snug Medical Centre:

- Diazepam 5 mg tablets;
- Venlafaxine 75 mg capsules;
- Temazepam 10 mg tablets; and
- Levetiracetam 500 mg tablets.

From the information provided, PSB say the Claremont Plaza Advantage Pharmacy was adhering to the correct repeat intervals for these high-risk substances according to the prescription instructions. However, it is unknown if Mr Tyrrell was using multiple pharmacies for supplies of these medications at the same time. The regular intervals of supply for both benzodiazepines prescribed (diazepam and temazepam) are suggestive of the medication being used regularly rather than on an as needed basis as the prescription instructions state.

At the time of his death, Mr Tyrrell was being prescribed two benzodiazepines, temazepam and diazepam, with supply repeat intervals suggesting Mr Tyrrell was using these substances on a regular basis rather than on an 'as required' basis noted on the dispensing labels for these substances. The Chief Pharmacist says the use of benzodiazepines are not typically endorsed for maintenance therapy and if ongoing therapy is considered necessary, this should only occur with relevant medical specialist input (such as a psychiatrist). It is unknown to PSB if there was any relevant medical specialist input into the ongoing prescribing of benzodiazepines for Mr Tyrrell.

It is clear from the dispensing records that Mr Tyrrell had his daily dose of diazepam reduced from 20 mg to 15 mg in October 2021, however, PSB is unaware if any further attempts were made or planned in regard to Mr Tyrrell's use of benzodiazepines. Dr Hamilton's phone discussion with PSB on 6 July 2021 indicates the doctors at that practice were aware of some of Mr Tyrrell's high-risk behaviours. These high-risk patient behaviours need to be considered by prescribers when initiating and continuing to prescribe high-risk substances, including documenting appropriate risk-benefit assessments and the implementation of appropriate risk mitigation strategies. The Chief Pharmacist says such clinical risk mitigation strategies could have included:

- Regular face-to-face appointments to undertake a comprehensive patient review;
- Frequent unannounced and supervised urine drug screens;
- Frequent full body checks for any short and long-term signs of injecting stigmata;

- Regular review of the need for continued high-risk prescribed substances;
- A treatment agreement with Mr Tyrrell which documents treatment goals, review periods and clear indicators for treatment failure and the need to cease a medication; and
- Prescribing the lowest effective dose for the shortest possible time, in-line with current therapeutic guidelines.

On 28 February 2022, Craig Shepherd, a transport safety and investigation officer with the Department of State Growth, examined the motorbike. Mr Shepherd is a qualified automotive mechanic with an excess of 18 years' experience in the automotive industry. As a result of his examination, he determined the motorbike was in a roadworthy condition prior to the crash. However, it was potentially non-compliant due to multiple aftermarket lighting substitutions and the removal of the foot pegs for the pillion passenger. Those modifications did not cause or contribute to the crash.

On 25 February 2022, Dr Andrew Reid performed a postmortem examination. As a result of that examination and after considering the results of radiology, toxicology and microbiology, Dr Reid determined the cause of death was multiple head, facial and spinal injuries sustained in this crash. These included compound, comminuted skull and facial bone fractures penetrating the cranial cavity, a basal skull fracture and an upper cervical spine fracture and dislocation. The pattern of blunt force trauma corresponded with severe damage to the front of the motorcycle helmet which was examined by Dr Reid. I accept his opinion.

Ms Tria reports that no alcohol or illicit drugs were detected. A number of prescribed medications and their metabolites were detected at therapeutic or sub-therapeutic levels. All the drugs detected act as depressants on the central nervous system (CNS) to varying degrees, and therefore, they all have the potential to impair driving performance due to an increased risk of causing sedation, drowsiness and associated effects. The level of possible impairment is however difficult to ascertain as it is known that drug responses can differ between individuals and that tolerance can develop to some drug effects after long term usage.

The coronial medical consultant, Dr Bell, considered all the medical evidence on file. He advised benzodiazepines, such as diazepam, have anxiolytic, hypnotic, anticonvulsive, and muscle-relaxing properties, which have made them a widely prescribed treatment; primarily for anxiety and insomnia. They also are associated with physical dependence and addiction.

Benzodiazepine use disorder can be a chronic, relapsing disorder and benzodiazepine use has been associated with increased morbidity and mortality in some studies. Misuse of benzodiazepines can be difficult to distinguish from undertreated anxiety or insomnia.

The term opioid refers to natural and synthetic substances that act on one of the three main opioid receptor systems (mu, kappa, delta). Opioids can have analgesic and central nervous system depressant effects as well as the potential to cause euphoria. Opioid use disorder (OUD) can involve misuse of prescribed opioid medications, use of diverted opioid medications, or use of illicitly obtained heroin. OUD is typically a chronic, relapsing illness, associated with significantly increased rates of morbidity and mortality.

Patients with OUD typically have impaired social functioning, which in clinical experience can vary widely in association with the severity and duration of the disorder. Patients with a mild disorder may maintain jobs and relationships, but detailed interviewing can often reveal problems related to drug use.

Dr Bell says Mr Tyrrell has a clear history of drug seeking behaviour. This he says, was recognized by all treating doctors at the Snug Medical Centre apart from Dr Hamilton. He says Dr Hamilton's notes makes no mention of drug seeking behaviour or of other therapies that may have been used to reduce the amount of drugs consumed. Dr Bell concludes the prescribing of opiates and a benzodiazepine appears excessive.

Because of this and the comments made by the Chief Pharmacist, comment was sought from Dr Hamilton. Dr Hamilton noted Dr Bell's conclusion that the prescribing of opiates and benzodiazepines appeared excessive and that he had not recognised drug seeking behaviour. He says his associate, Dr Gangell, had documented this and he had read and agreed with his assessment even if not documented in the clinical notes.

As to excessive medications, Dr Hamilton says Dr Bell records as part of his report that tramadol SR 200 mg was prescribed from 13 October 2021 until 23 February 2022. The clinical notes show however that during that period he was prescribed a lower dose of tramadol SR 150 mg. He noted this transcription error may change Dr Bell's opinion. The four medications detailed in Dr Bell's report were all prescribed under the maximum recommended dose supplied by the manufacturer in the prescribing information. With Panadeine Forte, the maximum recommended daily dose is eight. For tramadol, the maximum daily dose is 400 mg and Mr Tyrrell's daily

dose would have averaged around 350 mg. It was 300 mg daily from October 2021 to February 2022. For diazepam, the maximum dose was up to six daily and it was three per day from October 2021 to February 2022. For temazepam the maximum dose is three daily. The doses actually prescribed were all less than those calculated by Dr Bell. Therefore, Dr Hamilton says the amounts prescribed as a percentage of the maximum daily dose is 31% for Panadeine Forte, 75% for tramadol, 72.6% for diazepam and 90% for temazepam and as such were not excessive doses. Mr Tyrrell's medications would have had pharmacy labels advising him not to drive a motor vehicle or operate machinery.

As to what medications were indicated, Dr Hamilton says Mr Tyrrell had a mixture of acute and chronic pain during the time he was managed at the Snug Medical Centre. He had an ankle fracture in July 2021 and even a minor ankle fracture can be painful for six months or more. Mr Tyrrell suffered soft tissue knee injuries in December 2021 and February 2022. His pain management was an essential part of him being able to work while recovering from injuries. When he transferred from the Collins Street General Practice, he came with a diagnosis of anxiety disorder. His medications for anxiety had been significantly reduced prior to the transfer. He remained on Efexor XR 37.5 mg which was not controlling his anxiety at that time. Diazepam was introduced by Dr Gangell to help Mr Tyrrell adjust to the reduction of other medications. Dr Hamilton later increased his Efexor dose to 75 mg in the hope that it might control his anxiety and reduce the need for diazepam. This was not the case.

Dr Hamilton noted Dr Bell had mentioned the results of toxicology in his report. Of those medications, Dr Hamilton says temazepam and diazepam were prescribed medications. Diazepam is known to be metabolised to temazepam and oxazepam, but the latter are said to be minor metabolites and rarely detectable. This raises the possibility of an alternative source of oxazepam depending on the quantitative levels. Phenergan was not prescribed or recommended. No narcotics were detected. What was detected is consistent with the non-prescribing and cautious future dated prescribing on 23 February 2022.

In so far as drug seeking behaviour/dependence is concerned, Dr Hamilton says during September and October 2021 he had several discussions on medication overuse and the need to reduce the doses and number of medications Mr Tyrrell was taking. Stilnox was ceased. The need to reduce benzodiazepines and analgesics was documented on 6 October 2021. The dose of tramadol was decreased and diazepam was reduced to three per day. Unfortunately, Mr Tyrrell's ongoing ankle pain plus acute knee injuries interfered with the reduction process. His behaviour in

the presence of Dr Gangell on 16 February 2022 and himself on 23 February 2022, was clearly drug seeking behaviour. For this reason, despite Mr Tyrrell's pain, Dr Hamilton says he clearly indicated there would be no further oxycodone prescribed following his most recent knee injury. Because Mr Tyrrell still had signs of a significant injury, his regular pain medications were prescribed that day, but post-dated to 26 February 2022 to ensure they were dispensed at the prescribed interval. Dr Hamilton arranged an ultrasound of Mr Tyrrell's knee because his clinical signs were suggestive of a posterior capsule injury, a likely traumatic Baker's cyst. Dr Hamilton says he clearly recalls he intended to be sure of the severity of the injury before resuming the medication reduction which had previously been started, then stalled. Dr Hamilton says the clinical situation is never clear cut. Balancing the unmistakable clinical signs of an acute knee injury with the more subjective nature of drug seeking behaviour is not easy. A patient's acute clinical presentation must be given clear priority in their management. This is why he chose to investigate Mr Tyrrell's injury before dealing with his medications on 23 February 2022.

Dr Bell reviewed Dr Hamilton's response and advised me Dr Hamilton's response is sound. Dr Bell says the dose over a long period was usually within prescribed dosages. There was increasing demand by Mr Tyrrell over a significant period, usually an indication of using to need, not addiction. I accept Dr Bell's opinion.

Senior Constable Keegan from Crash Investigation Services of Tasmania Police attended this crash arriving at approximately 4:30pm. As a result of evidence he gathered at the crash scene, he concluded the evidence was consistent with the motorbike leaving the left-hand side of the roadway, crossing the left-hand median traffic island and slip lane, and continuing onto the grass verge where it struck a roadside tree. The motorbike has continued northbound before colliding with a second roadside tree, dislodging a tree limb before becoming airborne and tumbling for approximately 35 m before coming to rest. Mr Tyrrell became separated from the motorbike and has been fatally injured as a result of the crash.

Senior Constable Keegan concluded the crash was caused by Mr Tyrrell failing to apply the required right-hand steering input to maintain the motorbike's correct position on the highway. As to whether or not this failure or inability to steer the motorbike correctly was the result of excessive speed, inattention or otherwise, he was unable to say. He says the evidence permitted him to calculate the speed of the motorbike at the point it began tumbling on the grass surface, which was 21.8 m prior to its final resting point. The calculation revealed a speed at that point of 62 km/h. Mr Tyrrell was obviously driving a lot faster than that prior to this point and I note he had

collided with two roadside trees before the motorbike began to tumble. I accept the opinion of Senior Constable Keegan.

### **Comments and Recommendations**

Because of Mr Tyrrell's mental health struggles and his previous threats of suicide, I have had to consider whether or not Mr Tyrrell drove in the manner that he drove on this day in order to commit suicide. I have come to the conclusion, given the evidence of his family and friends, that Mr Tyrrell did not commit suicide. I have reached this conclusion for the following reasons:

- There is no documented evidence of Mr Tyrrell ever attempting suicide despite his threats;
- He did not leave a suicide note;
- A belief by his former partner Ms Harrison, which is a belief she reasonably holds given the evidence in this case, that if Mr Tyrrell intended to commit suicide he would have contacted her first. He did not do that;
- He was about to be employed in two different jobs again which is what he had wanted for a very long time;
- He had indicated that he felt his life was turning the corner after a number of very difficult years;
- There is evidence that shortly prior to his death he was happy and he had plans for the future; and
- The location where the crash occurred is not a place where you would conclude that if you attempted suicide you would definitely be successful.

In my view, this crash occurred due to Mr Tyrrell failing to apply the required right-hand steering input to maintain the motorbike's correct position on the highway. As to whether or not this failure or inability to properly steer the motorbike was the result of inattention or otherwise, I am unable to say. However, I suspect excessive speed was a significant factor in Mr Tyrrell's inability to apply the required steering input and maintain control of the motorbike.

The circumstances of Mr Tyrrell'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 thank Senior Constable Caitlin Francis for her investigation and report.

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

**Dated:** 13 January 2026 at Hobart in the State of Tasmania.

**Magistrate Robert Webster**  
**Coroner**