MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Minunyurra Wanita Lavinia Brown-West

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

a) The identity of the deceased is Minunyurra Wanita Lavinia Brown-West;

b) Ms Brown-West died as a result of multiple injuries sustained on 25 March 2020 as a passenger in a single motor vehicle crash;

c) The cause of Ms Brown-West's death was multiple injuries including traumatic closed head injury, blunt trauma of the chest and pelvis and blunt trauma of the right leg; and

d) Ms Brown-West died, aged 19 years, on 9 April 2020 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Brown-West's death. The material to which I have had regard includes:

- Tasmanian Health Service – Death Report to Coroner;
- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Post-mortem report – Dr Donald Ritchey, Forensic Pathologist;
- Patient Care Records – Ambulance Tasmania;
- Medical Records – Tasmanian Health Service – Royal Hobart Hospital;
- Medical Records – Aboriginal Health Service – Ms Brown-West;
- Medical Records – Clarence GP Super Clinic – Mr Blair Bailey;
- Affidavit – Ms Carol Brown, sworn 5 September 2020;
- Statutory declaration – Tracey Bailey, dated 25 March 2020;
- Statutory declaration – Scott Bailey, dated 26 March 2020;
- Statutory declaration – Clifford Bluett, dated 25 March 2020;
- Statutory declaration – Adrian Birkett, dated 26 March 2020;

- Statutory declaration – Janelle Clear, dated 25 March 2020;
- Statutory declaration – Mathew Wright, dated 25 March 2020;
- Statutory declaration – Briana Wright, dated 25 March 2020;
- Statutory declaration – Matthew Renshaw, dated 30 March 2020;
- Statutory declaration – Stephen Lunn, dated 26 March 2020;
- Statutory declaration - Robert Boost, dated 26 March 2020;
- Affidavit – Gary Clark, sworn 17 September 2020;
- Affidavit – Adelphia Hennessey-Tunks, sworn 15 September 2020;
- Affidavits (2) – Briarna Oldham, sworn 16 September and 26 September 2020;
- Statutory declaration – Steve Viney, made 25 March 2020 (and dash cam footage);
- Affidavit – Mitchell Noisier, sworn 16 September 2020;
- Statutory declaration – First Class Constable Justin Fountain, made 25 March 2020;
- Statutory declaration – Senior Constable Daniel Richards, made 25 March 2020 (and body worn camera footage);
- Statutory declaration – Senior Constable Joshua Tringrove, made 25 March 2020;
- Statutory declaration – Detective Senior Constable Sharee Maksimovic, made 25 March 2020;
- Statutory declaration – Constable Petria Button, made 25 March 2020;
- Affidavit – Detective Constable Rebecca Berriman, sworn 17 September 2020;
- Affidavit – Senior Constable Kelly Cordwell APM (Collision Analyst – Crash Investigation Services), sworn 21 September 2020;
- Affidavit – Detective Constable Amelia Baker, sworn 17 September 2020;
- Affidavit – Sergeant Adrian Leary, sworn 16 September 2020;
- Statutory declaration – First Class Constable Dean Walker, sworn 4 September 2020 (and scene photographs);
- Statutory declaration – Constable Ben Farquett, made 5 September 2020 (and photographs);
- Report – Acting Sergeant Adam Hall, September 2020;
- Affidavit – Ralph Wells, (Transport Safety and Investigation Officer), sworn 11 September 2020;
- Medical Records – Blair Bailey – Tasmanian Health Service – Royal Hobart Hospital;
- Toxicological report – Blair Bailey – Neil MacLachlan-Troup, Forensic Scientist; and

- Miscellaneous evidentiary material including surveys, maps, drone footage, body worn camera footage, vehicle service history, Mobile phone records, weather reports and drug exhibit records.

Introduction

1. Ms Brown-West died as a result of massive traumatic injuries sustained when she was a passenger in a motor vehicle driven by Blair Thomas Bailey, her boyfriend at the time.
2. At approximately 7.40 am on 25 March 2020, the Holden Cruz in which Ms Brown-West was a passenger and was being driven in a general westerly direction on the Tasman Highway near Mornington. The vehicle left the highway and collided with a large eucalyptus tree.
3. Several witnesses described seeing the Holden suddenly veer to the left, for no apparent reason. Certainly, there was no obstruction or obstacle that required Bailey to manoeuvre the car as he did.
4. Motorists stopped to render assistance. Emergency services were quickly on the scene. Ms Brown-West was unconscious. She did regain consciousness at any time before her death.
5. She was extracted from the vehicle and rushed by ambulance to the Royal Hobart Hospital where she died from her injuries some weeks later.
6. Bailey was seriously injured and remained in hospital for a lengthy period.

What a coroner does

7. Before considering the circumstances of Ms Brown-West's death, it is necessary to say something about the role of the coroner, and what she or he does and does not do.
8. When investigating a death a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. The investigation might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. The coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they 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.[1] The job of the coroner is to make findings of fact about the death from

[1] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

9. It is important to recognise 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. In this case Bailey was charged by the Director of Public Prosecutions (DPP) with causing Ms Brown-West's death by negligent driving. However, the DPP later withdrew that charge, apparently having reached the view that a successful prosecution of Bailey was unlikely. It is not any part of a coroner's role to comment on the decision to prosecute or discontinue a prosecution once commenced, whatever the coroner thinks of that decision.
10. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[2] 'How' has been determined to mean "by what means and in what circumstances",[3] a phrase which involves the application of the ordinary concepts of legal causation.[4] Any coronial inquest 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.
11. The standard of proof at an inquest is the civil standard. This means that where a coroner makes findings of fact, she or he must be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest 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, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[5]

Investigation

12. Officers from uniform, CIB and Crash Investigation Services were all on the scene shortly after the crash. An extremely thorough investigation was carried out in relation to the crash and Ms Brown-West's subsequent death. The investigation involved identifying and interviewing a number of witnesses, inspecting the scene of the crash, photographing the scene, obtaining medical records as necessary, having the vehicle inspected to determine if mechanical issues played any role and

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[2] *Coroners Act* 1995, section 28(1)(b).
[3] See *Atkinson v Morrow* [2005] QCA 353.
[4] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.
[5] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

endeavouring to interview Bailey. He refused to speak to investigators about the circumstances of the crash.

Conclusion

13. I am satisfied alcohol played no role in the happening of the crash. It is less easy to be definitive about the role of any other substances in the happening of the crash. There is clear evidence from Bailey's mother that he was under the effect of a substance prior to driving on the morning in question. However, no drugs or other illicit substances were detected in his blood after the crash when it was analysed at the laboratory of Forensic Science Service Tasmania (FSST). Balanced against that is Bailey's known regular use of so-called "nangs" (nitrous oxide) to become intoxicated. The gas when inhaled, typically by discharging from nitrous gas cartridges is known to produce a rapid rush of euphoria and a feeling of floating or excitement for a period of time. Nitrous oxide is not a substance able to be detected in blood as a result of toxicological analysis at FSST. I suspect Bailey may well have been under the influence of nitrous oxide in the immediate lead up to the crash.
14. I am satisfied that neither road or weather conditions caused or contributed to the happening of the crash. Similarly, I am also satisfied that no other person caused or contributed to the happening of the crash which caused Ms Brown-West's death.
15. The evidence also indicates that the Holden Cruze was in a roadworthy condition prior to the crash.
16. On the other hand, I am quite satisfied that Bailey was driving at an excessive speed (approximately 122 km/h in an area with a maximum speed limit of 110 km/h). There is no evidence that Bailey applied his brakes after leaving the highway nor that there were any steering inputs indicating an attempt to collide with the tree. Dash camera footage from a school bus shows that he did not indicate to leave the highway.
17. I cannot exclude as a reasonable hypothesis that the crash which killed Ms Brown-West was the result of a deliberate act on Bailey's part. Nonetheless, the state of the evidence does not allow me to reach an affirmative conclusion in that respect, particularly having regard to the standard of satisfaction required by *Briginshaw*.[6]

Comments and Recommendations

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

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[6] *Supra.*

19. The circumstances of Ms Brown-West's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.
20. I convey my sincere condolences to the family and loved ones of Ms Brown-West

Dated: 11 March 2024 at Hobart in the State of Tasmania.

Simon Cooper

Coroner