



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 Brian Thomas Carroll

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

- a) The identity of the deceased is Brian Thomas Carroll.
- b) Mr Carroll died as a result of injuries sustained by him as the driver in a single motor vehicle crash at Breadalbane. Mr Carroll was not wearing a seatbelt and was ejected from the cabin of his vehicle when it crashed;
- c) The cause of Mr Carroll's death was traumatic brain injury; and
- d) Mr Carroll died, aged 81 years, on 7 September 2022 at the Launceston General Hospital, Launceston, Tasmania.

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

- Police Report of Death for the Coroner,
- Tasmanian Health Service – Death Report to Coroner;
- Affidavits confirming identity;
- Report – Dr Andrew Reid, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Records – Ambulance Tasmania;
- Report – Dr Robert Smithers, ICU Registrar, Launceston General Hospital;
- Medical Records – Tasmanian Health Service;
- Medical Records – Launceston Central Medical Centre;
- Affidavit (sworn 5 October 2022) and statement – Mrs Gayle Carroll;
- CCTV Footage – Micra Accident Repair Centre, Breadalbane;
- CCTV Footage – Pet Crematorium, Breadalbane;
- Affidavit – Mr Barry Spencer, Transport Safety and Investigation Officer, sworn 27 October 2022;

- Affidavit – Senior Constable Rodney Walker, Forensic Services, Tasmania Police, sworn 17 October 2022 (and scene photographs);
- Affidavit – Braden Green, Tasmania Police, sworn 28 November 2022¹;
- Affidavit – Constable Jayden Monaghan, sworn 5 December 2022; and
- Affidavit – Senior Constable Michal Rybka Northern Crash Investigation Section, sworn 24 November 2022 (and sketch map).

Circumstances of Death

Mr Carroll died as a consequence of injuries sustained by him as the driver and sole occupant of a Toyota HiLux utility. The crash occurred in the early hours of 2 September 2022 when Mr Carroll was travelling south along Hobart Road near Breadalbane when he failed to negotiate a roundabout. His vehicle mounted a traffic island, hit a street sign and rolled across the entire centre of the roundabout destroying a central light tower in the process. Mr Carroll's vehicle came to rest on its wheels facing east on the roadway on the opposite side of the roundabout.

Mr Carroll was thrown from his vehicle (it is evident he was not wearing a seatbelt) and was found lying face down behind the utility on the road. When found by police, Mr Carroll was still alive. He was taken by ambulance to the Launceston General Hospital where he died 5 days later.

Investigation

Senior Constable Rybka from the Northern Crash Investigation Section, Tasmania Police attended the scene of the accident and carried out investigations and inquiries. He provided a detailed affidavit. Amongst other things, he calculated that the speed at which Mr Carroll was travelling in the immediate lead up to his death was in the order of 125 km/h. I note the sign posted speed limit for the section of Hobart Road where the accident occurred is 80 km/h.

Mr Carroll's death was reported in accordance with the requirements of the *Coroners Act 1995*. His body was formally identified and then taken to the Royal Hobart Hospital where the State Forensic Pathologist, Dr Andrew Reid carried out an autopsy. Dr Reid provided a report in which he expressed the opinion, which I accept, that the cause of Mr Carroll's death was a traumatic brain injury.

¹ Green's affidavit does not identify his rank. I have had occasion to comment on this practice which has become increasingly common in recent years. It must stop. It is essential that the rank of police officers investigating matters be included in any affidavit provided pursuant to the *Coroners Act 1995*

Ante-mortem blood samples were analysed as part of the investigation at the laboratory of Forensic Science Service Tasmania. Diazepam and paracetamol were both identified as being present in those samples. I do not think those drugs played any role in the crash.

Evidence indicates that Mr Carroll had recently undergone surgery to remove a benign mass from his mouth. His wife described him as a “changed man after his operation”. She said he suffered extreme panic attacks and in the day before the crash which caused his death she described him as delusional.

Conclusion

There are no suspicious circumstances, anomalies or inconsistencies associated with Mr Carroll’s death. There is no evidence that any other person was involved in the crash which claimed his life.

I am satisfied that excessive speed and a failure to wear a seatbelt were significant factors in his death.

There is no evidence that alcohol, drugs or whether road conditions played any role in the happening of the crash.

It is difficult, indeed impossible, to determine why Mr Carroll was driving where and when he was when he crashed. Some explanation may possibly be found in the symptoms of mental ill-health his wife described following his surgery.

Comments and Recommendations

The circumstances of Mr Carroll’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 Mr Carroll.

Dated: 5 March 2024 at Hobart, in the State of Tasmania.

Simon Cooper

Coroner