



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Michael Robert Thompson

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

- a) The identity of the deceased is Michael Robert Thompson;
- b) Mr Thompson died as a result of a single vehicle crash whilst driving a concrete truck on Tea Tree Road, Tea Tree in the course of his employment;
- c) The cause of death was multiple injuries; and
- d) Mr Thompson died on 14 December 2017 at Hobart in Tasmania.

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

- The Police Report of Death;
- An opinion of the forensic pathologist who conducted the autopsy;
- Life extinct and identification affidavits;
- Affidavit of the toxicologist who analysed Mr Thompson's post-mortem blood samples;
- Crash analysis report from a crash investigator attached to Southern District Crash Investigation Services;
- An affidavit of transport inspector, Mr Paul Wells, who inspected the truck after the crash;
- Ambulance Tasmania records;
- Royal Hobart Hospital records;
- Medical records from Mr Thompson's general practitioner;
- Affidavit of Joanne Fazackerley, Mr Thompson's partner;
- Affidavit of David Blackwell, witness at the scene of the crash;
- Affidavits of Andrea Jackman, operator of Best Mix Concrete Pty Ltd;
- Affidavit of Jarrod Hill, plant manager of Best Mix Concrete Pty Ltd;

- Affidavit of Sergeant Garth Hossack, the first police officer at the scene of the crash;
- Affidavit of Senior Constable Kelly Cordwell of Crash Investigation Services;
- Affidavit of Senior Constable Adam Hall of Crash Investigation Services and main investigating officer;
- Affidavit of forensics officer, Constable Tania Curtis and photographs of the scene;
- General information, vehicle registration history and vehicle service records for the truck;
- Best Mix driver daily run sheets;
- Prior convictions and licence history for Mr Thompson;
- Bureau of Meteorology information in respect of weather at the time of the crash;
- Information from Best Mix regarding safety processes; and
- Information from Tasmania Police regarding amendments to the Tasmania Police Manual.

Background

Michael Robert Thompson was born on 10 June 1962 in Launceston, Tasmania and was aged 55 years at the time of his death. Mr Thompson was in a relationship with Joanne Fazackerley and the couple resided together in Rokeby. They had been together for 31 years and have four adult children together.

Mr Thompson was an experienced truck driver who had been driving trucks for about 18 years. He had been working on a full-time basis for Best Mix Concrete Pty Ltd for approximately two years before his death.

Mr Thompson was the holder of a current Heavy Combination Driver's Licence. He had a number of prior driving convictions, including 11 convictions between 1984 and 2014 for failing to wear a properly fitted and adjusted seat belt.

Health

Mr Thompson was a non-smoker, rarely consumed alcohol, and was in good health. He regularly consulted his general practitioner and his last visit was on 15 November 2017 in relation to ongoing shoulder pain, diagnosed as rotator cuff tendonitis.

I am satisfied upon the evidence that a medical episode was not a contributing factor in the cause of the crash.

Circumstances of Death

At 6.15am on Thursday 14 December 2017, Mr Thompson commenced work at Best Mix at its facility in Sorell. Mr Thompson's start time was dependent on the workload for the day. The drivers would be notified at the conclusion of a work day and informed as to what time they were to commence the following day. On this occasion Mr Thompson was required to leave the plant at 6.45am with the first load of pre-mixed concrete.

Mr Thompson departed the concrete plant at approximately 6.45am with 4.5 cubic meters of concrete bound for an address at Primrose Sands. He was driving a 2007 Mack ML8x4 Metro Liner, registration D38YB. After delivering the first load of concrete to Primrose Sands he returned to the concrete plant at Sorell and was loaded with 6 cubic metres of concrete for a house slab which was to be delivered to an address at Old Beach. He commenced this trip at 9.35am after having a coffee with plant manager, Jarrod Hill. Mr Hill informed Mr Thompson that he should travel over Grass Tree Hill Road to reach his destination. However, Mr Thompson did not travel this route and instead travelled via Tea Tree Road.

At approximately 10.10am, Mr Thompson was driving west-bound on Tea Tree Road. Tea Tree Road has a general east to west orientation and links traffic from the Midlands Highway at Brighton to the Tasman Highway on the East Coast near Orielson. Tea Tree Road has a bitumen surface, and a single lane for eastbound and westbound traffic. As his truck entered the area of Tea Tree, it passed a clearly visible 70 km/h speed sign. Prior to that sign, the road had a posted speed limit of 100 km/h.

I find, based upon the scene examination and opinion of the experienced crash investigators who provided affidavits containing detailed analysis, that the following sequence of events occurred.

Approximately 225 metres past the 70km/h speed limit sign, Mr Thompson began to negotiate a right-hand curve in the road but was not able to maintain the line of the curve. As a result of Mr Thompson trying to keep the truck on the road, and due to the weight shift from one side of the vehicle to the other, a tyre scuff mark was made on the surface of the road by the passenger side tyres of the vehicle which continued for a total distance of 110 metres. At the conclusion of these scuff marks the truck left the road on the southern side. As it did so, it tipped onto its passenger side and hit an embankment, sliding on its side for a further 32 metres before coming to rest over a downhill embankment on the same side of the road just north of the driveway of 746 Tea Tree Road.

In the crash, the truck was severely damaged with the main areas of damage occurring to the front and front left areas of the vehicle.

Mr Thompson was likely ejected from the truck through the windscreen when it hit the embankment. In this regard, his injuries were consistent with sliding across the bitumen driveway. During the truck's slide to final rest, a power pole was snapped off at the ground, also bringing down power lines.

A witness, Mr David Blackwell, was at the front of his house at 729 Tea Tree Road about to mow his lawn when he saw the truck coming around the corner towards him. Mr Blackwell stated that the truck was "right over on the far left hand side of the road." He said that it went into the soft part of the shoulder and then the front of it hit the concrete area which protected the pipe running under the driveway of the Fire Station. He saw the front of the truck bounce into the air and collide with the power pole. He also saw the driver being ejected from the windscreen, hitting the power pole and bouncing towards the Fire Station. Mr Blackwell immediately ran inside and dialled 000 for the attendance of emergency services. He also flagged down another truck for assistance. In his affidavit, Mr Blackwell stated:

"I then ran up to the accident. There were about 11 people standing around on the road near the truck. Nearly all of them had their phones out and were filming the accident but no one had gone down to the truck. There were power lines across the road.

I went down the embankment at the front of the truck and saw a person lying on the ground near the left hand side of the truck. The person was lying face down and trying to get up. I went towards him and I heard him say "where's my lunch? I want me dinner".

I told him that he had been involved in an accident and that he needed to stay still. I pushed him in the middle of his back to keep him down as there were two power lines lying couple of inches above his head and I didn't know if they were live or not.

I kicked the Black Power line away with my foot and then I picked up a large splinter piece of the telegraph pole, slid it under the wire and laid it across a rock to keep it off him.

I then told him that I had to move him because of the power lines. I checked his sides to see if he had any major problems because if he was cut open across the belly I wouldn't have moved him. I grabbed his ankles and dragged him about 5 or 6 feet back towards the corner of the fire shed."

With the assistance of two passers-by who were both doctors, Mr Thompson was moved to a concrete apron in front of the nearby Fire Station. The two doctors assisted Mr Thompson with basic medical management until the ambulance paramedics arrived. Despite the efforts of the investigating officer, these two doctors have not been able to be located to provide statements in the investigation. It is clear from the evidence that Mr Thompson was critically injured during attempts to assist him. Although he was confused (and in and out of consciousness) there was no need for any resuscitation at the scene.

Mr Thompson was stabilised by Tasmania Ambulance paramedics and conveyed to the Royal Hobart Hospital in a critical condition, with severe injuries to his chest. Despite medical efforts, he died in hospital later that day as a result of his injuries. He was formally identified by his partner, Ms Fazackerley, at the Royal Hobart Hospital.

Post-Mortem Examination and Further Investigations

On 15 December 2017 forensic pathologist, Dr Donald Ritchey, performed an autopsy upon Mr Thompson. Dr Ritchey determined that Mr Thompson died as a result of multiple injuries sustained in the crash. These injuries included multiple rib fractures producing a flail chest, a laceration of the liver, and a contusion of the heart muscle.

Toxicological analysis of blood samples taken at autopsy revealed that no alcohol or illicit substances were present in Mr Thompson's system.

The scene was attended by experienced crash investigators, Senior Constable Kelly Cordwell and Senior Constable Adam Hall, who arrived soon after the crash occurred and commenced analysis of the scene. They noted that the weather at the time of the crash was fine and the road was dry. They also noted that the road surface was in good condition.

Analysis conducted by Senior Constable Hall showed that the truck, with its particular specifications, would roll over on the corner in question at a speed of between 89 km/h and 92 km/h. Senior Constable Hall was of the opinion that Mr Thompson was driving the truck at a speed in excess of the rollover speed of 92 km/h, and that such excessive speed was a causative factor in the crash.

Senior Constable Hall reported that, at the time of the crash, the truck (including the load) had a Gross Vehicle Mass of 26,850 kg, being 150 kg below the regulatory Gross Vehicle Mass of 27,000 kg.

The vehicle was fitted with an air suspension type, fully adjustable bucket style seat with an incorporated fixed head rest in the seat back and a lap sash seat belt was also fitted. Both the vehicles seat belts were uncoupled and retracted at the time of inspection, indicating they were not worn at the time of the crash.

The damaged truck was independently inspected by Transport Inspector, Paul Wells, on 18 December 2017. Mr Wells reported that the truck had pre-existing minor defects, these being a cracked chassis rail, non-compliant suspension spring and non-compliant rear mudguards. I accept the opinion of Mr Wells and of Senior Constable Hall that these defects were not causative factors in the crash.

Unfortunately, Mr Thompson died as a result of fatal injuries sustained when the truck rolled onto its side, causing him to be ejected through the windscreen. I am satisfied that his death occurred as a result of his excessive speed for the road in question and his failure to wear his seatbelt. If Mr Thompson had been wearing his seatbelt at the time of the crash, there would have been a high chance of his survival.

Comments

Pursuant to Section 28 of the *Coroners Act 1995* it is appropriate to make the following comments.

Mr Thompson's employment with Best Mix Concrete Pty Ltd

Mr Thompson died at his "workplace" (as that term must be construed) of unnatural causes. As such, his death would ordinarily be required to be the subject of a public inquest pursuant to section 24 of the *Coroners Act 1995*. However, I have received a representation from the senior next of kin, Ms Fazackerley, under section 26A(2) of the *Act* that she does not seek that an inquest takes place. Further, I am satisfied under section 26A(3) of the *Act* that it is not contrary to the public interest not to hold an inquest. I have therefore decided not to do so.

It is, however, appropriate to make brief comments upon my investigation into workplace issues that may have been connected to Mr Thompson's death. I am satisfied upon the comprehensive evidence that the owners of Best Mix, who had employed Mr Thompson on a full-time basis since October 2015, did not do any act or omission that contributed to Mr Thompson's crash. Mr Thompson had had previous employment driving concrete trucks and was an experienced truck driver generally. Mrs Jackman stated in her affidavit that, as only experienced truck drivers are employed with the company, specific training in relation to the company's trucks is not offered unless there is a specific need. She stated, however, that Best

Mix conducted workplace inductions, fortnightly toolbox meetings, safety discussions throughout the week and, in general, emphasised to the drivers the importance of wearing seat belts at all times. She stated that Mr Thompson was always seen to be wearing his seatbelt when he left the plant for deliveries and she was unable to understand why he was not wearing his seatbelt at the time of his crash. Similarly, Ms Fazackerley said that Mr Thompson had learnt from his prior offences and wore his seatbelt in both trucks and cars. Unfortunately, Mr Thompson chose not to wear his seatbelt at the time of the crash, a poor decision which most probably cost him his life.

I am also satisfied that the Best Mix trucks, including the truck driven by Mr Thompson on the day in question, were maintained appropriately and in good working order. I am satisfied that the evidence in the investigation reveals no other safety or procedural issues relating to the company bearing upon Mr Thompson's death. Best Mix has been forthcoming in providing all requested documentation for this investigation.

Mrs Jackman stated that the effect of Mr Thompson's death upon all personnel at Best Mix was profound. She stated: *"We miss him dearly, Michael was always at the plant first thing in the morning, had the loader out ready to go, kettle boiled for his mates and ready to go to work"*.

Investigation of fatal crashes involving a death in the course of employment

There was delay in completing this investigation. The officer allocated as investigating officer was not a qualified crash investigator and was attached throughout the investigation period to a police station with a heavy workload. Understandably, the officer was unable to complete this complex investigation to the requisite standard in a timely manner. I also observe that Work Safe representatives did not attend the crash nor undertake any workplace investigation which may have assisted the investigating officer. I am therefore very grateful to Senior Constable Adam Hall who completed the investigation, with the necessary focus upon specialist crash analysis and issues relating to Mr Thompson's employment.

On 26 June 2020 I received from the Deputy Commissioner of Police formal notification that the Tasmania Police Manual has now been amended to require officers of Crash Investigation Services to attend and investigate all single vehicle traffic crashes that involve a driver in the workplace or in the course of their employment. This positive development will mean that deaths in this category are likely to be investigated thoroughly and efficiently by appropriately skilled police officers.

Mr Blackwell's actions at the scene

I particularly acknowledge the actions of David Blackwell at the scene of the crash. Mr Blackwell placed himself in immediate danger and at risk of electrocution whilst removing Mr Thompson from under the fallen power lines. He then assisted with first aid and provided reassurance to Mr Thompson until further assistance arrived.

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

Dated: 29 July 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner