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 Michael William Hamlyn

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

a) The identity of the deceased is Michael William Hamlyn;
b) Mr Hamlyn died in the circumstances set out further in this finding;
c) The cause of Mr Hamlyn's death was hanging; and
d) Mr Hamlyn died between 10 July 2016 and 1 October 2016 in bushland off Valley Road near Fingal, in Tasmania.

Introduction

Mr Hamlyn was born in the Philippines. Aged 4 he was adopted by Peter and Sharon Hamlyn. He was raised and educated in Launceston.

At the age of 17, after interaction with police in respect of a driving offence, Mr Hamlyn took an overdose of Panadol, was hospitalised as a consequence and received psychiatric treatment. Shortly after he ran away from home. He lived at various addresses in the Launceston area and worked at both Woolworths and the Launceston Casino.

Aside from the period of treatment mentioned above, it is unclear whether Mr Hamlyn received any other treatment for mental health issues.

He was last seen alive by his family at a celebration of his brother's birthday in April 2016.

Circumstances of Death

At 9.35am on 10 July 2016 Mr Hamlyn was served with notices by police with respect to the alleged commission of several offences. Approximately 2 hours later he went to Kmart in Launceston and purchased 30 metres of 9mm Poly Rope. Later the same day Mr Hamlyn

rode his motorcycle to an area of bushland off Valley Road approximately 12 kilometres east of Fingal. Sometime the same day he took his own life by hanging himself by the rope from a tree.

Investigation

Mr Hamlyn's disappearance was reported to police by a friend on 11 July 2016. Extensive enquiries were conducted to attempt to locate him without success.

Eventually his body was located when his motorcycle was found by a trail bike rider on 1 October 2016. Police were called and able to identify the motor cycle as belonging to Mr Hamlyn. Uniform, Forensic Services and Criminal Investigation Branch officers attended and conducted a search of the area, eventually locating Mr Hamlyn's body 400 metres east of where the motorcycle was found.

Mr Hamlyn's body was examined and photographed *in situ*. His mobile phone was recovered for subsequent forensic analysis. Nothing was identified at the scene (or where the motorcycle was found) suggesting the involvement of any other person in his death, or that his death was anything other than suicide.

After investigations were completed at the scene, Mr Hamlyn's body was removed from the scene and transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital samples were taken from the body which were able to be analysed at the laboratory of Forensic Science Service Tasmania to confirm by DNA identification that the body located was in fact that of Mr Hamlyn. An autopsy was conducted by the State Forensic Pathologist, Dr Christopher Hamilton Lawrence. Dr Lawrence expressed the opinion that the cause of Mr Hamlyn's death was hanging. The autopsy revealed changes consistent with hanging. Although the body was partly skeletonised and partially decomposed, Dr Lawrence did not notice any unusual features at autopsy. I accept his opinion as to the cause of death.

Due to the advanced level of decomposition of the body no toxicological analysis was able to be undertaken.

Mr Hamlyn's mobile phone was forensically examined. On that mobile phone a video was found of Mr Hamlyn prepared by him, and in its nature it was a final message to his family and friends. It is apparent from examination of that video that it was made at the place where his body was found.

Conclusion

Viewing the evidence as a whole I am satisfied to the requisite legal standard that Mr Hamlyn died as a consequence of hanging. He acted voluntarily and alone with the express intention of ending his own life. I am satisfied that there are no suspicious circumstances surrounding Mr Hamlyn's death.

Comments and Recommendations

I extend my appreciation to investigating officer, Sergeant Chris Parr, for his investigation and report.

The circumstances of Mr Hamlyn'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 Hamlyn.

Dated 19 March 2018 at Hobart inTasmania.

Simon Cooper
Coroner