



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 Jacob Leigh Wilson

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

- a) The identity of the deceased is Jacob Leigh Wilson;
- b) Mr Wilson died as a result of injuries suffered in a single motorcycle crash;
- c) The cause of death was chest and abdominal injuries; and
- d) Mr Wilson died on 22 January 2018 at the Royal Hobart Hospital, Hobart in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Wilson's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; toxicology report; police and witness affidavits; crash investigator's report; medical records and reports; and forensic evidence.

Jacob Leigh Wilson was born on 25 June 1990 and was aged 27 years at the time of his death. He was the son of Alan Michael Wilson ("Alan") and Vicki Anne Wilson ("Vicki"). He was the youngest of four children. Alan and Vicki separated when Mr Wilson was approximately 8 years old.

At the time of his death, Mr Wilson attended TAFE where he was enrolled in automotive and welding studies. He had previously lived on his own in a unit in Goodwood. However, on 8 June 2017 he was involved in a single motorcycle crash on the Brooker Highway in Hobart. As a result of the crash, he moved into his father's home in Bridgewater.

Alan Wilson, in his affidavit for the investigation, did not believe that his son was a particularly experienced motorcycle rider. He had learnt to ride motorcycles as a child on his father's land and then developed an interest in road motorcycles later in life. At the time of his death, Mr

Wilson had a current Novice P1 motorcycle licence. He owned a black Kawasaki EX250H motorcycle, which was registered.

Mr Wilson struggled with prescription drug abuse since 2011, following the end of a difficult relationship. At that time, he also attempted to end his life by an overdose of medication. While living with his father, there was an agreement that Mr Wilson would no longer take excessive amounts of prescription medication. Alan suspected that his son was not abiding by this agreement and implemented measures to control all medication prescribed to him.

Mr Wilson regularly saw his general practitioner at Green Point Medical Centre. His medical records, which formed part of the evidence in the investigation, indicate that he suffered chronic pain from fracturing his right foot in the motorcycle accident and also that he had anxiety and depression. His general practitioners at that practice noted his issues with addiction to prescription medications. For example, on 11 September 2017, when his general practitioner denied the medication requested, Mr Wilson became verbally abusive, upset and began to cry. He told the doctor that if he had a gun he would shoot himself. He requested to be referred to a psychiatrist, which was done.

On 3 January 2018, Mr Wilson attended his doctor, on this occasion Dr Stephanie Mills, and stated that he had suffered a motorcycle injury two weeks previously. On examination there was no serious injury detected. He told Dr Mills that his foot injury from the first motorcycle crash was still causing him pain. He also disclosed that he had a heavy drug dependency. He outlined that, since 2011, he had suffered severe, chronic suicidal thoughts and anxiety. Mr Wilson agreed to again engage with Mental Health Services and Dr Mills sent a referral to Mental Health Services in the following terms;

'Thank you for seeing Jacob, aged 27 years. I feel he needs case management and psychiatric input. He is on extensive meds, prescribed initially by psych team and then by GP, and not getting any better. He has strong repetitive suicidal thoughts, acute severe debilitating anxiety and isn't coping. He presents distressed with paranoid thought and ideas people are against him. I am not comfortable to continue his current med regime without psych input and I am concerned that now his old GP has left he might disengage and deteriorate.'

The consultation with Dr Mills on 3 January 2018 was Mr Wilson's last interaction with medical professionals prior to his death. On the morning of his death, he was due to attend his scheduled appointment with Mental Health Services.

At 9.30am on 22 January 2018, Mr Wilson woke up in his bedroom at his father's residence in Bridgewater. His father offered to drive him to his appointment at Gavitt House but Mr Wilson insisted on riding his own motorcycle. Alan said that his son 'seemed good' that morning.

Mr Wilson showered and, at 9.57am, he travelled out of Bridgewater and began to travel south along Main Road, Austins Ferry. Mr Wilson passed Tavistock Road and approached number 161 Main Road. At that point Mr Wilson appeared to lose control of his motorcycle and crashed.

Mr Wilson's crash was witnessed only by Ms Lauren Frazer who was a passenger in a vehicle which pulled onto Main Road from Tavistock Road. Mr Wilson was travelling south some distance in front of Ms Frazer's vehicle. In her affidavit, Ms Frazer said that the rider appeared to lose control of the motorcycle. She did not see the rider fall from the motorcycle but saw the rider sliding along the footpath. Ms Frazer's vehicle stopped and Ms Frazer went to Mr Wilson. Mr Wilson was unresponsive and Ms Frazer observed that his helmet was lying on the ground. She contacted '000'. Another bystander, Ms Wendy Wyker, came to the assistance of Mr Wilson and began CPR.

At 10.08am ambulance paramedics attended the scene of the crash and commenced resuscitation efforts upon Mr Wilson, although he remained unresponsive and it was apparent that he had suffered likely fatal injuries. He was transported by ambulance to the Royal Hobart Hospital where resuscitation efforts continued but, at 11.00am, he was declared to be deceased. Formal identification of Mr Wilson was made by Alan Wilson in the Royal Hobart Hospital Mortuary.

An autopsy was conducted on 23 January 2018 by State Forensic Pathologist, Dr Christopher Lawrence. The autopsy revealed significant chest and abdominal injuries, including a laceration of the heart and skull fracture, which Dr Lawrence said would have caused very rapid death.

Police officers also attended the scene very shortly after the crash. They, too, assisted in resuscitation of Mr Wilson and commenced to investigate the crash. The attending officers noted that Mr Wilson was lying outside 161 Main Road. They noted that the motorcycle had travelled further in a southerly direction and was lying on its left side near the letter box of 159 Main Road.

Specialist crash investigators, Sergeant Rodney Carrick and Senior Constable Adam Hall, attended the scene the following day to assist in determining the circumstances surrounding the crash. They noted that the roadway comprised a single carriageway in each direction with a north/south orientation. The bitumen seal was in good condition and, on both sides of the roadway, there was guttering and a raised curb.

Sergeant Carrick and Senior Constable Hall recorded and analysed the marks, debris and other features of the scene for the purpose of reconstructing the crash. In his detailed affidavit, Sergeant Carrick stated that at the time of Mr Wilson's loss of control, the motorcycle had just entered a right hand curve. On the eastern curb, footpath and street reservations outside numbers 159 and 161 Main Road, they observed a number of yellow paint, scratch and scrape

marks left by the motorcycle. The marks commenced with an initial impact mark on the northern side of number 161 Main Road. In his affidavit, Sergeant Carrick formed the view that this mark was consistent with the wheel of a southbound motorcycle striking the raised curb on the eastern side of the road. Following this mark was the commencement of light scrape and scratch marks 22 metres in length extending south along the footpath and concluding on the southern side of number 159 Main Road.

Sergeant Carrick formed the view, based on the marks, that once the wheel of the motorcycle had struck the raised curb on the eastern side of the road, it mounted the eastern side footpath where it slid on its side along the footpath and across the nature strips, coming to rest on the nature strip directly to the south of the driveway entrance to number 159 Main Road.

It appears from the evidence that Mr Wilson was separated from the motorcycle part way through the slide. He came to rest near a power pole on the nature strip outside 161 Main Road, about 15 metres north of the resting position of the motorcycle. The photographic evidence suggests that Mr Wilson's body may have made contact with the power pole.

Sergeant Carrick calculated that the speed of the motorcycle at the time it commenced to slide on the footpath was between about 40km/h and 46km/h. He noted that this speed estimate does not take into account the loss of energy associated with the impact of the motorcycle with the curb and therefore the rider was therefore travelling at a higher speed at the time he struck the curb. Sergeant Carrick was unable to estimate the speed on impact, but there is no evidence that Mr Wilson was travelling at a vastly excessive speed at the time he lost control of his motorcycle.

Toxicological examination of Mr Wilson's post mortem blood sample revealed a large number of prescription and illicit drugs in his system. These included diazepam, fluvoxamine, quetiapine, pregabalin, morphine, codeine, thebaine, orpivane and cannabis. Of these, only diazepam, quetiapine, fluvoxamine and pregabalin were currently prescribed to him. The toxicology report prepared by forensic scientist, Miriam Connor, outlined that morphine, codeine, thebaine and orpivane, in combination, are opium alkaloids. In particular thebaine and orpivane are alkaloids that are only found in opium poppies and not able to be obtained in pharmaceutical preparations. Ms Connor was of the opinion that the results suggested that Mr Wilson had consumed either poppy tea or a poppy extract prior to death. She further stated that the combination of the substances found in Mr Wilson's blood would likely result in a spectrum of symptoms, including sleepiness, lack of coordination, impaired thinking and perception and slow reflexes. In particular, she stated that central nervous system depressants cause driving impairment as they result in symptoms such as disorientation, decreased inhibitions, fumbling, sluggishness, slowed reflexes and sedation. I accept her opinion and find

that the combination of substances ingested by Mr Wilson before driving affected his ability to control the motorcycle.

Mr Peter Moses, transport inspector, conducted an inspection of the motorcycle. He found the motorcycle to be unroadworthy due to the tread wear on the front tyre, missing front indicators and missing rear passenger foot pegs. It is possible, that the lack of tyre tread may have played some part in Mr Wilson's loss of control but I cannot make a positive finding to this effect.

I am satisfied that no other vehicle was involved in the crash. I am also satisfied that weather and road conditions played no part in the crash. There was no evidence of any obstacle or obstruction on the roadway.

I am also able to rule out that the crash was an intentional act on the part of Mr Wilson with a view to ending his life, even though he suffered strong suicidal thoughts and had previously attempted suicide. There was no evidence of high speed, no evidence indicating that Mr Wilson swerved suddenly and no evidence of suicidal intentions expressed to his family or other people at that time. He was actively seeking assistance from his treating health professionals and was willingly travelling to his scheduled appointment with Mental Health Services.

Mr Wilson was not a particularly experienced rider and did not hold a full licence. I note that he sustained a serious injury to his foot in a motorcycle crash in the previous year.

I am satisfied that Mr Wilson's death was accidental and occurred as a result of him losing control of his motorcycle whilst affected by numerous drugs.

I extend my appreciation to investigating officer Constable Claire Honey for her investigation and report.

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

Dated: 9 September 2019 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart

Coroner