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, Robert Webster, Coroner, having investigated the death of Jethro Wolf Douglas

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

a) The identity of the deceased is Jethro Wolf Douglas (Mr Douglas);

b) Mr Douglas died from injuries sustained as a driver in a single motor vehicle crash;

c) Mr Douglas' cause of death was multiple blunt trauma injuries; and

d) Mr Douglas died on 1 May 2021 at Zeehan in Tasmania.

In making the above findings, I have had regard to the evidence obtained in the investigation into Mr Douglas' death which includes:

- Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavit of the forensic pathologist Dr Donald Ritchey;
- Affidavit of the forensic scientist Mr Neil McLachlan–Troup of Forensic Science Service Tasmania;
- Affidavit of Mr Alan Fitzpatrick;
- Records of Ochre Health, Zeehan;
- Records obtained from Ambulance Tasmania (AT);
- Affidavit of Mr Shayne Douglas;
- Affidavit of Ms Suzanne Vallis;
- Affidavit of Mr Jobe Nichols;
- Affidavit of Ms Maranda Baker;
- Affidavit of Mr Dayle Meers;
- Affidavit of Mr Rhys Maine;
- Affidavit of Senior Sergeant Adam Stanwix;
- Affidavit of Senior Constable Caroline McGregor;

- Affidavit of Senior Constable Adam Lloyd;
- Licensing records with respect to the Heemskirk Motor Hotel (the Hotel)
- Correspondence from Tasmania Police (Inspector Nicholas Clark and Assistant Commissioner Adrian Bodnar) and the Commissioner for Licensing (Mr Jonathon Root and Ms Fiona McIntyre);
- Correspondence from Abetz Curtis, lawyers for Mr Mark Cleary, together with affidavits of Mr Cleary and Mr Mark King and policy documents of the Hotel; and
- Photographs and forensic evidence.

In summary at approximately 12:25 am on Saturday, 1 May 2021 Mr Douglas was driving his Toyota Land Cruiser dual cab utility registered number 1QM5DS in a north west direction on Main Street Zeehan. Mr Douglas was licensed to drive that vehicle and it was registered.

Main Street Zeehan consists of 2 lanes; one for traffic travelling in the direction Mr Douglas was driving and one for traffic travelling in the opposite direction. As Mr Douglas attempted to negotiate a left hand curve his vehicle entered into a yaw[1]. As a result the vehicle crossed onto the incorrect side of the road, hit the curb and started to roll. The vehicle then impacted with a brick and concrete pillar near the driveway to the Jehovah's Witness Kingdom Hall at 126 Main Street. This impact caused very significant damage to the vehicle and resulted in Mr Douglas sustaining fatal injuries. At the time of the crash the road was dry and in good condition and the weather was fine. The road had recently been resurfaced. The sign posted speed limit at the scene is 50 km/h; the nearest sign being approximately 300 m south east of the curve in the roadway which led to the point of impact.

Background

Mr Douglas was 24 years of age (date of birth 23 July 1996) and although he was not married he was in a relationship with Maranda Baker who says she was 9 weeks pregnant to Mr Douglas at the time of his death. Mr Douglas' parents are no longer together. His father, Shayne, resides in Zeehan whereas his mother, Suzanne, lives in Moe in Victoria. Mr Douglas has an older sister and 2 step siblings.

Mr Douglas grew up in Zeehan where he lived until he was 17 years of age at which point he moved to Moe. He went to school in Queenstown until year 9 after which he completed a Certificate III in building and construction and he commenced a carpentry apprenticeship. He lost his employment 3 months into that apprenticeship. It was at this point he moved to

[1] Made by a tyre that is rotating and sliding parallel to that tyre's axle. In this case it resulted when the rear of the vehicle which was cornering at high speed slipped sideways from the curved path of the corner it was negotiating.

Victoria where he worked for P and P Metal Fabrication for a period of about 5 years before Mr Douglas returned to Tasmania. In January 2021 Mr Douglas commenced an apprenticeship as a boilermaker welder with GBE Maintenance in Zeehan. He remained in that employment until the date of his death.

Mr Douglas enjoyed camping and motorcycle riding. He played in the local darts competition and enjoyed playing golf. He never had any major physical or mental health issues. He suffered some broken bones as a result of motorcycle riding however they were not serious, debilitating injuries. When he was 17 to 18 years of age he suffered from headaches and attended a neurosurgeon at which point a cyst was discovered on his pituitary gland however the cause of the headaches was not determined. His father says there were no concerns over his state of mind or his health generally. Records obtained from the medical practice Mr Douglas attended corroborate this evidence. Those records indicate he had not attended that practice since 2010.

Circumstances Leading to Death

Ms Baker says she saw Mr Douglas at around 11:00 am on 30 April 2021. He had a welding job to do and she says he was going to a party later that night and therefore he would be home late.

At approximately 3:00 pm Mr Douglas consumed some beer at Mr Nichols' home. They had been good friends for over 20 years. Mr Nichols says they *"planned on having a big night"* so they left Mr Douglas' vehicle at Mr Nichols' home and walked the 450 m or so to the Hotel situated at 25 Main Street. Mr Nichols estimates they were at the Hotel for about 6 hours until it closed. He was drinking Great Northern mid strength beer whereas Mr Douglas was drinking Carlton dry beer. Mr Nichols believes Mr Douglas may have had some top shelf alcohol as well. He estimates they consumed well over 20 10 ounce beers each. Mr Douglas gave Mr Nichols the keys to his vehicle at about 9:00 pm *"because he was pretty drunk and did not want to lose the keys."* Mr Nichols says Mr Douglas was struggling to walk. Before he left the hotel Mr Douglas asked for his keys back and said he was going to get something but would be back. He did not return. Mr Nichols says he and some other people went to his home for a party. On his return home Mr Nichols noticed Mr Douglas' vehicle was not present and so he tried to contact him on a number of occasions but did not receive an answer. He subsequently learnt about the crash and that Mr Douglas had passed away. He says if he knew Mr Douglas was going to drive he would never have given him his keys back because he was *"way too drunk to drive."*

Ms Baker says Mr Douglas told her he was going to have a counter meal at the Hotel at about 5:00 pm. She says he was messaging her throughout the afternoon sending her pictures of himself at the Hotel. At around 6:30 pm she and a friend went to the Hotel for dessert. She says she saw Mr Douglas and his friends outside smoking and he appeared to her to be drunk as he was speaking very loudly and he was unsteady on his feet. She did not speak to him and left about an hour later.

Between 7:00 pm and 7:30 pm she received a message from Mr Douglas indicating there was a rumour he was not the father of their child. She says the message sounded disturbed and Mr Douglas indicated he needed time away from her to get his head around things. He telephoned her between 10:00 pm and 10:30 pm and she says he was slurring his words. He said he wanted to pick her up and talk about what was being said. He said he was walking to Mr Nichols' home and would see her in 5 minutes.

CCTV footage shows Mr Douglas was present at the hotel until at least 12:14 am and he was significantly intoxicated[2]. It is at that time he walks out of the bar. Ms Baker says her last contact with him was at 12:06 am.

Investigation

The crash involving Mr Douglas was reported to police at 12:27 am. It was initially attended to by officers from Zeehan, Strahan and Rosebery police stations and the road was closed soon after their arrival. Personnel from AT, the Tasmania Fire Service and the State Emergency Service also attended the scene. AT received the call to attend this crash at 12:30 am and ambulance officers were at the scene 10 minutes later. There was nothing they could do to assist Mr Douglas as he had already passed away from the injuries he sustained.

At 12:48 am the crash investigation officer on call, Senior Constable Lloyd, was tasked to attend this crash. He was advised en route the crash involved one fatality. He arrived at 3:11 am at which time he was briefed by the officers who initially attended. The scene was marked and measured and a scene survey was prepared. Measurements of relevant incident marks were recorded. Senior Constable McGregor from Western Forensic Services photographed the scene at Senior Constable Lloyd's direction. Subsequently Constable Squire from Zeehan police station who is forensically trained took photographs of the scene in daylight hours at Senior Constable Lloyd's direction. The vehicle was inspected and transported to a nearby police compound.

[2] See the discussion about this issue from page 16 and following.

Senior Constable Lloyd says the north west bound lane in which Mr Douglas was driving transitions to a westbound lane with a left hand curve for traffic travelling in that direction. It was near the point where the road lanes start to straighten out that he observed yaw marks. He says both marks commenced approximately 3 m into the incorrect side or south east bound lane. He says the lanes are very wide in the area where the vehicle entered the yaw. Senior Constable Lloyd says the driver side rear yaw mark was the longest visible mark and it measured 43.6 m in length to where it ended at the edge of the concrete curbing for the south east bound lane. There were visible striations[3] through the yaw marks. The shorter yaw mark was 42.8 m in length and Senior Constable Lloyd attributed that to the driver side front tyre. There was evidence of both driver-side rims hitting the curbing with gouges at the end of each yaw mark. From the initial impact with the curbing the vehicle travelled approximately 13.5 m to where it impacted with a brick and concrete pillar. The vehicle commenced rolling over onto the driver-side after impact with the curbing. It did not fully end up on this side however as it remained slightly off the ground at the point of impact with the pillar. The impact with the pillar crushed the driver side behind the A pillar of the vehicle. This caused the B and C pillars and the entire vehicle roof to concertina back approximately 2.8 m and into the front of the flat tray area. There was minor bending of the passenger-side A pillar however the B and C pillars remained intact on the passenger side. The impact forced Mr Douglas sitting in the driver seat backwards causing the seat to break and the seatbelt which was being worn tear as the B pillar housing the seatbelt was totally destroyed. There was a secondary impact with a second brick pillar and a brick fence at which point Mr Douglas was thrown forward through the remainder of the windscreen where he impacted with the bonnet prior to being ejected. The vehicle has ended up in an upright position on all 4 wheels across the footpath and facing back in the general direction from where it came. Mr Douglas came to rest face down on the road surface although half of his body was resting on the footpath.

Senior Constable Lloyd calculated the critical curve speed of the curve which Mr Douglas travelled through. That speed is the maximum speed a vehicle can travel through the curve without losing traction resulting in a loss of control. The minimum speed at which traction would be lost was calculated to be 59 km/h. It was determined, as a result of downloading data from the airbag control module fitted to the vehicle, it was travelling at 101 km/h just

[3] Tyre marks sometimes exhibit striations; that is a pattern of lines or grooves on the surface of the road. In the absence of braking or partial braking, yawing tyres are simultaneously rolling and sliding which creates striation marks that run at an angle to the direction of the tyre mark. In the absence of braking, these striations are aligned at an angle perpendicular to the direction of travel of the tyre. In the case of full braking (lock-up) the striations are aligned with the tyre mark, or parallel to the wheel hub velocity direction. Because the striations are affected by both the angle in which the tyre is heading and the amount of braking, these tyre marks provide clues as to the actions of a driver when the tyre marks were deposited on the road.

prior to the crash. This speed is twice the signposted speed limit. Accordingly Senior Constable Lloyd concluded the vehicle could not have negotiated the curve and maintained control at the speed it was travelling at. Senior Constable Lloyd also concluded the weather conditions did not contribute to this crash and while there was loose metal, given the road had recently been resurfaced, towards the road edges which exacerbated the loss of control it was not a major contributing factor. I agree with his conclusions which he is well qualified to provide.

The vehicle was inspected by Mr Fitzpatrick who is a transport inspector employed by the Department of State Growth. He is a qualified diesel mechanic with 14 years' experience in the motor trade. At the date he inspected the vehicle he had been employed as a transport inspector for in excess of 8 ½ years. After inspecting the vehicle he concluded that prior to and at the time of the collision the vehicle would have been mechanically sound but was deemed to be unroadworthy due to it not having a rear number plate light or any mud flaps fitted. These deficiencies were not in any way causative of this crash. I accept Mr Fitzpatrick's opinion.

Dr Ritchey performed a post-mortem examination on 4 May 2021. As a result of performing that examination he says the cause of death was multiple blunt traumatic injuries which were sustained in this crash. The post mortem examination revealed Mr Douglas had suffered a number of severe traumatic injuries to his head and chest with associated internal bleeding and injuries to his arms and legs.

Mr McLachlan–Troup says he determined, from the blood sample taken at autopsy, a blood alcohol reading of 0.261 g of alcohol in 100 mL blood. He says a blood alcohol reading at that level has the potential to significantly impair driving performance and increase relative crash risk. It has been estimated the relative risk of a driver with a blood alcohol concentration of 0.180 g of alcohol in 100 mL blood being involved in a crash is approximately 50 times that of a driver with no alcohol in his or her blood. The risk in this case was therefore, given the reading, significantly higher than that. He says ethanol is a central nervous system (CNS) depressant and its effects on the CNS are proportional to its concentration in the blood and cognitive, sensory and motor disturbances increase at higher blood alcohol concentrations. Mr McLachlan–Troup says the general effects of alcohol include loss of critical judgement, incoordination, reduced perception and awareness, impaired balance, sedation, nausea and vomiting, reduced responsiveness and decreased intellectual performance. The depression of psycho motor and cognitive functions due to alcohol causes impairment of critical functions required for driving including reaction time, coordination, information processing and reflexes. There is also an associated increase in risk-taking and speed variation. I accept his opinion.

Liquor Licensing Act 1990

Part 2 of the *Liquor Licensing Act* 1990 (the Act) regulates the sale of liquor.[4] Division 5 of Part 2 sets out the obligations of a licensee. The major obligations of a licensee which are relevant to this case are set out in s46 and s46A. Section 46 requires that a licensee must ensure the business carried on, on the licensed premises, is carried on in such a way that the licensee can exercise effective control of the sale and any consumption of liquor on the premises. Section 46A requires a licensee to ensure the responsible sale and service of liquor. This is achieved by way of a licensee not allowing a person to serve or sell liquor on the licensed premises unless that person has completed an approved course which means a course of instruction or training in the service of liquor approved by the Commissioner; that is the Commissioner for Licensing.[5] In addition an applicant for a liquor permit must successfully complete an approved course if directed by the Commissioner and the licensee must keep such records on the licensed premises as the Commissioner, by written notice served on the licensee, may from time to time require and the licensee is to produce all or any of those records to the Commissioner or an authorised officer on demand.

Division 6 of Part 2 sets out a number of offences. Relevant to this case are ss78, 79 and 79A. Section 78(1) prohibits a person from selling or serving liquor on licensed premises to a person who is intoxicated. Subsection 2 deems a licensee guilty of an offence if a person authorised by the licensee sells or serves liquor on licensed premises to a person who is intoxicated. Section 79 prohibits the supply of liquor to a person who is intoxicated on licensed premises and section 79A provides a licensee who knows or has reason to believe that an offence under this or any other Act is being, or is about to be, committed on the licensed premises must take reasonable action to prevent the commission of the offence.

Division 7 of Part 2 provides for the administration of licensed premises by authorised officers and police. An authorised officer is a person appointed by the Commissioner, pursuant to s209, *"…for the purposes of this Act…"*. Section 209(5) provides that any power or duty that may be exercised or performed under the Act by an authorised officer may be exercised or performed by the Commissioner. Section 85 permits an authorised officer, at any time, to enter and inspect licensed premises and any other premises belonging to the

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[4] Liquor is defined in s3 as meaning a) a beverage (other than a medicine) that –
(i) is intended for human consumption; and
(ii) has an alcoholic content greater than 0 ·5 per cent by volume when at a temperature of 20 degrees Celsius; or
(b) any other substance that –
(i) is prescribed as liquor for the purposes of this definition; and
(ii) has an alcoholic content greater than 0 ·5 per cent by volume when at a temperature of 20 degrees Celsius.

[5] Commissioner for Licensing is defined in s3 as the Commissioner for Licensing appointed under s207.

licensee or under the licensee's control which are provided for the use of patrons of the licensed premises. Section 86 provides an authorised officer with wide powers which include:

(1) requiring a person, by written notice served on the person, to provide the officer within the period specified in the notice with a statement containing such particulars relating to dealing with liquor as are specified in the notice.

(2) an authorized officer may, without warrant and with such assistants as he or she considers appropriate –

- at any time during which liquor may be sold on permit premises, enter and remain on those premises; and
- at any reasonable time, enter and remain on licensed premises; and
- at any reasonable time, enter and remain on any premises (other than any premises used as a residence) which the authorized officer has reason to suspect is being, or has been, used for the purpose of –

  (i) carrying on the business of selling liquor; or

  (ii) storing liquor or records or other documents in connection with the business of selling liquor.

(3) an authorized officer may, with the authority of a warrant issued under subsection (5) and with such assistants as he or she considers appropriate –

- use such reasonable force as is necessary to enter and remain in any premises specified in subsection (2) at the relevant time so specified; or
- use such reasonable force as is necessary, at any reasonable time enter and remain in any premises used as a residence.

(4) In any premises lawfully entered, an authorized officer may do any one or more of the following:

- inspect the premises;
- search for, examine, take possession of, make copies of, take extracts from or secure against interference any records or other documents relating to the purchase, other obtaining, sale or other disposal of liquor;
- search for, examine, take possession of or secure against interference any liquor that –

(i) may be evidence of a contravention of this Part, a liquor licence, a liquor permit, a liquor restriction order or a condition of a liquor licence, liquor permit or liquor restriction order;

- if it is necessary to do so, break open and search anything on the premises in which such records or other documents or liquor may be stored or concealed;
- require any person on the premises to produce any such record or other document;
- require a person on the premises to answer a question relevant to any of the following matters if the officer reasonably suspects that the person has the knowledge necessary to answer it:

  (i) the contravention of a liquor licence, liquor permit, liquor restriction order or condition of such a licence, permit or order;

- seize anything which the authorized officer believes appears to indicate that an offence under this Act has been, or is being, committed;
- require any person on the premises to provide his or her name and address.

(5) On the application of an authorized officer, a magistrate or justice may issue a warrant to the authorized officer named in the warrant authorizing the authorized officer to use such force as is reasonably necessary to enter and remain in any premises specified in subsection (2) or to enter and remain in any premises used as a residence, using such force as is necessary, if the magistrate or justice is satisfied that there are reasonable grounds for believing it necessary for the officer –

- to use such force to enter any premises specified in subsection (2) ; or
- to enter any premises used as a residence, using such reasonable force as is necessary, for the purpose of exercising or performing his or her powers or duties under this Act.

Section 89 empowers police to enter licensed premises at any time to ascertain if Part 2 of the Act is been complied with. Section 90 permits a police officer, who has reasonable grounds for believing that liquor is being sold on premises contrary to Part 2, to enter those premises. Section 91 provides police may use reasonable force to enter premises if they are barred and to be accompanied by as many other people as the officer reasonably considers necessary. Police are afforded further powers in ss92 to 97.

Division 8 of Part 2 provides for the taking of disciplinary action against a licensee. The grounds for taking disciplinary action are set out in s99 and they include a licensee contravening a provision of the Act and the licensee being no longer able to exercise effective control over the sale or consumption of liquor on all or any part of the licensed premises. The procedure for taking disciplinary action against the licensee by the Commissioner is set out in s100. Sections 101, 102 and 103 provide for disciplinary action to be taken by letter of censure, fine or cancellation or suspension of a liquor licence.

Given this regime I asked both Tasmania Police and the Commissioner for Licensing the following questions:

1. What, if any, investigation was conducted with respect to this motor accident and whether the licensee had complied with his obligations under the *Liquor Licensing Act* 1990 and whether the licensee had committed an offence under that Act?
2. If no investigation was conducted could they please explain why?
3. If an investigation was conducted, then copies of all documents produced as a result of that investigation was sought.
4. What, if any, enquiries were made in the 12 months prior to this motor accident and in the 12 months after it to ensure compliance with the Act by the licensee?
5. If no enquiries were made then an explanation was sought.

Tasmania Police responded as follows:

1. No investigation was conducted by the Licensing Division of Tasmania Police.
2. This is because the West and Northern districts of Tasmania Police do not have a full-time licensing section. Only the South does. However I was advised that in the days and months after this accident the officer in charge of the scene/Rosebery area undertook operations aimed at licensed premises in the area which included:
    - licensed premises check;
    - high profile random breath test and oral fluid test activities near licensed premises;
    - engagement with staff at licensed premises;
    - specific liaison with staff at the licensed premises involved in this accident; and
    - Western Road policing services also undertook road safety operations in the following weeks to provide an additional high visibility policing presence in the Zeehan area.
3. No documents were produced.

4. No enquiries were made in the 12 months prior to this motor accident and in 12 months after it to ensure compliance with the Act by the licensee.
5. No enquiries were conducted because there was no licensing section. I was informed if issues were identified then these were passed on to the local police division for attention.

Since receiving my questions I have been advised there has been a discussion with Inspector Gary Williams who is the State Road Safety Coordinator with respect to what actions should be taken when crash investigations identify that significant alcohol consumption may have taken place at licensed premises prior to a serious or fatal motor vehicle crash. This is to be discussed at the next Senior Traffic Officers (STO) forum to determine a consistent state-wide approach to ensure this information is passed to the relevant officers and/or the Commissioner for Licensing for further follow-up with respect to any perceived licensing issues.

My comments with respect to the response from Tasmania Police are the Act gives police certain powers. It does not restrict those powers to police officers attached to any licensing division. The police response is those powers were not exercised in this case because there is no licensing division. Accordingly there was no police oversight of the sale of liquor in this case and no investigation after the death of Mr Douglas. I note the purpose of the Act, as set out in the Long Title, is to regulate the sale of liquor. The objects of the Act, set out in s2A, are to regulate the sale, supply, promotion and consumption of liquor so as to, amongst other things, minimise harm arising from its misuse. That did not occur here. While I accept the measures implemented by Tasmania Police are helpful in ensuring the proper regulation of the sale of liquor the problem is they were implemented after Mr Douglas' death. Unfortunately I was not provided with any more detail about these measures other than what is set out on pages 10 and 11. I therefore do not know for example what licensed premises were checked and what those checks entailed, what liaison with staff at licensed premises and at the Hotel occurred, what that liaison consisted of, who was spoken to, when they were spoken to and what was said. Importantly there seems to have been no liaison with the Office of the Commissioner for Licensing about this licensee or about this motor accident.

The Commissioner for Licensing responded as follows:

1. No investigation was conducted into the accident by him personally or by his office.
2. No investigation was conducted because neither himself nor any person in his office knew that the circumstances of the accident may have had any connection with a possible contravention of the Act. My associate's email to his office of 30

May 2023 was the first time he or any person in his office was made aware of the fact the accident may be related to alcohol consumption at a licensed premises. In addition he advised *"that in January 2014 the Department of Police and Emergency Management (Tasmania Police Service) and the Department of Treasury and Finance entered into a memorandum of understanding establishing protocols for the exchange of information for the purposes of the Liquor Licensing Act 1990. The objective of that document was to assist in meeting the legislative obligations of both Agencies as they relate to the Act and "To describe the process for the exchange of information between Tasmania Police and Liquor and Gaming relating to an incident of violence, anti-social behaviour, disorderly conduct, annoyance or disturbance being reported to have occurred inside, on, or in the neighbourhood of licensed premises." This memorandum of understanding has since been updated to a Letter of Understanding and Guidelines for Information Sharing between the Department of Police, Fire and Emergency Management and the Liquor and Gaming Branch, Department of Treasury and Finance."* The letter of understanding is dated 26 October 2020 and the Guidelines are dated September 2020 and I was provided with a copy of both documents. The letter of understanding indicates information exchange is predominantly from Tasmania Police to the Liquor and Gaming Branch of the Department of Treasury and Finance and takes the form of routine disclosures and ad hoc requests. An example of information shared by the Liquor and Gaming Branch with Tasmania Police is notice of any significant action taken by the Commissioner for Licensing under the Act. An example of information shared by Tasmania Police with the Liquor and Gaming Branch is the provision of a monthly spreadsheet detailing a brief summary of incidents that occurred within the proximity of licensed premises. A police liquor licensing report is also to be provided when a serious incident involving the sale, consumption or control of liquor occurs on licensed premises. Given the response by the Commissioner for Licensing that did not occur in this case.

3. No documents were produced because no investigation was undertaken.
4. The enquiries which were undertaken were on 10 July 2019 the licensee, Mr Mark Cleary, was interviewed by telephone. Then on 14 October 2020 there was an inspection of the Hotel undertaken by an authorised officer. Finally after the accident, on 29 September 2021, there was an inspection of the Hotel undertaken by an authorised officer. I was provided with documents in relation to the interview with Mr Cleary and the 2 inspections. The interview document sets out what transpired when Mr Cleary was interviewed at the time he made application for the liquor licence for the Hotel to be transferred to him. The interview was conducted by an authorized officer. The Commissioner for Licensing advised he

requires every applicant for a liquor licence to undertake an interview with one of his staff. This process requires the authorized officer to ask a series of questions of the applicant, relevant to a licensee's obligations under the Act. The purpose of the interview is to ensure the Commissioner can be satisfied the applicant understands the legislative requirements of the Act and to assist in his determination as to whether an applicant is qualified to be granted a liquor licence pursuant to s22 of the Act. Section 22 of the Act requires the Commissioner, amongst other things, to be satisfied that the person will be able to exercise effective control over the service, and any consumption, of liquor on the premises relevant to the licence. Following the interview with Mr Cleary, the authorized officer advised *"…the applicant was well prepared for the interview after reading the "Guide to Tasmanian Liquor Licensing Laws for licence holders". The applicant demonstrated a very responsible attitude during the interview and displayed an intention to exercise effective control over the sale and consumption of liquor on the premises"*. Further the authorised officer advised *"[a]fter interviewing the applicant, I can confirm that the applicant demonstrated a satisfactory knowledge of the Liquor Licensing Act 1990, including being able to answer specific questions concerning responsible service of alcohol, effective control, young people, associates of a liquor licence and the conditions on the Licence being applied for"*. The checklist for the inspection of the premises on 14 October 2020 contains 16 sections marked A to O, only one question in section C and section M deal with liquor. The question in section C asks whether certificates or proof of enrolment in a responsible service of alcohol course are available for inspection and section M asks questions as to whether the liquor licence, restricted area and prohibited area signs and an out of hours permit are on display. Three of the questions in section M are not applicable to the Hotel. The inspection was conducted with the licensee of the premises, Mr Mark Cleary. The Commissioner advises the process of the inspection is an audit of the premises against the legislative requirements of both the Act and the *Gaming Control Act* 1993. He also advised the checklist lists items the inspector must discuss with the licensee to confirm whether legislative requirements are being met. As part of the inspection process, the inspector reviews the responsible service of alcohol certificates of those staff working within the premises to ensure they are valid. The checklist for the inspection of the Hotel on 29 September 2021 by an authorized officer is in the same form as the previous inspection on 14 October 2020. This inspection was again conducted with the licensee of the premises, Mr Mark Cleary.

5. This question is not applicable given the answer to question 4.

Finally the Commissioner for Licensing advised:

"[o]fficers of the Liquor and Gaming Branch undertake functions under both the Liquor Licensing Act 1990 and the Gaming Control Act 1993. Compliance Inspectors employed by the Department of Treasury and Finance are appointed as authorized officers pursuant to section 207 of the Liquor Licensing Act 1990 and as inspectors pursuant to section 128 of the Gaming Control Act 1993 and inspections typically review compliance against both Acts, to ensure efficiency and the ability to regularly undertake inspections at all licensed premises across Tasmania. Premises with General liquor licences and gaming licences are inspected annually, at a minimum. This is increased should I, or the Liquor and Gaming Commission consider the premises has a higher risk profile, for example, the premises has had recent contraventions of either Act".

My comments with respect to the response by the Commissioner for Licensing are that given he, or anyone in his office, were unaware that there was a connection between this accident and a possible breach or breaches of the Act then this suggests the Letter of Understanding and the Guidelines for the sharing of information between the Police and the Liquor and Gaming Branch of the Department of Treasury did not operate as intended. The statements by the licensee that he intended to exercise control over the sale and consumption of liquor at the Hotel and that he was able to answer questions with respect to the responsible service of alcohol are taken at face value or on trust. Apart from ensuring, at yearly inspections, that staff are appropriately trained in the responsible service of alcohol there are no other checks and balances to ensure compliance with ss46, 46A, 78, 79 and 79A. Neither Police or the Commissioner for Licensing, either in his capacity as the Commissioner or via authorised officers, used their extensive powers in this case to determine whether there had been compliance with the Act. In addition I note the Commissioner, authorised officers and the police are required to further the objects of the Act, which include regulating the sale, supply, promotion and consumption of liquor so as to minimise harm arising from its misuse, when performing any function or exercising any power under the Act[6].

The enforcement of offences under the Act is the responsibility of Police, who have authority to issue infringement notices[7]. The Commissioner's statutory responsibilities include consideration of applications for liquor licences[8] and liquor permits[9] and, where appropriate, undertaking disciplinary action against a licensee or permit holder.[10]

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[6] Section 2A(2).
[7] See s223(1). For what amounts to a prescribed offence in this section see *Liquor Licensing (Infringement Notices) Regulations* 2018. A breach of ss46, 46A,78, 79 and 79A are prescribed offences. See regulation 4 and schedule 1 of those Regulations.
[8] Section 24.
[9] Section 33.
[10] Sections 98-104.

Opportunity to Comment

My draft findings were forwarded to Tasmania Police, the Commissioner for Licensing and to the licensee, Mr Mark Cleary, of the Hotel for comment. The response of Assistant Commissioner Bodnar on behalf of Tasmania Police is in the following terms:

"Tasmania Police acknowledges that there are opportunities to take further action where crash investigations identify that significant alcohol consumption may have taken place at a licensed premises, prior to a serious or fatal motor vehicle crash. I can confirm that the next Senior Traffic Officers (STO) meeting will consider this issue to ensure a consistent state-wide approach regarding information sharing and actions that should be undertaken with Liquor and Gaming in respect to such matters. I note that the Letter of Understanding between the Department of Police Fire and Emergency Management (DPFEM) and Liquor and Gaming referred to in your draft findings, enables the sharing of information in respect of such matters.

Having considered the draft findings, Tasmania police is not opposed to any of the recommendations to be made regarding this unfortunate death."

The Commissioner for Licensing indicated he did not have any comments to make with respect to the draft findings.

My office received a letter from lawyers acting on behalf of Mr Cleary which indicated he was concerned with a number of the draft findings which were identified in the letter and that he had not had an opportunity *"to be directly involved in the investigation, lead evidence, or provide detailed submissions in [his] defence"* or *"an opportunity to challenge any of the evidence of Mr Nichols or Ms Baker, nor to lead any evidence from bar staff as to what they observed or were in a position to observe. In particular, we are instructed that the Hotel was not ever asked to produce records to verify the number of drinks consumed by Mr Douglas or Mr Nichols."* Accordingly Mr Cleary was invited to provide any affidavits as to these issues and to produce any records with respect to the number of drinks consumed by Mr Nichols and Mr Douglas. Some affidavits and documentation, detailed below, were provided. I was advised by Mr Cleary's lawyer that apart from the provision of CCTV footage by a staff member of the Hotel no staff were interviewed nor did they provide a written statement to police in the weeks or months following the accident. The letter says: *"[i]n saying this, the Hotel makes no criticism of the police or the way the investigation was conducted, but simply makes the observation that more information may have been available closer to the date of the accident."* I agree with that comment but unfortunately as is clear from the response from Tasmania Police the motor accident circumstances of this death were the only circumstances investigated by that organisation and that resulted in no bar staff or Mr Cleary being interviewed.

The statement made by Mr Cleary's lawyers that Mr Cleary had not been given an opportunity to be involved in the investigation, lead evidence or provide detailed submissions in his defence demonstrates a misunderstanding of the nature of an inquest. This proceeding is an inquiry or inquisitorial proceeding. It is not a proceeding between parties[11], nobody is on trial and a defence is not required. A coroner is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the C*oroners Act* 1995 asks. Those questions include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions. A coroner therefore does not have the power to charge anyone with offences arising out of the death the subject of investigation. That said Mr Cleary has been given an opportunity by me to comment on my draft findings, challenge any of the evidence, make submissions and provide evidence which was not sought by Tasmania Police.

In his affidavit Mr Cleary says he was not on duty at the hotel on 30 April 2021 but he did attend to *"catch up with the locals for a quick drink and chat."* He says he met Mr Douglas at around 9:00 pm and *"he did seem okay to me at this stage..."* Mr Cleary left shortly thereafter. He says he does not have a culture of sales over patron safety and when required water is offered or patrons are simply refused service if it is deemed a patron *"has had or getting close to having too much."* He says on Friday nights his hotel provides substantial bar snacks for free which run between 6:30 pm to around 7:30 pm. Last drinks are called between 11:00 pm and 11:30 pm so that all patrons have left by midnight which he says was the case on this particular evening. As to the responsible service of alcohol he says there is no requirement in relation to the number of drinks to be monitored but that staff take into account a customer's behaviour and mannerisms including speech patterns. He says it is extremely difficult to monitor how many drinks a person has at the bar as there are different areas in the hotel e.g. the public bar and Lounge bar and people sometimes get involved in shouts as well. It is also unknown to bar staff how much alcohol a person had to drink before they arrive at the Hotel.

A second affidavit of Mr Mark King was provided by the lawyers for Mr Cleary. Mr King was employed at the Hotel as a gaming attendant between 2021 and 2022 and he says a major component of his job included the responsible service of alcohol. He does not specifically recall the night of 30 April 2021 but says he was on duty because he worked every Friday night. He does not recall Mr Douglas. He has held a responsible service of alcohol qualification in both New South Wales and Tasmania for approximately 10 years and he says

[11] *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASFC 4 at [21] and the cases cited therein.

he stringently monitors patrons for signs of intoxication and employs strategies for providing non-alcoholic beverages and when applicable he cuts off the service of alcohol to patrons. He says management of the Hotel has always supported staff when a patron is denied alcohol and he says management are strict when it comes to the responsible service of alcohol. He goes on to say management is serious about not creating a culture of excessive alcohol consumption. He says any patron demonstrating physical signs of intoxication is no longer served alcohol but is given bottles of water and removed from the premises if they are aggressive or antisocial. He confirms bar snacks are provided between 6:30 pm and 7:30 pm and the dinner service at the Hotel runs between 6:00 pm and 8:30 pm. Outside of those hours food is available until closing time in the form of bar snacks. Water is provided free of charge at all times. He commences closing the gaming room down between 9:00 pm and 9:30 pm and that task is complete by 10:30 pm. He then starts to close the TAB and where possible Keno. While he is doing that other staff are located in the main bar monitoring patrons and once he completes his tasks one staff member will be signed off leaving one other staff member and himself in the main bar. Last drinks would then be called. He says on numerous occasions he has provided a lift home to patrons given that he resided in Queenstown at the time.

In addition I was provided with notices the first to all staff indicating it was their right to refuse service to intoxicated or disorderly customers and they had the support of management if they requested a customer to leave the premises. The second notice is titled *Code of Conduct House Policy* and it indicates intoxicated people will not be served and will be asked to leave the premises and those failing to do so will be reported to police. In addition underage persons will not be served alcohol and any person purchasing alcohol for an underage person will be asked to leave. There are a number of other rules set out in the Code but these are not related to the sale, service or consumption of alcohol.

It was submitted by Mr Cleary's lawyers that statements made by Mr Nichols and Ms Baker on pages 3 and 4 above imply Mr Douglas was significantly intoxicated. The evidence in the affidavits of Mr Cleary and Mr King suggest the contrary given the stringent implementation of the responsible service of alcohol policy.

Despite the evidence and the submissions provided by Mr Cleary it is clear to me Mr Douglas was significantly intoxicated. Even if the statements made by Mr Nichols and Ms Baker are ignored the blood alcohol reading of Mr Douglas shows his reading was in excess of 5 times the legal limit. In addition I have carefully considered the CCTV footage provided by Mr Cleary's bar manager Mr Maine. It reveals the following:

- Mr Douglas arrived at the Hotel at 4:45 pm on 30 April 2021 and he left at 12:14 am the next morning. He was therefore at the Hotel for almost 7 ½ hours.
- Bar staff are still serving customers at approximately 12:10 am on 1 May 2021.
- During the period Mr Douglas is at the Hotel he purchases 26 glasses of beer and consumes 25. The glasses are at least 10 ounce glasses (285 mL) but they may be larger. He purchases one glass of beer for one other patron but does not receive a beer in return from that patron. At one stage he buys two glasses of beer one of which he consumes while the other is consumed by a friend and then on the next occasion his friend purchases a glass of beer for Mr Douglas. He was only ever in this one shout with one other person which consisted of them buying each other one beer each.
- Three dinner size plates of bar snacks are served to patrons at 6:42 pm. At that time there are 31 people in the bar. Mr Douglas is not observed to consume any food in the bar. It is unlikely he purchased a meal and ate it elsewhere in the Hotel because even though he left the bar regularly I suspect this was to smoke a cigarette[12] as he is seen rolling a cigarette from time to time. The longest period he is absent from the bar at any stage is 24 minutes. When exiting he uses the same door to the bar that many other patrons are regularly using to leave and then he re-enters a short time later, on each occasion, through the same door.
- There is a marked difference in his demeanour and steadiness on his feet when footage depicting his arrival is compared with later footage. By 7:53 pm, by which time Mr Douglas has just purchased his 14th beer, his walking and balance appear affected by the consumption of alcohol. By 9:21 pm he attempts to trip a male person and 2 minutes later he is patting another person on the head. His coordination is clearly affected and he loses his balance at 9:28 pm. As time passes he becomes more disinhibited as he hugs a male person, and pats a number of other people on the head. He then trips getting off a chair. On a number of occasions thereafter he appears to be unsteady on his feet. By approximately 11:00 pm when he leaves the bar for a short period he is staggering. Ten minutes later while trying to send a text message he is unsteady on his feet and shortly thereafter he stumbles back. At 11:45 pm he nearly falls into the bar and 3 minutes later the barman brings Mr Douglas his 25th beer without much more than observing him at the bar from the other end. At the time he observes Mr Douglas the barman is speaking to the barmaid at the

[12] Toxicology also revealed the presence of nicotine in the blood sample of Mr Douglas.

other end of the bar to Mr Douglas so it appears Mr Douglas does not even order a beer. When paying Mr Douglas appears to have difficulty handing over the money. Mr Douglas is also observed to drop his phone.

- Shortly after midnight Mr Douglas nearly falls onto and then off a bar stool prior to sitting on it without falling to the floor. A couple of minutes later he falls to the floor and is helped to his feet by another patron. As he walks towards the exit door he trips into a chair before shaking hands with a male person and hugging him. He then leaves the premises for the final time.

Comments and Recommendations

Having considered all of the evidence in this matter I am satisfied this crash occurred because Mr Douglas drove with a blood alcohol reading in excess of 5 times the legal limit and at excessive speed. This case serves as yet another reminder that driving with an excessive blood alcohol concentration and/or at excessive speed can have very tragic consequences.

As mentioned above one of the objects of the *Liquor Licensing Act* 1990 is to regulate the sale, supply, promotion and consumption of liquor so as to minimise harm arising from its misuse. One of the methods by which s2A says the minimisation of harm is achieved is through encouraging a culture of responsible consumption of liquor. Clearly Mr Douglas did not responsibly consume alcohol while present at the Hotel on the 30 April and 1 May 2021. There has been an absence of such a culture in a number of other cases I have examined as a Coroner. Relying on any licensee and his or her staff "to do the right thing" in circumstances where the licensee has a direct financial interest in selling as much liquor as possible does not encourage the responsible service or consumption of liquor. In my view the only way this can be achieved is for there to be regular, random spot checks of licensed premises to ensure that alcohol is being served responsibly, and where there is evidence of a breach in this regard then that breach is fully investigated, and if appropriate, proceedings against a licensee are instituted. Where a breach is established either by an infringement notice being accepted by the licensee or by a subsequent complaint being proved then disciplinary proceedings should be instituted by the Commissioner for Licensing.

I therefore **recommend** there be improved communication between Tasmania Police and the Office of the Commissioner for Licensing with respect to potential breaches of the Act and that there be a joint initiative so that regular, random spot checks of licensed premises are conducted, any potential breaches are fully investigated and prosecuted and any appropriate disciplinary action is then taken against the licensee. Should this not occur then I expect there will continue to be deaths in similar circumstances to that of Mr Douglas in the

future because there appears to be nothing which deters a licensee to comply with his or her obligations under the Act.

The circumstances of Mr Douglas' death are not such as to require me to make any further comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I extend my appreciation to investigating officer Senior Constable Adam Lloyd for his investigation and report.

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

Dated: 31 August 2023 at Hobart in the State of Tasmania.

Robert Webster
Coroner