



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Leigh Mackey, Coroner, having investigated the death of Russel David Morrison

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

- a) The identity of the deceased is Russel David Morrison (date of birth 23 February 1965). Mr Morrison was born in Orbost, Victoria. He was one of eight children and spent his childhood and much of his adult life in the Orbost region. He was a single man, having separated from his wife Paula Morrison, and enjoyed cars, boats and sailing.

Mr Morrison was a qualified mechanic and held a wide variety of positions, primarily within the mechanical and transport industries as a mechanic and driver. He worked throughout Australia and overseas, including in the oil and gas industry in India, Singapore, China, Russia, Borneo, the Timor Sea and Bass Strait. In later years he returned to the logging industry and operated his own log truck business in East Gippsland before relocating to Tasmania in search of employment opportunities following a decline in the Victorian logging industry.

Mr Morrison had a psychiatric history. In approximately 2012 he was diagnosed with bipolar disorder and was prescribed sodium valproate as a mood stabiliser. Whilst his condition was generally stable, at times he experienced manic episodes characterised by impulsivity, reduced need for sleep, excessive spending, risk-taking behaviour, erratic driving, aggression, and poor judgement. He was largely estranged from his seven full and half brothers and sisters.

Mr Morrison had a longstanding history of alcohol abuse. He regularly consumed alcohol and lost his driver's licence on two occasions for drink-driving offences. Prior to his death he had been motivated to reduce his alcohol intake and was prescribed medication to assist with his alcohol dependence. He also held a firm belief that he was infected by parasites

particularly in his mouth and internally. These complaints were investigated by his doctor, with no parasitic invasion identified.

- b) In 2022, Mr Morrison moved to Tomahawk, Tasmania. He brought his log truck and trailer with him and secured work as an independent contractor hauling logs and other freight in north-west Tasmania. He was a skilled and experienced operator of vehicles, trucks, boats and machinery.

In the weeks prior to his death Mr Morrison experienced episodes of collapse, difficulty standing and fatigue. On 5 March 2024 he was taken by ambulance to the emergency department of the North West Regional Hospital (NWRH) with a history of dizziness over the last month, multiple blackouts and agitation. A CT scan identified a resolving left frontal haemorrhage with minimal residual abnormality. This injury had been sustained following a head strike on 17 January 2024 when Mr Morrison fell whilst drinking and in respect of which he had previously self-discharged from the NWRH declining treatment. At the NWRH on 5 March 2024 Mr Morrison's liver function tests were markedly deranged however he refused admission for treatment of his likely alcoholic liver disease and again self-discharged.

On the morning of 10 March 2024, Mr Morrison drove his 2004 Ford XR8 utility vehicle (the Ford) from Burnie to Newnham, to visit his friend, Leslie Brown. He arrived at 8.00am. The distance between Burnie and Newnham is approximately 152 km and is an approximate 2.5-hour drive. He told Mr Brown that he was tired and had stopped during the drive to nap for approximately one hour.

Later that morning Mr Morrison left Newnham and drove to George Town to consult a general practitioner because of an acute attack of gout. During that consultation he reported increased alcohol consumption. He returned to the Newnham house at approximately 2.00pm. During that afternoon and evening, he remained at Newnham with Mr Brown, drank beer and had a meal. Whilst there he napped in an armchair and, given the presence of blankets, likely slept on the couch. At 1.10am Mr Brown heard Mr Morrison leave the Newnham home, driving the Ford. Mr Morrison headed home to Tomahawk, a journey of approximately 116 km taking 1.5 hours.

After leaving Mr Morrison called Mr Brown from a service station and appeared “*fine, good as anything*”.¹ At approximately 4.45am on 11 March 2024 a motorist driving on Tomahawk Road saw the Ford on the side of the road with significant damage. The motorist notified a local resident and volunteer firefighter, David Burnie. Mr Burnie attended the location contacted emergency services and recognised the Ford as belonging to Mr Morrison. He found Mr Morrison, deceased, lying approximately 20 metres away from the wreckage.

Toxicological analysis of a sample of Mr Morrison’s post-mortem blood detected alcohol, diazepam, doxylamine, meloxicam, loperamide and loratadine. Alcohol was present at a concentration of 0.067 g/100ml of blood. The combination of alcohol, diazepam and doxylamine can impair driving performance by causing reduced alertness, sedation, and impaired concentration.

- c) Mr Morrison’s cause of death was multiple (head spine, chest, pelvic and limb) injuries due to a single motor vehicle crash.
- d) Mr Morrison died on 11 March 2024 at Tomahawk, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavit confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Affidavit of Paula Morrison, sworn on 13 February 2025;
- Affidavit of Leslie Brown, sworn on 11 March 2024;
- Affidavit of David Burnie, sworn on 11 March 2024;
- Affidavit of Ben Mumford, sworn on 13 June 2024;
- Crash Investigation Services Report;
- Police reports and corresponding affidavits, statutory declarations, body worn camera footage, and scene photos;
- General practitioner and Tasmanian Health Service records;
- Toxicology report of forensic scientist, Mr N McLachlan-Troup;
- Affidavit of Barry Spencer, Transport Safety and Investigation Officer, sworn 7 March 2025;

¹ Affidavit of Leslie Brown sworn 11 March 2024 p2.

- Crash history records;
- License and registration details, and police records;
- Traffic Crash Report; and
- Phone records.

The cause of the accident

The accident occurred on Tomahawk Road between Waterhouse Road and the township of Tomahawk, a remote coastal town in the northeast of Tasmania. The road is a bitumen sealed carriageway orientated in a generally north/south direction and is open for use for traffic travelling in either direction. It was 5.7 m wide with 0.9 m verges on its eastern and western sides wide. The road did not have centre or edge line markings and, after an approximate 1.5 km straight stretch, gently curved to the left. The applicable speed limit was 100 km/h.

At the time of the accident Mr Morrison was travelling toward Tomahawk on Tomahawk Road in a northerly direction. The road surface was dry and in good condition. There were no matters relating to the road, the environment nor the weather that contributed to the accident. The Ford was inspected by, Mr Barry Spencer, a Transport Safety and Investigation Officer with the Department of State Growth, who identified several defects; three tyres were worn below the legal tread depth; the front tyres were mismatched in profile size; and a rear brake calliper slide was seized. None of the defects were believed to have contributed to the accident

Examination of the accident scene identified tyre marks beginning on the gravel verge on the eastern side of the roadway extending for approximately 47.5 m before returning to the sealed road surface created by the right-side wheels of the Ford. These marks reflected the movements of the Ford drifting onto the incorrect side of the road and entering the verge. The tyre marks returned to and continued on the bitumen surface of the road for approximately 32.8 m and then to scuff marks, scrapes and gouges on the grass verge on the western side of the road. The tyre marks, scrapes and gouges are consistent with the Ford, re-entering the road, travelling across it and onto the opposite verge, tipping and rolling over. The vehicle rolled for approximately 73 m before coming to rest upright on the western side verge facing towards the road.

The tip and rollover of the Ford caused catastrophic structural damage. The driver's door was torn completely from the vehicle. The driver's side roof structure collapsed significantly, and major deformation occurred throughout the vehicle body. Mr Morrison's personal belongings were scattered across a wide area around the crash

site. Mr Morrison was ejected from the Ford as it rolled and landed approximately 20 m from the Ford's final position.

The driver's seatbelt was found to be clipped into its buckle and intact after the accident. The belt had markings consistent with it being worn and force being exerted on it at least twice prior to Mr Morrison's ejection from the Ford. The Ford was fitted with airbags which were not fired by the rotational forces of the accident.

Investigators were unable to obtain pre-crash data from the Ford's airbag control module due to the age of the system. Consequently, data establishing the Ford's speed immediately prior to the crash could not be obtained. The extent of the damage to the Ford, the distance travelled whilst it rolled, the detachment of the driver's door and the ejection of Mr Morrison some distance from the Ford, all indicate that the Ford was travelling at significant speed and above the applicable speed limit at the time of the accident.

The accident was investigated by Constable Matthew O'Neil, an experienced traffic crash investigator. On the basis of his attendance at and examination of the scene of the accident Constable O'Neil concluded that the Ford, after travelling approximately 1.5 km along a straight stretch of Tomahawk Road, entered the broad left-hand curve and in doing so gradually drifted to the right and onto the gravel verge on the road's eastern side. The movement of the Ford was gradual consistent with a loss of concentration by Mr Morrison or him experiencing an episode of microsleep. Once the vehicle entered the gravel verge on the eastern side of the road, Mr Morrison applied steering input to the left to return the Ford to the roadway but over-corrected causing the Ford to cross back over the roadway and enter the grass verge on the western side and roll. I accept Constable O'Neill's conclusions and observations.

The gradual angle of entry of the Ford onto the eastern side verge and the effort made by Mr Morrison to correct the positioning of the Ford indicates that the departure of the Ford from the road surface was not the product of a deliberate and intentional steering input by Mr Morrison. Mr Morrison had driven approximately 350 km over the previous 24 hours. He was fatigued having had to stop on his journey to Newnham to rest. He drank approximately 13.5 standard drinks and drove with alcohol, diazepam and doxylamine in his system. Fatigue, alcohol and medication would have combined to impair his concentration and driving performance. He drove the Ford at a speed likely to have exceeded the applicable speed limit.

A local farmer provided a statement that at approximately 8.00pm on 10 March 2024, he saw a purple Ford Falcon utility matching the Ford and a white BMW sedan

travelling at very high speeds on Waterhouse Road. At this time Mr Morrison was in Newnham with Mr Brown and it was many hours before the accident occurred. I accordingly find that the vehicles sighted were not associated with Mr Morrison nor the accident.

Comments and Recommendations

I extend my appreciation to investigating officer Constable Matthew O'Neil for his investigation and report.

The circumstances of Mr Morrison's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995 but I do make comment on a matter connected with his death.

The Ford was not fitted with electronic stability control which has become a standard safety feature on later model vehicles. Had the system been fitted to the Ford it may have decreased the severity of the accident or could possibly have prevented it. To improve vehicle safety, it became mandatory for all new passenger vehicles to be fitted with electronic stability control from 2013 in Australia.² A significant portion of the passenger vehicle fleet being driven in Tasmania was manufactured before 2013 and as such do not have electronic stability control systems fitted. Owners of these vehicles should be reminded that they lack the important safety features of this system.

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

Dated: 3 September 2026 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner

² The *Motor Vehicle Standards Act* 1989 (Cth) s 7 and the *Australian Design Rules* 31/03 and 35/05.