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 Tracey Fay Hamill

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

a) The identity of the deceased is Ms Tracey Fay Hamill;
b) Ms Hamill died as a result of injuries sustained by her in a motor vehicle crash;
c) The cause of Ms Hamill's death was blunt force trauma; and
d) Ms Hamill died on 22 June 2017 at the Launceston General Hospital.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Hamill's death. The evidence comprises an opinion of the pathologist who conducted the autopsy; the results of toxicological analysis of samples taken both at autopsy and from the driver of the other vehicle involved; relevant police and witness affidavits; medical records and reports; and forensic and photographic evidence.

Ms Hamill was 55 years of age at the time of her death and was a full-time carer for her gravely ill elderly mother. The investigation surrounding the circumstances of her death indicates she had an extensive medical history dating back to at least 1983. Ms Hamill suffered from depression, anxiety and a panic disorder which had been diagnosed in 2008.

As at the time of her death she was prescribed 19 different medications for a range of physical and mental health ailments. She was seen by a general practitioner two days prior to her death. In that consultation Ms Hamill did not indicate she was feeling suicidal (although she acknowledged having had suicidal ideation in the past). I have touched upon her mental health and the possiblity that she had suicidal thoughts because of the circumstances of the crash in which she died. I turn to those circumstances now.

At about 9.20am on Thursday, 22 June 2017 Ms Hamill was driving her Hyundai Getz north on Penquite Road. It would appear she was returning home from a visit to a chemist in Newstead. She was the only occupant of her vehicle. At the same time a Scania MTT bus was travelling in its correct lane in the opposite direction. The evidence satisfies me that Ms Hamill's vehicle failed to keep left of the road centre dividing line, travelled directly into the path of the bus and collided with it. The driver of the bus had no chance to avoid Ms Hamill's vehicle.

The circumstances of the crash are vividly illustrated by the 'dash-cam' of the bus. The footage clearly shows Ms Hamill's vehicle veering into the path of the bus, the car hitting the bus and then the bus coming to a halt.

The bus driver and members of the public attempted to render assistance to Ms Hamill. Police and emergency services were quickly on the scene. However, Ms Hamill suffered injuries so severe that although whe was rushed to hospital she died shortly after admission.

Ms Hamill's body was removed from the scene and transported to the mortuary at the Launceston General Hospital for an autopsy. Enquiries were also conducted contemporaneously at the scene. The scene was photographed. Both vehicles were impounded. The driver of the bus provided a blood sample for analysis. Witnesses were interviewed. The 'dash-cam' footage was obtained. The scene was carefully inspected. All of the material obtained as a result informed this finding.

The autopsy indicated that Ms Hamill had suffered massive blunt force trauma largely to her chest and lower body. These injuries were the cause of her death. Toxicological analysis of samples taken at autopsy did not detect the presence of alcohol or any illicit drugs. An antidepressant medication was detected in those samples at greater than therapeutic level. An analgesic – oxycodone – was also detected at a therapeutic level. In all of the circumstances, particularly given that the identified antidepressant medication is known to be susceptible to post mortem redistribution (which may account for the apparently elevated level of the drug in Ms Hamill's blood), I am satisfied that neither drug individually or in concert with the other explains why Ms Hamill drove into the path of the bus.

The bus driver's analysis was unremarkable. No illicit drugs or alcohol were detected as being present in the sample. Two prescription drugs were detected but the evidence was that both were at therapeutic levels and incapable of having impaired the driver's ability, perception or reaction time.

Both the Hyundai Getz and the Scania bus were examined by a transport inspector after the crash. The inspector provided a report in which he expressed the opinion that neither vehicle had, at the time of the crash, any mechanical defect which either caused or contributed to the crash. I accept his opinion.

Particularly important in the context of determining the circumstances of Ms Hamill's death was the fact that the brake light bulbs of her vehicle were recovered and examined. The Tasmania Police crash investigator, Senior Constable Rybka, in his very comprehensive report explained that the absence of distortion to the brake light filament indicated that the bulbs were cold at the time of impact. He went on to say that under circumstances when braking is applied the brake light filament becomes incandescent (due to heat) and any major impact of the vehicle usually result in it being deformed or distorted due to impact forces acting upon it. Senior Constable Rybka said that no deformation or distortion was present in either bulb. This is objective evidence that at the time of the happening of the crash Ms Hamill had not applied the brakes of her vehicle.

I am satisfied on the evidence that neither weather nor road conditions caused or contributed to the happening of the crash.

As mentioned earlier in this finding I am satisfied that there is no evidence to support a conclusion that Ms Hamill's death was suicide by driving into the bus on purpose. Specifically, despite lengthy mental health issues and despite the fact that she was struggling with the fact that her mother was gravely ill, no suicide notes were located in her vehicle or in a residence following the collision. As mentioned earlier, only two days before the crash Ms Hamill had been seen by a general practitioner and evinced no signs of suicidal ideation or intent. Given the physical evidence suggesting that Ms Hamill's vehicle did not have its brakes applied immediately prior to and at the time of the crash the most likely explanation for it is either inattention or perhaps a momentary loss of consciousness on Ms Hamill's behalf causing her to veer from her lane into the path of bus.

If some type of medical condition was responsible for the happening of the crash then it is unclear what that condition might have been, particularly given in all of her medical records there appears to be no complaint by her of loss of consciousness or fainting or similar.

I am satisfied on all of the evidence that the crash which claimed Ms Hamill's life occurred in the circumstances set out above. The evidence does not allow me to reach

a conclusion as to why her vehicle veered into the path of the bus. However I am affirmatively satisfied that the driver of the bus bears no responsibility for the happening of the crash. It is clear that he was not speeding, that the vehicle he was driving was mechanically sound, that his driving ability was not impaired by alcohol or drugs and that he was in the correct lane on the road at the time of the crash. It is also clear that he had no opportunity whatsoever to avoid Ms Hamill's vehicle.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Michael Rybka for his investigation and report.

The circumstances of Ms Hamill'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 Ms Hamill.

Dated 3 September 2018 at Hobart, Tasmania.

Simon Cooper
Coroner