Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Blaze Christian Roberts-Burton

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

a) The identity of the deceased is Blaze Christian Roberts-Burton;

b) Mr Roberts-Burton died as a result of being unintentionally run over by a truck at about 3.50am on 10 May 2015 whilst lying on a roadway in a state of drug and alcohol intoxication;

c) Mr Roberts-Burton died as a result of multiple blunt traumatic injuries;

d) Mr Roberts-Burton died on 10 May 2015 at Lampton Avenue, Derwent Park in Tasmania; and

e) Mr Roberts-Burton was born in Sydney, New South Wales on 11 May 1983 and was aged 31 years.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Blaze Christian Roberts-Burton’s death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy, relevant police and witness affidavits, medical records and reports, and forensic evidence. I have also been greatly assisted by a detailed report compiled by crash investigator, Sergeant Rod Carrick.

I make the following further findings as to how death occurred.

On the evening of Saturday 9 May 2015 and into the early morning of 10 May 2015, Mr Roberts-Burton was at a premises known as the ‘Slaughterhouse Gymnasium’ (“the gym”) situated at 61A Lampton Avenue, Derwent Park.

Access to the gym is gained from a driveway entrance which is situated between numbers 59 and 61 Lampton Avenue, being the southern side of Lampton Avenue. The gym is located approximately 70 metres from the footpath of Lampton Avenue. The driveway also services a number of small businesses and warehouses.
On this evening and morning there was a social function being held at the gym, with a number of persons present.

Mr Roberts-Burton, whilst at the gym, displayed overt signs of alcohol intoxication. These signs included staggering, falling over, and being loud and incoherent in voice. At one stage whilst outside the gym Mr Roberts-Burton was being supported by two people. By reason of his intoxication and consequent behaviour, he fell over, bringing to the ground the female who was supporting him.

Shortly before 3.00am Mr Roberts-Burton was last seen by the persons attending the gym staggering along the driveway towards the direction of Lampton Avenue. He was shouting incoherently.

At about 3.00am Ms Lynn Buckley of 32 Lampton Avenue heard a male voice shouting out for a period of about 20 minutes. It appeared to Ms Buckley as if the person was moving around as the voice became softer and louder at different times.

Sometime later Ms Buckley again heard the same male voice shouting out. She looked out of her window and observed a male person staggering across Lampton Avenue in the vicinity of the driveway entrance to 61A Lampton Avenue. The male fell to his hands and knees on the road surface. He continued to shout, using offensive language. He appeared to be arguing with himself. After a period of time the male was able to get to his feet and stagger to the northern side of Lampton Avenue and was then out of the view of Ms Buckley.

Having regard to all of the evidence, I conclude that the male person observed by Ms Buckley was Mr Roberts-Burton. It would appear that her last observation of him was shortly before his death.

Before his death, Mr Roberts-Burton either fell or laid down on the road surface of Lampton Avenue, close to where he was observed by Ms Buckley. His position on the road was at about the centre of the road tending towards the north. He was lying laterally across the road, supine (face up) on a straight section of slightly uphill road for east bound traffic. The area was dark and street lights to the east and west of Mr Roberts-Burton did not light that section of road.

Lampton Avenue at this location does not have any central road markings. The total width of the road is 9.8 metres, including the guttering on both sides. The notional width of each lane, including the gutters, is therefore 4.9 metres.

At 3.47am Mr David Mayne was driving a Toyota Prius taxi with a fare in an easterly direction on Lampton Avenue approaching the position of Mr Roberts-Burton on the roadway. Mr Mayne’s headlights were on low beam. The roadway was wet and dark but it was not raining. Mr Mayne was driving at a speed of about 40km/h to 45km/h. He observed what appeared to be a garbage bag lying across the road in front of him. He turned his headlights onto high beam and then realised it was a person lying on the road.

Mr Mayne took evasive action by braking and swerving left (to the north) around Mr Roberts-Burton. He did not impact with Mr Roberts-Burton.
Mr Mayne did not stop at the scene but continued driving along Lampton Avenue towards the Brooker Highway. The evidence indicates that he travelled a further 180 metres in this direction and then telephoned police to advise of the male laying on the road. The time of Mr Mayne’s telephone call to police was 3.48am.

Police officers were immediately tasked to attend Lampton Avenue. The time of the tasking was 3.50am with arrival of officers at the scene at 3.55am.

Within two minutes of Mr Mayne calling police, Mr Malcolm Jacobson was driving an Isuzu rigid truck (“the truck”) east bound on Lampton Avenue. Mr Jacobson was driving in the course of his work delivering bread. The speed of the truck was between 30km/h and 40km/h, with the headlights on low beam. Mr Jacobson’s adult autistic son was a front seat passenger in the truck. The front passenger headlight on the truck did not operate on low beam but the park light in the headlight assembly was illuminated. Mr Jacobson was unaware of the passenger headlight failure on low beam.

Whilst travelling in the east bound lane Mr Jacobson observed what he thought was a green garbage bag on the roadway. The object was located in the centre of the road. He initially did not consider the object to be a hazard. He maintained his speed at between 30km/h to 40km/h.

Mr Jacobson believed the distance between his truck and the object on the road when initially observed was about 20 to 30 metres. He flicked his headlights onto high beam. It was at this stage that he realised the object he saw was a person. Mr Jacobson states that he had insufficient time and distance to stop or swerve around the person. He manoeuvred the truck over the top of Mr Roberts-Burton so that the wheels would not contact his body. Mr Jacobson was hopeful that there was sufficient room between the under carriage of the truck and the roadway for the truck to pass over Mr Roberts-Burton without injury being caused.

Whilst the truck was passing over Mr Roberts-Burton, the centre of the sub-frame under the cabin at the front struck him. Mr Roberts-Burton was dragged east bound prior to coming to rest in the notional east bound lane adjacent the junction of Elmsleigh Road approximately 14 metres east of impact.

Mr Jacobson stopped the truck, alighted and checked Mr Roberts-Burton’s condition. He ascertained that Mr Roberts-Burton was deceased. He called emergency services. Ambulance paramedics attended. Mr Roberts-Burton was formally declared deceased at the scene.

On the evidence, including that of the crash investigator, I am able to find that the truck was not travelling at a speed in excess of the speed limit of 50km/h at the time of the crash.

There was sufficient space between Mr Roberts-Burton and the northern road edge for the truck to pass between him and the road edge without him being struck. However, Mr Jacobson did not have time to take such a course upon realising that the object on the road was a person.
Mr Jacobson submitted to a blood test pursuant to the Road Safety (Alcohol and Drugs) Act 1970, producing a negative result for alcohol.

Toxicological examination of Mr Roberts-Burton’s blood, vitreous humour and urine returned very high blood alcohol concentrations between 0.250 and 0.268 grams of alcohol in 100 millilitres of blood. The substances diazepam, temazepam, alprazolam and methylamphetamine were also detected in his blood at a toxic level. With the presence of such drugs, the effects of the alcohol consumed were greatly enhanced. I find that, in such circumstances, Mr Roberts-Burton would not have been aware of or appreciated any risks associated with his precarious behaviour. Ultimately he succumbed to the sedation created by the ingestion of the alcohol and multiple drugs.

I am satisfied that the state of Mr Roberts-Burton’s intoxication caused an utter indifference on his part to his own survival. The circumstances do not indicate a deliberate intention to place himself in harm’s way. At the time of his death Mr Roberts-Burton was on parole in respect of a sentence for aggravated burglary. He was in breach of the conditions of his parole in that he was absent from his residence between 10.00pm and 6.00am, he had ingested an illicit drug and consumed a substantial quantity of intoxicating liquor.

The truck was mechanically inspected. Inspection revealed non-operational clearance lamps and the front passenger side headlight on low beam non-operational. Through testing the crash investigator concluded that the non-operational passenger side headlight on the truck was not an influencing factor in this crash. I accept his opinion. The non-compliant lamps and headlight were the subject of a defect notice issued by the motor vehicle inspector at the time of inspection.

The evidence in this investigation indicates that there was no involvement of any other person in the circumstances of Mr Roberts-Burton’s death.

I am satisfied on the evidence that Mr Roberts-Burton was only struck by one vehicle, being the truck driven by Mr Jacobson.

I note that the circumstances surrounding the death of Mr Roberts-Burton were reviewed by the Director of Public Prosecutions as to whether charges should be raised against Mr Jacobson. The Director considered that no charges should lie.

Comments:

I extend my appreciation to investigating officer Rod Carrick for his high quality investigation and report. I am satisfied that the evidence is extremely comprehensive and no other avenues of investigation could have been undertaken to assist me in my conclusions.

Mr Roberts-Burton’s father, Mr George Burton, expressed views during the course of the investigation that there were suspicious circumstances surrounding his son’s death and that there were inadequacies in the investigation of this matter. He submitted that a public inquest should be held. In the early months of 2016 the Coroners’ office wrote to both Mr Burton and his legal counsel providing an opportunity to make submissions as to whether an inquest should be held. No submissions were received. At the time of writing to Mr Burton he
had knowledge of the evidence in the investigation by virtue of having inspected the documentary file.

I am fully satisfied that it would not have been desirable to hold an inquest into the death of Mr Roberts-Burton as the evidence does not contain any material conflict and clearly enables the requisite findings to be made.

In relation to the actions of Mr Mayne and Mr Jacobson, I do not consider criticism is appropriate. Mr Mayne had a fare in his taxi and called police almost immediately after passing Mr Roberts-Burton. Ideally, he might have stopped his vehicle on the road adjacent to Mr Roberts-Burton until police arrived. However, his actions were not unreasonable in the circumstances.

Whilst Mr Mayne was able to avoid Mr Roberts-Burton, it was fortuitous that his vision was directed towards the middle of the road at that time. At that time of the morning, the chance of encountering objects on the road was low, and the chance of any object being a person on the road was remote. Additionally, it was dark and the area was poorly lit. Mr Jacobson was travelling at a slow speed. In the circumstances his failure to notice Mr Roberts-Burton at an earlier time did not fall outside the realms of the reasonably prudent driver.

Mr Roberts-Burton’s death highlights the tragic consequences of consuming high levels of alcohol in combination with methylamphetamine and other substances. In this case the consequences of such intoxication were an inability to control his own behaviour and actions, resulting in him lying in an unconscious or sleeping state on the middle of the roadway. In this position, he placed himself at high risk of death by passing vehicles, a risk that sadly eventuated.

The circumstances of Mr Roberts-Burton’s most unfortunate death do not require me to make any recommendations pursuant to section 28 of the Coroners Act 1995.

I convey my sincere condolences to the family and loved ones of Mr Roberts-Burton.

Dated: 20 April 2017 at Hobart, in the state of Tasmania

Coroner
Olivia McTaggart