



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 David Scott Holmes,

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

- (a) The identity of the deceased is David Scott Holmes;
- (b) Mr Holmes's died as a result of injuries sustained on 7 April 2016 in a rollover of the prime mover truck he was driving in the course of his work as a truck driver;
- (c) The cause of death was hypoxic/ischaemic brain damage; and
- (d) Mr Homes died on 7 April 2016 at the Royal Hobart Hospital, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into the death of David Scott Holmes. The evidence comprises a detailed report by crash investigators, an opinion of the State Forensic Pathologist as to cause of death, relevant police and witness affidavits, medical records and reports, and forensic evidence.

I make the following further findings, based upon the evidence, as to how Mr Holmes' death occurred.

David Scott Holmes was born on 10 December 1964 in Latrobe, Tasmania. He was aged 51 years at death. He was married to Tracey Maree Holmes for almost 27 years before she passed away from cancer on 10 July 2014. There are three adult children from the marriage.

Mr Holmes was employed by De Bruyn's Transport at the time of his death and had been employed there for approximately 12 months. He had been a truck driver for his entire working life and was the holder of a current multi-combination licence. He underwent a Fitness to Drive medical in his employment 11 months before his death. As a result he was certified as fully fit to drive. Specifically, no heart-related issues were identified at that medical or subsequently. He was in sound mental health.

At about 5.30am on 7 April 2016, Mr Holmes arose and prepared for his usual daily work route from Devonport to Hobart. Mr Holmes conducted the drive to Hobart in a Volvo Cab Over Prime Mover registration number C97LL towing "B" Double trailers registration numbers 96545S (Victorian) and 02147S (Victorian) ("the truck"). The truck was owned by De Bruyn's Transport and the trailers by Bass Strait Freight. The truck was loaded the night

before to ensure that the drivers only had to attend the depot and obtain the appropriate paperwork and the truck before commencing the drive to Hobart.

The evidence indicates that Mr Holmes' journey proceeded uneventfully. Mark Delaney, a truck driver currently employed by Barry Walsh Transport in Ulverstone, was conducting a daily drive from Devonport through to Cambridge on 7 April 2016. He was behind Mr Holmes' truck from Epping Forrest on the Midlands Highway when he began to have a conversation with him on the UHF radio. Mr Delaney knew Mr Holmes' as his son was in a relationship with Mr Holmes' niece. Mr Delaney followed Mr Holmes through the road works at Bagdad at about 9.30am which had the speed restricted to 60km/h and was controlled by traffic controllers. Whilst exiting the road works Mr Holmes and Mr Delaney increased their speed to approximately 65km/h. Mr Delaney stated that as they were in the road cutting adjacent to Bagdad Primary School he had just finished talking to Mr Holmes. Mr Delaney then witnessed Mr Holmes' truck very suddenly veer hard right and travel up the bank on the opposite side of the road. It fell down on its left hand side. Mr Delaney stopped in the middle of the road at that point to render assistance to Mr Holmes.

Motorist Patricia Ollington was travelling north on the Midlands Highway with her elderly mother in the vehicle. As she was approaching the cutting in the road on the Midlands Highway adjacent to the Bagdad Primary School she observed the truck coming towards her apparently accelerating and crossing to her side of the road. Ms Ollington stated that when the truck crossed into her lane she had to brake heavily as the truck travelled up the bank and landed about three metres from the front of her vehicle on the road. Ms Ollington immediately alighted from her vehicle and went to render assistance to Mr Holmes.

Ms Collette Harrold, volunteer ambulance officer and Principal of Bagdad Primary School, also attended the scene of the crash to render assistance.

At about 9.30am Senior Constable Rowena Watling was working in an unmarked police vehicle on the Midlands Highway approaching Bagdad. She observed a truck on the left side of the road lying on its side. The passenger's roof was crushed. Senior Constable Watling contacted Police Communications and requested ambulance, police and the Tasmanian Fire Service to attend. At 9.30am off duty Constable Angela Lang and her husband, Ray Cooper, a volunteer SES worker, also stopped to assist.

The persons who were assisting at the scene stated that they could see Mr Holmes in the truck upside down and unresponsive. Ms Harrold checked Mr Holmes for a pulse but could not find one. After observing that the truck was smoking and had a fuel leak she cut Mr Holmes from his seat belt with the assistance of Mr Cooper and others and lifted him from the cab of the truck and placed him on the roadway.

Ms Harrold took charge of the first aid for Mr Holmes. With the assistance of Tasmania Ambulance Communications on a speaker phone, she attempted to clear the airway of Mr Holmes who had broken teeth and was bleeding from the mouth. Constable Kevin Smith who was working day shift in a marked police vehicle was tasked to the crash at 9.29am and arrived at the scene at 9.34am. He observed a large De Bruyn's truck lying on the left side of

the Midlands Highway facing south. He observed Mr Holmes who was purple in the face lying on the roadway adjacent to the truck with people administering first aid.

Mr Holmes was conveyed by ambulance to the Royal Hobart Hospital (RHH). Upon arrival Mr Holmes was treated prior to being taken to surgery for a decompressive Craniotomy and Evo insertion. Mr Holmes also had two chest drains inserted to assist him. He was transferred directly to the Intensive Care Unit after surgery due to the severity of his injuries including severe multi organ failure. Due to the increasingly futile outcome for Mr Holmes, his family, in consultation with medical specialists, decided to withdraw treatment. Mr Holmes died at 10.15pm with his family by his side.

A detailed inspection of the crash scene was carried out by senior crash investigator, Sergeant Rod Carrick. He marked and photographed the scene of the crash and a survey was completed. He later produced a scaled diagram of the scene and an animated crash reconstruction of the vehicle path prior to and at the impact with the embankment. He also obtained an engine download from the truck which indicated that the truck was travelling at 61km/h six minutes prior to the crash. He concluded that the truck would have been travelling at 60km/h at the crash point. He also concluded that there was no maximum braking at any time prior to coming to rest.

The weather at the time of the crash was clear and fine with an ambient temperature of 12.9 degrees. The traffic flow was medium in the area due to the road works being carried out through the Bagdad area on the Midlands Highway. The road surface was of good condition constructed of a bituminous material. The sun was shining but did not affect the vision of drivers in either direction in the area.

The truck was inspected by Transport Inspector, Mr Paul Wells, who concluded that it was in all respects well maintained and roadworthy. I accept his conclusion.

Dr Christopher Lawrence, State Forensic Pathologist, carried out an autopsy upon Mr Holmes. He determined that Mr Holmes died of hypoxic/ischaemic brain damage following head and chest injuries due to the crash. He also determined that Mr Holmes had left ventricular hypertrophy of the heart probably due to hypertension.

In his affidavit, Dr Lawrence stated:

“The cause of the rollover is not explained and it is possible that a cardiac arrhythmia from the left ventricular hypertrophy could have caused a loss of consciousness causing the collision and also contributed to the hypoxic/ischaemic brain damage. In plain English he died of a lack of oxygen to the brain due to a combination of injuries to the head and chest from the collision and enlargement of the heart due to high blood pressure.

The decedent was driving a truck on the Midlands Highway near Bagdad. Witnesses describe the truck veering across the road and up an embankment causing it to roll. According to the hospital report of death to the coroner Mr Holmes was allegedly suspended for a period upside down by a seatbelt. There was some delay in

resuscitation (down time -35 min). He was brought to hospital and chest drains and a decompressive craniotomy were performed however he ultimately died.”

Dr Lawrence further stated:

“This man's brother Peter Gordon Holmes (DOB 11/08/1961) died in 2008 aged 46 years. His autopsy (Launceston PM No. 110/08) showed severe coronary artery disease with occlusion of the left anterior descending coronary artery and left ventricular hypertrophy and cardiomegaly (520g). Mr David Holmes does not have significant coronary artery narrowing (30%) but does have left ventricular hypertrophy and cardiomegaly. It is possible that a cardiac arrhythmia from the left ventricular hypertrophy could have caused a loss of consciousness causing the collision and also contributed to the hypoxic/ischaemic brain damage.

It is difficult to tell whether both brothers have left ventricular hypertrophy due to hypertension or whether both brothers have some form of hypertrophic cardiomyopathy. If this is some form of hypertrophic cardiomyopathy it is likely to affect up to half of the siblings.”

I accept the conclusions and observations of Dr Lawrence. I find that Mr Holmes had a sudden heart-related episode. This was due to the unknown condition of either left ventricular hypertrophy or hypertrophic cardiomyopathy causing a sudden and unexpected cardiac arrhythmia and loss of consciousness. This, in turn, caused the truck he was driving to veer to the incorrect side of the road and crash.

Comments and Recommendations

The Coroners Act, section 24(1)(ea), provides that where a coroner has jurisdiction to investigate a death he or she is obliged to hold an inquest if the *“deceased died at, or as a result of an accident or injury that occurred at, his or her place of work and the coroner is not satisfied that the death was due to natural causes”*. This requirement is subject to section 26A(3) of the Act which provides that despite section 24(1) a coroner may decline to hold an inquest if requested by the senior next of kin of the deceased not to hold an inquest and if satisfied it *“would not be contrary to the public interest or the interests of justice if the inquest were not held”*.

I am satisfied that the death of Mr Holmes occurred as the result of injury or accident. Even though it was his heart condition that caused the loss of control of his truck, his death ultimately resulted from injuries sustained in the crash. I am also satisfied that his death occurred at his place of work. (See, for example, the definition of workplace in section 8 of the *Work Health and Safety Act 2012*).

Mr Holmes' senior next of kin requested that no inquest be held. In deciding not to hold an inquest, I was satisfied that it would not be contrary to the public interest or the interests of justice if an inquest was not held. In coming to this decision I was firstly satisfied that the circumstances of the crash was most comprehensively investigated such that no additional material was likely to be uncovered as a result of the holding of an inquest. Secondly, the

circumstances of the fatal crash were clear and contained no conflict in any important respect. Thirdly, I was satisfied that the employer of Mr Holmes undertook all reasonable steps to ensure his safety in his work duties and that it conducted a thorough review of the incident subsequent to Mr Holmes' death.

I extend my appreciation to investigating officer, Constable Kevin Smith, for his investigation and report and to crash investigator, Sergeant Rodney Carrick, for his thorough crash investigation report.

The circumstances of Mr Holmes' 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 Mr Holmes' family and loved ones.

Dated: 8 September 2017 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner