



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 Barry Smith

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

- a) The identity of the deceased is Barry Smith;
- b) Mr Smith died in the circumstances set out in this finding;
- c) Mr Smith died as a result of suffering a heart event whilst driving his truck;
and
- d) Mr Smith died on 19 March 2018 at Ringarooma, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Barry Smith's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; police, family and witness affidavits; crash investigation evidence; vehicle inspection evidence; medical records and reports; employment records; and forensic evidence.

Mr Barry Smith was born on 19 November 1956. He was aged 61 years at the time of his death. He was married to Mrs Karen Smith. There are three adult children of the marriage.

Mr Smith had extensive experience as a truck driver. He had worked as a truck driver for around 40 years and had driven various kinds of trucks. He had previously operated his own small business as a truck driving instructor, teaching people to drive trucks before their final assessments.

Prior to his death, Mr Smith was reasonably healthy. He had, for some years before his death, suffered hypertension. He saw his general practitioner, Dr Paul McGinity, on a

regular basis until his death and was prescribed medication for hypertension and cholesterol. In 2012, he was seen by a cardiologist who reported to his general practitioner that there were no issues with his heart and that his hypertension was under control. I note that the evidence in the investigation indicates that both of Mr Smith's parents died aged in their 60s as a result of heart conditions.

At the time of his death, Mr Smith was working as a truck driver for Perotti Brothers in Scottsdale, delivering logs around the northern area of Tasmania. He had been in this employment for approximately four years prior to his death. At the commencement of his employment with Perotti Brothers, Mr Smith underwent an Employment Health Assessment, which was completed in February 2014. As part of this assessment, Mr Smith had an electrocardiogram heart test, which returned a normal result. Mr Smith was duly certified as fully fit to drive. Specifically, no heart-related issues were identified at the time in this assessment. A year later, on 24 February 2015 his general practitioner completed a further "Health Assessment for Fitness to Drive" in which he certified that Mr Smith was fit to drive. That document was part of the evidence in the investigation. Dr McGinity noted on the assessment that Mr Smith suffered no heart conditions and that his blood pressure had been "well controlled over many years".

On 19 March 2018, Mr Smith followed his usual routine of waking up at 1.00am to begin work delivering loads of logs around the north of the State in his Kenworth T404 twin steer prime mover, registration number FP6630. This vehicle was towing a fully laden 2006 Custom skeletal log trailer, registration number Z87BW. His driving log obtained for the investigation specified that he commenced driving at around 1.30am and had delivered two loads of logs to Bell Bay from other locations around the north of the State.

Mr Smith was observed by fellow truck driver, Mr Peter Leslie Brown, at the Perotti Brothers Ringarooma Basin landing at approximately 12.20pm. Mr Brown said in his affidavit in the investigation that Mr Smith had just finished loading his truck and strapping his load of logs onto his truck. He saw Mr Smith drive out of the load area, stop and then get out of his truck to sort out the load. Mr Brown noted that there was nothing unusual about Mr Smith and he did not appear to be unwell in any respect at this time. This was, on the evidence, the last occasion that Mr Smith was observed to be alive by any person.

At or around 1.00pm on that same day, truck driver, Mr Christopher Adrian Paul, was travelling along an unnamed road that he and other truck drivers referred to as 'Basin Road', located approximately 8.5 kilometres from Ringarooma. Around this time, he saw a flash of light in his right side mirror that he identified as a truck's reversing light.

Mr Paul stopped and jumped out to check on the truck which he recognised to be Mr Smith's Kenworth truck. Mr Paul had known Mr Smith for many years. The truck, at the time, was still running and was leaning against some trees over a steep embankment to the western side of the road. The truck had a full load of logs strapped into the bolsters on the trailer. Mr Paul further recalled that the windscreen of the truck was smashed and the driver's door was shut. Mr Paul did not observe any marks on the road itself.

Mr Paul could not see Mr Smith anywhere upon first observation of the truck. When he climbed down to the cabin and opened the driver's door, Mr Smith was lying face down with his head and shoulders in the passenger side foot well and his arm was tucked up behind him. His mid-section was lying over the area of the gear levers. Mr Smith was not wearing his seatbelt at this time. Mr Paul turned off the ignition on the truck and called out to Mr Smith but received no response. Mr Paul checked for a pulse but could not find one. However, he noted that Mr Smith felt warm. Mr Paul then proceeded to run back to his truck to contact the police and ambulance.

Mr Brown, driving his truck, then came upon the scene. Mr Brown said that he checked Mr Smith's hand and could not find a pulse. Police, ambulance and fire service personnel later attended the scene and removed Mr Smith from the vehicle. Ambulance personnel confirmed that Mr Smith was deceased. The steering wheel of the vehicle was removed in order to extricate Mr Smith from the vehicle.

An investigation of the crash was conducted by First Class Constable Nigel Housego. In his inspection of the scene of the accident later that afternoon, Constable Housego observed that there were no visible braking or steering marks on the road. There were, however, visible tyre marks and gouges on the north western road verges and embankment. He saw no faults in the road that would have contributed to the crash.

Whilst a speed analysis could be conducted from observations of the scene, Mr Brown stated that the Kenworth truck was in fifth gear at the scene of the crash. The evidence

indicates that this gear would have limited the truck to a maximum speed of 35km/h, being a gear and a speed which was commonly used by truck drivers in this location, as noted in the affidavits of Mr Brown and Mr Paul.

Constable Housego concluded that Mr Smith was travelling at a speed not exceeding 35km/h when negotiating a sweeping right hand bend. Upon exiting the bend, the Kenworth rolled off to the left side of the road and onto the steep embankment. Once on this embankment, the vehicle exceeded its rollover threshold and commenced rolling counter-clockwise down the embankment. Large trees stopped this rolling after one quarter of the rotation. As Mr Smith had not been wearing his seatbelt at the time, he struck the interior of the cab with his head and fell face down into the foot wells. I accept the conclusions of Constable Housego.

An inspection of the Kenworth was undertaken by transport inspector, Mr Andrew Robotham, on 26 and 27 March 2018. Mr Robotham concluded in his report for the investigation that there was no fault in the vehicle that would have caused or contributed to the crash. Mr Robotham further noted that there were no faults in the seatbelts, which were described to be in good working condition.

The toxicological evidence showed that Mr Smith did not have alcohol or illicit drugs in his system at the time of the crash.

A post mortem examination of Mr Smith was conducted by Dr Christopher Hamilton Lawrence, State Forensic Pathologist on 20 March 2018. Dr Lawrence observed that Mr Smith had severe heart disease, observing (among other things) an enlarged heart and occlusion of the coronary arteries. Dr Lawrence reported that he was unable to form an opinion regarding a definite cause of death. Dr Lawrence nonetheless provides two possible scenarios as the cause of death: firstly, that Mr Smith lost consciousness and control of his vehicle due to a cardiac arrhythmia brought upon by the ischaemic heart disease, which in itself was the cause of death; or secondly, that Mr Smith suffered loss of consciousness due to the same condition, but that the ultimate cause of death was positional asphyxia brought upon by his flexed, head down position in the vehicle post-collision.

I accept the opinion of Dr Lawrence as to the possible causes of Mr Smith's death. Whilst it is not possible to make a finding regarding the ultimate cause of his death, I

am satisfied that Mr Smith did suffer a loss of consciousness by reason of a cardiac arrhythmia whilst he was driving lawfully and slowly on a section of road upon which he had driven many times in the past. The scene, as described by Constable Housego, showed no evidence of any braking or steering input immediately before the crash occurring, this being consistent with an unconscious driver.

The heart event may in itself have been fatal for Mr Smith, in which case the fact that he did not wear his seatbelt would not have affected the outcome. However, if Mr Smith's heart event was not fatal, it is likely that he would not have died by positional asphyxia if he had been restrained by his seatbelt. In such case, it is possible that he may have received timely medical treatment.

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”*.

In this investigation, I was satisfied that the death of Mr Smith may have occurred as a result of an injury or accident. I was 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 Smiths' senior next of kin, Mrs Smith, requested in this case that I not hold a public inquest into the death of her husband. 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 were comprehensively investigated such that no additional material was likely to be uncovered as a result of the holding of an inquest. Secondly, the evidence contained no conflict in any important respect. Thirdly, I was satisfied that the employer of Mr Smith undertook all reasonable steps to ensure his safety in his

work duties as well as reasonable steps to ensure that Mr Smith was fit to drive prior to his death. The failure of Mr Smith to wear a seatbelt, a fact that may have contributed to his death, is a matter for which Mr Smith, himself, should have taken responsibility.

I extend my appreciation to investigating officer, First Class Constable Nigel Housego, for his investigation and report.

The circumstances of Mr Barry Smith's death are not such as to 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 Smith.

Dated: 20 September 2019 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner