



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Kerry Paul Wilson,

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

- a) The identity of the deceased is Kerry Paul Wilson;
- b) Mr Wilson died as a result of injuries sustained in a motor vehicle and truck collision;
- c) The cause of Mr Wilson's death was multiple injuries, specifically to his chest, heart and spine; and
- d) Mr Wilson died on 3 March 2020 at Black River, Tasmania.

#### **Introduction**

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Kerry Wilson's death. The evidence includes:

- Tasmania Police Report of Death;
- Opinion of the Forensic Pathologist who conducted an examination of the body;
- Forensic Science Service Tasmania toxicology report;
- Affidavits relating to the formal identification of Mr Wilson;
- Information from Mr Wilson's wife, Jacky;
- Report from Crash Investigation Services;
- Affidavit of Transport Inspector, Philip Evans;
- Affidavit of National Heavy Vehicle Regulator Safety and Compliance Officer, Kent Mullins;
- Affidavit of Grant Morice, driver of the milk tanker involved in the collision;
- Affidavit of Leon McLaren, work colleague of Grant Morice;
- Affidavit of Kerry Popowski, witness to the collision scene;
- Affidavit of Dr Robert Pianta, witness to the collision scene;
- Affidavit of Chamindu Hapuarachchi, work colleague of Mr Wilson;

- Affidavit of Rosemary Walker, accommodation owner of Rosebank Cottages at Smithton where Mr Wilson was staying;
- Affidavit of attending and investigating police officers;
- Medical records and reports;
- Recorded footage from the dash-cam of the milk tanker; and
- Forensic and photographic evidence.

## **Background**

Kerry Paul Wilson was born in Albuquerque, New Mexico, United States of America on 20 December 1965, and was aged 54 at the time of his death. He spent most of his life in Albuquerque with his parents, William and Phyllis Wilson. His parents later separated. He had three siblings, and one half-brother after his father remarried in 1998.

In his twenties, he met and married Michelle Wilson. They had two boys together, Kevin and Aaron. They separated and divorced in 1997. However, Mr Wilson met Jacky Wilson in 2005. In 2007, they married and continued a loving relationship until his passing. He was the stepfather to six more children.

Mr Wilson began his career as a field engineer with Turkington in 2010. However, since 2013, he was employed by Bulher Aeroglide and had been working at McCains Foods Pty Ltd in Smithton, Tasmania as a field technician since February 2020. He was in Australia on a temporary work visa.

In 2004, Mr Wilson participated in a sleep study. He was subsequently diagnosed with sleep apnoea and prescribed the use of a continuous positive airway pressure (CPAP) machine. He used this every night except on flights where there is no power for the machine. He was using a new CPAP machine which had improved his symptoms and was feeling healthier.

Between 2 and 22 February 2020, Mr Wilson and his wife stayed at the Rosebank Cottages in Smithton. They left Tasmania and returned to Alabama in the United States, where they were currently living. Mr Wilson spent three weeks there before returning to Tasmania on his own.

## **Circumstances of Death**

On 1 March 2020, Mr Wilson began his return journey to Tasmania after spending three weeks in the United States. He took two domestic flights, an international flight from Los Angeles to Sydney before arriving at Launceston Airport on 3 March 2020 at 4.15pm.

On arrival, he hired a Mitsubishi Outlander motor vehicle and commenced his journey to Rosebank Cottages – where he had rebooked to stay while in Tasmania. He expected to arrive there late and asked that the cottage be left unlocked. The weather was fine and clear, the road dry and traffic conditions were light. The road itself is flat and the bitumen in good condition without obvious defect.

On or about 8.27pm, Mr Wilson was driving west along the Bass Highway at Black River where the road curved significantly. At the same time, a truck - a b-double Fonterra milk tanker - was being driven in the opposite direction around the curve in the road by Mr Grant Morice. Mr Wilson's vehicle and the Fonterra truck collided. Mr Wilson's vehicle became embedded in the front of the Fonterra truck and pushed 72.4 metres from the point of impact to a stop.

Mr Morice had been on a mobile telephone call, speaking via headset, at the time of the collision. He told the person on the other end of the call that a collision had occurred and asked them to call emergency services. Mr Morice observed Mr Wilson slumped over the steering wheel, non-responsive, and without a pulse. A witness who arrived on the scene, identified as an orthopaedic surgeon, attempted to rouse Mr Wilson verbally and with painful stimuli without success. Mr Morice and the witness then cut Mr Wilson free from his seat belt and extricated him from the vehicle. It was evident that Mr Wilson was deceased and no resuscitation was attempted. Paramedics who arrived at the scene shortly after confirmed death.

Mr Morice was physically uninjured, but was taken by ambulance to North West Regional Hospital for observation. While in hospital, Mr Morice submitted to a blood sample taken by police for analysis. The toxicology report indicated no presence of alcohol and no significant drugs were detected in his system.

After death, Mr Wilson's body was repatriated home to his family in Alabama.

### **Investigation**

An investigation into the crash was conducted by Senior Constable Barnard, an experienced crash investigator attached to Western Crash Investigation Services. I accept Senior Constable Barnard is qualified to express the opinions he did in his report. In that report, Senior Constable Barnard said, and I find accordingly:

- a) The weather was fine and clear;
- b) The road was dry and traffic conditions light;
- c) The road was sealed and in good condition without obvious defect;

- d) The road was almost completely flat, and had a cross fall of 4.9 degrees over both lanes to assist vehicles negotiate corners and disperse water from the road surface;
- e) The road was well marked with painted white lines and reflective guideposts;
- f) There was no evidence of Mr Wilson's vehicle braking prior to impact;
- g) The Fonterra truck was at maximum braking prior to impact evidenced by the rear trailer leaving 51 metres of skid marks;
- h) The point of impact indicates that Mr Wilson's vehicle was on the incorrect side of the road. This is consistent with dash cam footage showing Mr Wilson's vehicle was at all times on the incorrect side of the road;
- i) The headlights of both vehicles were on;
- j) The Fonterra truck's speed was 92km/h;
- k) Analysis of Mr Wilson's vehicle via dash cam footage shows him driving at least 80km/h; and
- l) It was an unavoidable high-speed collision that was non-survivable.

Dash cam footage recovered from the Fonterra truck confirms that Mr Wilson was driving on the incorrect side of the road at all times. It shows the Fonterra truck moving left onto the verge and Mr Wilson's vehicle moving right onto the verge where impact occurred. It confirms that Mr Morice was wearing a headset device.

Mr Morice is an experienced driver of milk tankers, with approximately 23 years of experience. He has no relevant history of driving offences, except for one infringement notice relating to driving without a seatbelt in 1999. On the day of the collision, he was working an afternoon shift and was well rested. He had no evidence of alcohol in his system. Senior Constable Barnard formed the view that Mr Morice did all that was available to him. I am satisfied that Mr Morice was driving in a safe and proper manner and that his actions did not contribute or cause the crash.

An autopsy was carried out by the State Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey found that the cause of Mr Wilson's death was multiple injuries. He noted that, specifically, there were marked abrasions and bruises of the chest and abdomen that included an oblique linear abraded contusion of the chest and low transverse abraded contusion of the lower abdomen - all consistent with a driver's side shoulder restraint and lap belt. Dr Ritchey found that Mr Wilson suffered blunt trauma to his chest, neck, heart and spine. I accept Dr Ritchey's opinion.

Samples taken at autopsy were subject to toxicological analysis at the laboratory of Forensic Science Service Tasmania. The analysis found a blood alcohol content of 0.054 per 100 mL of blood and Atorvastin (which is used to treat high cholesterol and does not affect driving) in his system.

Both vehicles involved in the crash were examined by a transport inspector. The inspector found, and I accept, that neither had any defects which caused or contributed to the happening of the crash.

### **Conclusion**

Upon considering the significant volume of evidence gathered during the investigation, I am satisfied that the death of Mr Wilson was not suspicious.

It is difficult to determine whether Mr Wilson came to be on the incorrect side of the road due to a lapse in attention, drowsiness, or whether he made an error in driving on the incorrect side of the road. Mrs Wilson indicates that her husband, Mr Wilson, did not have difficulty driving on the left-hand side of the road. He had driven in Tasmania, and in New Zealand, without incident before. There is no evidence of Mr Wilson braking or attempting to change direction prior to impact. This tends to indicate he may not have been fully attentive to the act of driving.

In the ensuing head-on collision, Mr Wilson suffered multiple blunt trauma injuries that were the cause of his death.

I doubt that Mr Wilson's sleep apnoea or the inability to use a CPAP machine for a short time contributed to this death.

I find that contributing factors to the crash and subsequent death of Mr Wilson are:

- a) Fatigue caused by long-haul travel consisting three domestic flights and one international flight in the excess of at least 20 hours; and
- b) Presence of alcohol within his system consumed at some stage prior or during his travel from Launceston.

### **Comments and Recommendations**

I extend my appreciation to Senior Constable Barnard for his thorough investigation and report.

I also wish to thank Ms Stephanie Venetsanakos, Graduate Legal Trainee, for her assistance in relation to this finding.

The circumstances of Mr Wilson's death are not such that 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 Mr Wilson.

**Dated** 2 November 2020 at Hobart in the State of Tasmania.

**Simon Cooper**  
**Coroner**