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 Luke Callum Mayes

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

a) The identity of the deceased is Luke Callum Mayes;
b) Mr Mayes died as a result of becoming trapped under a bench in his electric wheelchair;
c) The cause of Mr Mayes' death was positional and mechanical asphyxia; and
d) Mr Mayes died on 20 August 2020 at 19/210 Chapel Street, Glenorchy, Tasmania.

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

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Christopher Lawrence, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Affidavit – Mr Nigel Mayes, sworn 23 February 2021;
- Affidavit – Ms Pamela Mayes, sworn 14 October 2020;
- Affidavit – Ms Paige Singline, sworn 23 October 2020;
- Affidavit – Ms Karmo (Riya) Devi, sworn 31 December 2020;
- Affidavit – Ms Ella Browning, sworn 12 March 2021;
- Affidavits (3) – Ms Sarah-Jane Picken, sworn 21 August, 24 August 2020 and 23 February 2021;
- Affidavit – Ms Krista Small, sworn 7 December 2020;
- Affidavit – Ms Linda Duggan, sworn 5 March 2021;
- Affidavit – Mr Ronan Dawe, sworn 23 March 2021;
- Medical Records – Royal Hobart Hospital;
- Medical Records – Hopkins Street Medical Centre;

- Records – Anglicare;
- Records – Ambulance Tasmania – 20 August 2020;
- Affidavit – Senior Constable Allison Woolley, sworn 16 April 2021;
- Affidavit – Monica Featherstone, Tasmania Police (rank not stated), sworn 10 March 2021;
- Affidavit – Anna Seymour, Tasmania Police (rank not stated), sworn 25 February 2021;
- Affidavit – Constable Oliver Scott, sworn 26 March 2021;
- Affidavit – Grant Creswell, Tasmania Police (rank not stated), sworn 14 December 2020;
- Affidavit – Sergeant Timothy Etheridge, sworn 27 April 2021;
- Affidavit – Senior Constable Nicholas Evans, sworn 22 February 2021;
- Affidavit – Constable Andrew Melbourne, sworn 28 February 2021;
- Body worn camera footage and photographs; and
- Miscellaneous medical reports.

Background

Mr Mayes was born in Hobart on 4 August 1987 the second son of Nigel and Pamela Mayes. Mr Mayes was educated and raised on the east coast of Tasmania before dropping out of school aged 15 to become a deckhand with his father on a fishing boat.

On Saturday, 23 August 2003 Mr Mayes, aged just 16, was a rear seat passenger in a vehicle driven by an intoxicated friend who lost control and crashed. Mr Mayes was thrown from the vehicle and suffered significant injuries including T5 level tetraplegia.

Following months of treatment in the Austin Hospital and rehabilitation at the Royal Talbot Rehabilitation Centre in Kew, Victoria, Mr Mayes eventually returned to Tasmania. After initial placement at St John's Hospital he moved into a unit in Montrose.

Following settlement of a damages claim for personal injuries arising out of the motor vehicle crash on 23 August 2003, Mr Mayes was able to buy his own home in Chapel Street, Glenorchy.

He continued to live in that residence, with his bull terrier Bruno, receiving ongoing care through Anglicare Tasmania, 3 hours each morning and 3 hours each evening. He also received support from both his father and sister.

Mr Mayes was unable to work. He never married and had no children but was in a relationship with Ms Krista Small.

His physical health was of course dominated by his spinal injury. He had very limited mobility and required the use of an electric mobility wheelchair. His mental health seems to have been good, particularly in light of his physical health.

Given the extent of his physical disability, Mr Mayes independence was quite remarkable. He was able to drive, mobilise in his electric wheelchair, use a grab stick to pick up things off the floor and broadly speaking, with assistance, live independently in the community.

Circumstances of death

On 20 August 2020 Mr Mayes' Anglicare day shift disability support worker Ms Devi arrived at about 7.30 am. It was her first shift at Mr Mayes' home. She assisted him out of bed helped him with his shower routine and also vacuumed the unit.

During some of the time Ms Devi was carrying out household chores Mr Mayes took Bruno for a walk. Reportedly he was, as normal, in very good spirits. Ms Devi said she enjoyed her shift with Mr Mayes "as he was happy and easy-going".

In the early afternoon, Mr Mayes went to the Coles supermarket at Northgate Shopping Centre. He bought groceries including cooking chocolate and brown sugar, and was served at a checkout by Ms Linda Duggan who had known him for 7 or 8 years as a regular customer. Ms Duggan served him at about 1.30 pm and said he was happy and "left in a happy mood".

Between 2.30 pm and 3.00 pm Mr Mayes was seen by a neighbour Ms Ella Browning. She saw him with groceries on his lap, obviously returning from Coles. Ms Browning and Mr Mayes waved to each other.

At 3.39 pm Mr Mayes sent his father a text message with a video of Bruno licking soup up off the kitchen counter. At 4.12 pm Mr Mayes sent the same video to his mother. This is the last known contact Mr Mayes had with anyone.

At 7.50 pm Anglicare worker Ms Sarah Picken arrived for her shift and found Mr Hayes in his wheelchair, wedged under his kitchen bench. Bruno was next to Mr Mayes. Ms Picken put the dog outside and called 000. Ambulance Tasmania records show that the call was made at 7.54 pm. An ambulance was dispatched immediately and arrived in just over 10 minutes. As she waited for the ambulance to arrive Ms Picken performed CPR upon Mr Mayes.

Ambulance paramedics were unable to detect any signs of life and Mr Mayes was declared deceased at 8:12 PM.

Investigation

Mr Mayes' body was formally identified at the scene by his father. It was photographed and examined by specialist police investigators. The scene was examined and photographed. Everything that occurred at the scene was captured on police body worn camera footage.

After the scene had been forensically examined Mr Mayes' body was taken by mortuary ambulance to the Royal Hobart Hospital. At the mortuary experienced forensic pathologist Dr Christopher Lawrence performed an autopsy. He provided a report in which he expressed the opinion that the cause of Mr Mayes' death was positional and mechanical asphyxia as a result of his entrapment under the bench in his electric wheelchair. I accept Dr Lawrence's opinion. Toxicological analysis of samples taken at autopsy proved unremarkable. Certainly, neither alcohol nor drugs played any part in Mr Mayes' death.

Mr Mayes' electric wheelchair was seized and subsequently examined by a technician at Scooters and Mobility (Tas Mobility). The technician – Mr Dawe – did not detect any mechanical deficiencies with the wheelchair which could have caused or contributed to Mr Mayes becoming trapped in it under his kitchen bench. He found the opposite: that the wheelchair worked correctly and that there were no issues with the controls of the brakes or speed. Mr Dawe also attended the scene of Mr Mayes' death at the request of the Coroner's Office and conducted a check confirming that the controls of the wheelchair were too tall to fit underneath the bench.

I am satisfied on the basis of Mr Dawes' evidence that there was nothing about the wheelchair which caused or contributed to Mr Mayes' death.

Conclusion

There is absolutely no evidence to suggest that Mr Mayes' death was the result of anything other than a tragic accident. There is no evidence to suggest his death was suicide.

The circumstances of Mr Mayes' death have been fully and comprehensively investigated by Tasmania Police at the request and direction of the Coronial Division of the Court. That investigation has not identified a scintilla of evidence to suggest a foul play or the involvement of any other person. On the contrary, all the evidence points to an accident by Mr Mayes losing control of his wheelchair.

Quite why he lost control of his of his wheelchair and became wedged under the bench is not something that can be determined. However, once he was trapped under the bench there was no method by which he could extract himself.

Comments and Recommendations

I acknowledge in particular Senior Constable Allison Woolley's extremely thorough investigation and comprehensive report.

The circumstances of Mr Mayes' 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 Mr Mayes.

Dated: 5 May 2023 at Hobart in the State of Tasmania.

Simon Cooper
Coroner