



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 Vanessa Claire Hayward

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

- a) The identity of the deceased is Vanessa Claire Hayward;
- b) Ms Hayward died as a result of injuries sustained in a motor vehicle crash;
- c) The cause of Ms Hayward's death was chest and abdominal injuries; and
- d) Ms Hayward died on 22 June 2017 at the Royal Hobart Hospital, Hobart, Tasmania.

Introduction

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Hayward's death. The evidence comprises:

- The Police Report of Death for the Coroner;
- Affidavit of Mary Hayward, Ms Hayward's mother;
- Victim impact statement of Mary Hayward;
- Report from the forensic pathologist who conducted the autopsy;
- Results of toxicological analysis of samples taken at autopsy;
- Affidavits of a number of witnesses to the crash and actions leading to it;
- Report of a transport inspector;
- Detailed report from crash investigation service officers;
- Complete DPP prosecution file; and
- Forensic and photographic evidence.

Background

2. Just after 9.00pm in an unroadworthy Mitsubishi Magna sedan, being driven at great speed by an unlicensed driver Zach [sic] James Muir-Bennett collided with a Holden Commodore sedan being driven by Ms Hayward. The collision occurred at the intersection of Roope and Pirie Streets in suburban New Town. Muir-Bennett drove through a stop sign immediately prior to the crash.

3. Ms Hayward was terribly injured as a result of the crash. She had to be cut from the vehicle before being rushed to the Royal Hobart Hospital (“RHH”) by ambulance but died at the hospital soon after her arrival there.

What a Coroner Does

4. Before looking at the circumstances surrounding Ms Hayward’s death something should be said about the role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any ‘reportable death’¹. A ‘reportable death’ includes a death where the death occurred in Tasmania and it was unexpected, unnatural or resulted from an accident or injury². Ms Hayward’s death obviously meets that definition.
5. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner’s role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Coroners Act 1995* asks. Those questions include who the deceased was, how he or she died, what was the cause of the person’s death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions. A coroner may also, if he or she thinks fit, make comments about the death being investigated or, in appropriate circumstances, recommendations with a view to preventing similar deaths in the future. Any comment or recommendation must be connected to the death and arises from the obligation to make findings³.
6. A coroner does not impose punishment nor award monetary compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner have the power to charge anyone with crimes or offences arising out of the death the subject of investigation. I note that in this case Muir-Bennett was charged, convicted and sentenced to a term of imprisonment in relation to him causing Ms Hayward’s death.
7. As noted above, one matter that the *Coroners Act 1995* requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

¹ See section 21 of the *Coroners Act 1995*.

² See section 3 of the *Coroners Act 1995*.

³ See *Harmsworth v State Coroner* [1989] VR 989 AT 995 - 996

Circumstances of Death

8. In the evening of Thursday, 22 June 2017 Ms Hayward took two friends, Mr Jesse Davies and Mr Nicholas Menzie to Kmart at New Town. Mr Davies wanted to buy some bedding. Ms Hayward picked the men up on Cascade Road in South Hobart at about 8.45pm.
9. Mr Menzie described her driving as “fine”. He said she did not appear to be affected by alcohol, that she drove in accordance with the speed limit and that she (and the others) were wearing seat belts to the best of his recollection. Mr Menzie was a front seat passenger; Mr Davies sat in the back of the Commodore.
10. After Mr Davies had completed his shopping they left Kmart via the Pirie Street exit (which was closest to where they had parked). It was dark. Ms Hayward had her headlights on as they drove south on Pirie Street, intending to head to Mr Davies’ house in South Hobart.
11. At the same time, Muir-Bennett was driving a Magna sedan West on Roope Street. He had earlier been drinking in a hotel in Moonah. Muir-Bennett and Jones left the hotel at 8.55pm. Muir-Bennett was driving; Jones was the front seat passenger. Muir-Bennett then drove the vehicle along Springfield Avenue into Highfield Street, Moonah. Each time the vehicle travelled towards and over speed humps, he turned its headlights off. He also turned the vehicle’s lights off whilst approaching intersections. He travelled consistently at over the speed limit of 50 km/h. Jones later told investigators the vehicle travelled consistently at speeds between 70 and 90 km/h.
12. At one stage, Muir-Bennett turned up a side street to avoid a police vehicle near Risdon Road because Jones had at least one outstanding arrest warrant.
13. Muir-Bennett then drove through the streets of New Town. He did so at high speed. Each time he approached intersections he turned the lights off - apparently considering this was a mechanism by which he could detect the approach of other vehicles.
14. Muir-Bennett then turned into Roope Street and crossed the Main Road past the Talbot Tavern. While travelling on the incorrect side of Roope Street, in an easterly direction, he accelerated heavily as he approached the intersection with Pirie Street. He then turned the vehicle’s headlights off, braked, turned the headlights back on and again accelerated heavily into the intersection, through a clearly visible stop sign before smashing into the driver’s side door of Ms Hayward’s Commodore.

15. Crash investigators later determined that at the moment of collision the Magna was travelling at between 77 and 80 km/h. I note the speed limit where the collision occurred is 50 km/h.
16. Without checking on the welfare of Ms Hayward or either of her passengers both Muir-Bennett and Jones fled the scene.
17. Police, Fire and Ambulance officers were soon on the scene. Mr Menzie and Ms Hayward were both trapped in the vehicle and were extracted by Fire Service personnel. Mr Davies was able to get out of the wreck unassisted. Ms Hayward was taken by Ambulance to the RHH in a critical condition. She arrived there at 10.10pm and was immediately admitted. Despite the best efforts of medical staff, she died just before midnight on 22 June 2017.

Investigation

18. Ms Hayward's body was transferred to the hospital's mortuary and formally identified⁴. After identification, an autopsy was performed by the then state forensic pathologist Dr Christopher Hamilton Lawrence. At autopsy, Dr Lawrence found that Ms Hayward had suffered massive injuries to the right side of her chest. She had lacerated lungs, heart and liver. He described the injuries as "unsurvivable". Dr Lawrence expressed the opinion, which I accept, that the cause of Ms Hayward's death was chest and abdominal injuries sustained in a motor vehicle crash.
19. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. No alcohol was detected as having been present in those samples. The drugs pseudoephedrine, methylamphetamine and cannabis were all detected as having been present in Ms Hayward's body at the time of her death.
20. Ms Hayward's motor vehicle was inspected by a transport inspector. That inspector provided a report in which he said, and I accept, that at the time of the crash the Commodore was roadworthy.
21. Police eventually apprehended Muir-Bennett and Jones. Jones afforded police a measure of co-operation in the investigation in relation to Ms Hayward's death; Muir-Bennett did not. The vehicle he was driving was also inspected by a transport inspector. It was found to have three defective tyres at the time of the crash. It should not have been driven on a public street.

⁴ See affidavit of Sgt A Peters sworn 23 June 2017.

22. Muir-Bennett was charged with Ms Hayward's manslaughter. He eventually pleaded guilty in the Supreme Court of Tasmania to causing Ms Hayward's death by dangerous driving. On 21 February 2018, he was sentenced to five years imprisonment. In addition, a two-month suspended sentence was activated by the sentencing judge.

Conclusion

23. I am satisfied to the requisite legal standard that Ms Hayward's death was caused by the driving of Muir-Bennett. Whilst some drugs were identified as having been present in Ms Hayward's body at the time of her death, I am satisfied that those drugs neither caused nor contributed to the occurrence of the crash in which she sustained her fatal injuries. All responsibility for her death rests with Muir-Bennett.

Comments and recommendations

24. The circumstances of Ms Hayward's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.
25. I convey my sincere condolences to the family and loved ones of Ms Vanessa Claire Hayward.

Dated 23 April 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner