



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 deaths of Jacob Allan Donohue, and Will Cecil Oliver

Find, pursuant to Section 28(1) of the Coroners Act 1995, in respect of Jacob Allan Donohue that:

- a) The identity of the deceased is Jacob Allan Donohue, date of birth 11 February 2003;
- b) Mr Donohue died from injuries sustained as the driver in a motor vehicle crash, in the circumstances set out in this findings;
- c) Mr Donohue's cause of death was multiple (head, trunk and limb) injuries; and
- d) Mr Donohue died on 14 October 2022 at Oatlands, Tasmania.

And I find, pursuant to Section 28(1) of the Coroners Act 1995, in respect of Will Cecil Oliver that:

- a) The identity of the deceased is Will Cecil Oliver, date of birth 11 July 2003;
- b) Mr Oliver died from injuries sustained as a front seat passenger in a motor vehicle crash, in the circumstances set out in this finding;
- c) Mr Oliver's cause of death was severe traumatic closed brain injury and hypoxic brain injury due to haemorrhagic shock caused by extensive chest and abdominal injuries; and
- d) Mr Oliver died on 15 October 2022 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into both deaths. The evidence includes;

- The Police Reports of Death to the Coroner for both deceased;
- An opinion of the forensic pathologist regarding cause of death for both deceased;
- Affidavits confirming identification of both deceased;
- Toxicology reports of Forensic Science Service Tasmania for both deceased;
- Reports of qualified vehicle inspectors regarding the condition of both vehicles involved in the crash;
- Affidavit of Michelle Donohue, mother of Mr Donohue;
- Affidavit of Beverley Leopold, grandmother of Mr Oliver;
- Affidavit of Keith Glyde, driver of the truck involved in the crash;
- Affidavit of Isabelle White, friend of Mr Donohue;
- Affidavits of two attending and investigating police officers, together with body worn camera footage and scene photographs;
- Report and affidavit of Constable Jared Gowen, qualified crash investigator;
- Medical records for Mr Donohue from Deloraine Medical Centre;
- CCTV footage from the truck at the time of the crash;
- Bureau of Meteorology weather observations;
- Download from Mr Donohue's mobile phone;
- Vehicle registration and driver licencing information;
- Roadworks information and crash history data report from Department of State Growth;
- Independent audit of the safety of the roadworks by Pitt & Sherry (Operations) Pty Ltd; and
- Records and drive-through videos from AWC Pty Ltd, engineering group overseeing the roadworks.

Background

Jacob Donohue was 19 years of age when he died. He lived in Telita in north-east Tasmania. He was one of four children of his parents, Michelle Donohue and Christopher Wilson. He completed his last years of schooling at Scotch Oakburn College in Launceston and, at the time of his death, he operated his own business testing milk in the dairy farming industry. He loved sport and was a member of the South Launceston Cricket Club. Just before his death, he met Isabelle White, and he was hopeful that his relationship with her would continue. Mr Donohue held a current Novice P2 driver licence. He was known to be a responsible driver and had lost only one demerit point for a low range speeding incident in 2022.

Will Oliver was 19 years of age when he died. He is the son of Matthew Oliver and Kim Oliver and has a twin brother, Samuel. He was a resident of Western Australia. The family had previously lived in Tasmania for a period of time during which Mr Oliver attended Cressy District School. There, he became friends with Mr Donohue and they would play cricket together. Mr Oliver subsequently completed his schooling in Western Australia and was a popular and conscientious student. He was well liked in his casual employment and aspired to join the police force. He enjoyed spending time at the gym with his brother and stayed in touch with Mr Donohue and his family. Sadly, Mr Oliver's mother passed away several months before his death.

Circumstances surrounding the deaths

At about 3.30pm on Thursday 13 October 2022, Mr Donohue left the Launceston area in his 2010 Kia Sportage SUV vehicle ("the Kia") to collect Mr Oliver from the Hobart airport. Mr Oliver had flown to Tasmania to attend Mr Donohue's mother's fortieth birthday party at her home address in the north-west of the state.

Late in the evening after collecting Mr Oliver, the pair went to McDonald's restaurant (likely in Bridgewater) for food before continuing towards Launceston on the Midland Highway. Mr Donohue was driving the Kia and Mr Oliver was a front seat passenger. Both were wearing their seat belts. Neither had consumed alcohol. At the time, the weather was inclement and rainy. Mr Donohue was not using his mobile phone whilst he was driving. However, at 11.59pm, Mr Oliver sent a Snapchat message to Isabelle White on behalf of Mr Donohue, advising her that they were driving.

Whilst navigating roadworks to the north of Oatlands, Mr Donohue unintentionally manoeuvred his vehicle to the incorrect side of the road and began to drive north in the southbound lanes. At the point at which he did so, it was raining and dark with no overhead street lighting.

The roadworks in the Oatlands area at that time extended north from Lower Marshes Road at Jericho to one kilometre north of Oatlands. Deviations in the road were marked with orange reflective bollards, orange cones (witches hats), speed reduction signage and lane deviation signage. At the conclusion of the roadworks on the northern side of Oatlands, there is a distance of approximately 1.4 kilometres before the northbound single lane and southbound lane become separated by a brifen wire dividing fence.

Prior to the commencement of the length of brifen fencing, the opposing lanes are separated by painted double white audible centrelines. At the commencement of the brifen fencing, a large “Keep Left” sign with a left-pointing arrow is present in the centre of the road to ensure that northbound traffic remains to the left of the brifen fence. Additionally, a “No Entry/Wrong Way” sign is present on the right hand road edge at that spot to warn vehicles from incorrectly entering the southbound lane. Prior to and at this location, there were visible orange reflective posts restricting travel in part of the left hand northbound lane. These were marking the transition of the roadworks area back to the existing road.

Most unfortunately, Mr Donohue drove across the audible centrelines just before the commencement of the stretch of brifen fencing, failing to observe the road signs which cautioned him against doing so. There is no evidence to suggest that this action was deliberate. He may have been distracted or did not pay careful attention to the signs. The rainy weather, the darkness and presence of the orange roadworks posts in the left lane were likely to have contributed to his action of driving into the opposing lane and then continuing on that path of travel.

With the brifen fencing dividing the lanes for opposing directions of travel, there is no opportunity for a vehicle in the incorrect lane to cross back into the correct lane. However, there was no evidence that before the crash Mr Donohue or Mr Oliver appreciated that they were travelling in the incorrect lane.

As the Kia was travelling north in the dual southbound lanes, a Scania Cab Over Prime Mover with an unladen 45-foot trailer attached (“the truck”) was travelling south in the southbound lanes.

The driver of the truck was Mr Keith Glyde, who was in the course of his employment with SRT Logistics. He held the appropriate licence to drive the truck and had been driving trucks for almost 40 years. He was travelling at 98 km/h, the speed limit for the highway being 110km/h. He had not consumed alcohol or drugs and the truck CCTV footage showed that he was paying attention to the road.

Mr Glyde, in his affidavit, stated that about 100 metres after the single southbound lane became double lanes, he saw a set of lights come around the curve ahead which were not flickering as he would have expected to see of a car travelling in the northbound lane on the opposite side of the dividing fence. He then realised that the headlights of the car were approaching directly at his truck and that the oncoming vehicle was on his side of the dividing barrier. Mr Glyde then saw the other vehicle moving to its right side to the edge of the road and he started to move the truck into his right hand lane to avoid a crash. However, the other vehicle then turned towards the truck and he had insufficient time to avoid the crash. The crash occurred in a location between York Plains Road and the St Peters Pass Rest Area.

In the crash, the Kia sustained massive damage, predominantly to the front end and driver side.

Mr Glyde exited his truck and went to assist the occupants of the other vehicle. He also called for emergency services. Mr Donohue was clearly deceased, confirmed by attending paramedics.

Mr Oliver was taken by ambulance to the Royal Hobart Hospital in a critical condition. Following scans in hospital it was determined that Mr Oliver, amongst other injuries, had suffered a catastrophic brain injury that was not compatible with life. After his death on 15 October 2022, Mr Oliver's organs were donated.

Comments and Recommendations

I am satisfied that a very thorough investigation has taken place into the tragic deaths of Mr Donohue and Mr Oliver. I am satisfied that Mr Donohue unintentionally drove onto the incorrect side of the road and the Kia was struck by a truck travelling lawfully in its correct lane. The driver of the truck was unable to avoid the crash. I am also satisfied that there were no defects in either vehicle that contributed to the crash.

The poor weather and darkness were likely contributors to Mr Donohue's driving error. It is possible that the roadworks and changed markings prior to the crash, including at the point of commencement of the brifen fencing, may have distracted him or caused him some confusion. However, I am satisfied that the roadworks were marked and configured appropriately. I note that an independent audit found that the signage was clear but recommended that at the point of transition from the end of the roadworks to the existing road, arrows be painted in the lane to mark direction of travel.

I extend my appreciation to investigating officer, Constable Jared Gowen, for his comprehensive and helpful investigation and report.

The circumstances of the deaths of Mr Donohue and Mr Oliver 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 both deceased.

Dated: 28 November 2023 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner