MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Decision and reasons pursuant to section 27 of the Coroners Act 1995 following an application to hold an Inquest

Pursuant to section 27(2) of the *Coroners Act* 1995 ("the Act") I now record my decision and specify the reasons for not holding a public inquest into the death of Jason Lee Patmore.

Hearing dates

15 February 2017 and 5 October 2017.

Counsel

Applicant - Sheridan Patmore	Mr A Gaggin
Motor Accidents Insurance Board ("MAIB")	Ms L Mackey

Introduction

The deceased is Jason Lee Patmore, born on 19 November 1970 and aged 44 years at the time of his death. He was married to Sheridan Patmore ("Mrs Patmore" or "the applicant"), who has applied pursuant to section 27 of the Act for a public inquest to be held into her husband's death. That provision allows a person considered by the coroner to have a sufficient interest in a death to request the coroner to hold an inquest. The same provision requires the coroner's decision in relation to that request must be recorded in writing with reasons specified.

The evidence indicates that Mr Patmore died on 25 August 2015 at the Royal Hobart Hospital as a result of injuries sustained by him in the morning of 29 July 2015 whilst in the course of riding his bike ("the crash").

The applicant submitted that an inquest should be held in order to properly determine the role that may have been played in the crash, and therefore Mr Patmore's fatal injuries, by a motor vehicle that was travelling in the opposite direction to that of Mr Patmore at around the same time as the crash.

The MAIB, as an interested party, opposed the application to hold an inquest.

In hearing the application, both interested parties were provided with the documentary evidence obtained in the investigation. A scene visit by both counsel with the main police crash investigator was also facilitated. Submissions in the application were made to me both in writing and at a case management conference convened for the purpose of the application.

The applicable law and principles

The death of Mr Patmore is not one in which a coroner is mandated to hold a public inquest under section 24 of the Act. Nevertheless, section 24 (2) provides that "a coroner may hold an inquest into a death which the coroner has jurisdiction to investigate if the coroner considers it desirable to do so".

Mr Patmore's death was a reportable death with a coroner having jurisdiction to investigate. This is because it occurred in Tasmania and was a result of an accident or injury. (Sections 3 and 21 of the Act).

The discretion conferred by section 24 is, in its wording, very wide.

In *Clancy v West* [1996] 2 VR 647 at [653] it was held by the three members of the Victorian Court of Appeal in respect of an identical provision that "a more absolute discretion conferred upon a coroner to hold or not to hold an inquest… could scarcely be formulated". See also *Taing and Nuon v Territory Coroner and Attorney General for the Northern Territory* [2011] NTSC 58 at [45]-[46].

In *Veitch v State Coroner* [2008] WASC 187, also dealing with provisions conferring indistinguishable discretion, Beech J at [35]-[38] stated that in determining whether it is necessary or desirable in the interests of justice that an inquest be held, regard may be had to the scope and focus of an inquest, having regard to the policy and objects of the legislation.

In *Conway v Jerram* [2011] NSWCA 319, in dealing with the discretion of a coroner to hold an inquest, the members of the New South Wales Court of Appeal confirmed the breadth of the discretion but observed that there was not an unlimited mandate, and that the question depended upon the scope of the coroner's functions. The court observed that it is important that extraneous factors do not obstruct the primary duty of the coroner to investigate thoroughly any reportable death under the legislation. Their Honours also observed that the scope of an inquest is a matter for the coroner to determine using both proper discretion and common sense [47]. Campbell JA referred to *Harmsworth v State Coroner* [1989] VR 989 in which Nathan J discussed the fact that the enquiry must be relevant in the legal sense to the death and that a coroner is not permitted to conduct a "wide, prolix and indeterminate" inquest surrounding remote issues.

The judgments of *Re State Coroner; Ex parte Minister for Health* [2009] WASCA165 *and R v Doogan; Exparte Lucas-Smith* [2005] ACTSC 74 also emphasise that the coroner is not authorised within his or her proper limits to undertake a roving enquiry into any possible causal connection, no matter how tenuous, between a particular fact or circumstance and the death of the deceased. This is the case even if some relevant factors might come to light.

In the context of the scope, a Tasmanian coroner has the function of finding, if possible, *how* death occurred pursuant to section 28 (1) of the Act. Such function usually requires the coroner to make an assessment for the purposes of scope of the enquiry as to substantial or

operating causes of the death that are not merely part of the background or too remote. The question of causation should be determined by applying common sense to the facts and not resolved by speculative or hypothetical theories. See for example *E & MH March v Stramare Pty Ltd* (1991) 171 CLR 506; *Campbell v The Queen* (1981) WAR 286; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1.

The authorities have provided guidance as to some particular factors to take into account in the exercise of the wide discretion to hold or not to hold an inquest.

In *Taing and Nuon v Territory Coroner* (*supra*) at [53] Blokland J stated that the discretion should be approached by assessing the strength of the available evidence and determining whether there would be any benefit in the holding of an inquest and whether it would yield further information that has not come to light.

In *Clancy v West* (*supra*) Tadgell JA (with whom Ormiston JA and Charles JA agreed) said [at 655 – 656] that it was reasonable for the coroner to consider the relative costs of holding an inquest as compared to doing without one, whilst duly weighing the benefits that an inquest may or may not produce. Similarly, in *Chol v White* [2016] VSC 561 at [55] Forrest J noted that it is peculiarly within the coroner's knowledge as to how to utilise the resources of the Coroner's Court in determining whether to hold an inquest as he or she is aware of the demands on the Court for mandatory inquests and in relation to other deaths which may necessitate the holding of an inquest.

In *Taing and Nuon v Territory Coroner* Blokland J at [13] noted that generally, assistance to pursue a private claim is not a reason to order a coronial inquest. In that case, the holding of an inquest to gain evidence for eligibility to obtain victims' compensation was held not to be a proper basis for the exercise of the coroner's discretion.

Some of the other factors that might be considered by a coroner in deciding whether or not to hold an inquest include but are not limited to: the need to resolve conflict between witnesses on essential facts regarding the immediate circumstances of death; the causing of gratuitous distress; whether the death is a high profile one or productive of public concern, such that there is a need to clarify the public record and dispel rumours; whether the death arises from circumstances that could pose a danger to others; whether recommendations will arise; the potential involvement of criminality; and evidence of breach of duty or standards by interested parties associated with the death.

Summary of evidence obtained in the investigation

The evidence in the death of Mr Patmore comprised the police report of death; affidavits of the applicant, eyewitnesses to the crash, attending police officers, crash investigators and a transport inspector; an affidavit and footage from a simulation ride; an opinion of the forensic pathologist as to cause of death; and ambulance and medical reports. A summary of the evidence is as follows.

Mr Patmore lived with his family at 69 Rosehill Crescent in Lenah Valley for almost 15 years. He was in good health.

He had increased his exercise regime over the preceding few months for reasons of fitness. He had been riding a bicycle nearly every day and would ride for between an hour and an hour-and-a-half on each occasion.

Mr Patmore bought his most recent bike from the Anaconda store for $520 in August 2014. He had the bike serviced on the 19 December 2014 where he had the derailleur replaced and the gears and brakes tuned.

At approximately 8.40am on 29 July 2015, Mr Patmore left home for his bike ride and told his wife that he would be home by 10.00am. Mr Patmore was wearing a bike helmet, black bike tights and shorts with other layers of clothing over the top. He rode down Rosehill Crescent in an easterly direction towards the city.

Mr Michael Triffitt was one of three workmen who were working on the road for the NBN installation in the front of 23 Rosehill Crescent at the time. In his affidavit he stated that he heard Mr Patmore approaching before he saw him. Mr Triffitt said that he heard the roaring sound of tyres coming down the street, almost like a 4-wheel drive vehicle. Mr Patmore then went past on his bicycle at a speed that Mr Triffitt estimated as being between 60kmh and 70kmh. He stated that he had noticed Mr Patmore on his bicycle because he was going so fast.

Mr Patmore subsequently passed a blue Ford Laser hatch, registration number EM 6270, being driven by Ms Louise McKinnon. Also in the vehicle was Ms McKinnon's 5-year-old daughter. Ms McKinnon was travelling west and along Rosehill Crescent. She had dropped her son to school and was intending to return to her residence at 25 Rosehill Crescent. In her affidavit she said that she was approximately 100 metres from number 25 when she saw Mr Patmore on his bicycle. She stated that she was travelling on her correct side of the road at a speed between 20kmh and 40kmh.

Ms McKinnon stated that she thought that Mr Patmore was going very fast and was travelling on his correct side of the road. Mr Patmore passed her vehicle just short of the bend near number 25 Rosehill Crescent, according to Ms McKinnon's account.

After Mr Patmore had gone past, Ms McKinnon immediately looked in her rear vision mirror and saw Mr Patmore's bicycle wobbling as though he had lost control of it. Ms McKinnon stated that Mr Patmore was still travelling very fast. She also stated that she was the only vehicle travelling on the road at the time. Ms McKinnon was worried for the safety of Mr Patmore so she drove a very short distance and turned around in the driveway at her home and returned to Mr Patmore. She also spoke to the workmen in front of number 23 and told them about her concerns for Mr Patmore.

Mr Patmore had come off his bicycle and was lying on the road outside number 36 Rosehill Crescent, the home of Nicholas Arnott, a nurse. In his affidavit, Mr Arnott stated that he was at his garage and putting his children in his car when he heard two short skidding sounds. Mr Arnott described the sounds as the skidding of a bike tyre when braking and they came from about 20 to 30 metres west up Rosehill Crescent. He stated that these skids were followed by a crash sound that was in front of his house. He walked to the road to assist.

When Ms McKinnon arrived at the crash scene in her vehicle Mr Arnott heard her say something like *"This looks really bad. We'll need an ambulance."* Ms McKinnon then rang '000'. Mr Patmore was lying face down on the road next to a parked blue Holden Nova with his head tilted to the right. His head was aligned to the east and his feet to the west. Mr Patmore's bicycle was towards the centre of the road, approximately 2 metres west of his feet.

Mr Triffitt had arrived at the scene and moved Mr Patmore's bicycle to the side of the road as other vehicles were attempting to get past.

Mr Arnott administered first aid to Mr Patmore and stated that his eyes were closed and he was non-verbal but breathing audibly. He stated that Mr Patmore had blood coming from his nose and possibly his mouth. He noted that Mr Patmore was still wearing his bike helmet.

An ambulance arrived at the scene at 8.52am, shortly after the crash. Police officers also arrived at the accident scene and closed the road to preserve the area and secure the safety of all persons present.

Mr Patmore appeared to have sustained significant life threatening injuries and was stabilised by paramedics before being transferred to the Emergency Department of the Royal Hobart Hospital where he received immediate attention and treatment.

A CT scan of Mr Patmore's brain showed a traumatic subarachnoid haemorrhage and diffuse brain injury. After initial treatment, Mr Patmore was stabilised and transferred to the Intensive Care Unit. Mr Patmore underwent significant treatment in the days and weeks that followed. He remained unconscious. On 24 August 2015, Mr Patmore suffered a major intracerebral haemorrhage and, sadly, died the next day, being 25 August 2015.

Investigation

I now set out the main evidence as to the manner of the investigation and the conclusions reached by the investigators regarding the crash.

Constables Andrew Tye and Caleb Wilson initially attended the scene where Mr Arnott was attending to Mr Patmore on the road. Constable Tye assisted in blocking the road to preserve the integrity of the scene. At 9.20am Sergeant Shane Sinnott attended to supervise the scene whilst Constables Tye and Wilson obtained statutory declarations from Mr Arnott, Mr Triffitt and Ms McKinnon.

Constable Tye attended 69 Rosehill Crescent, the home address of Mr Patmore, and advised Mrs Patmore of the accident.

Constable Adam Hall of Police Crash Investigation Services, a trained crash investigator, attended the scene at 9.50am. He then commenced to examine the scene with a view to forming conclusions as to how the crash may have occurred. Among other matters, he noted the presence of a 50 millimetre wide tyre scuff mark 1.8 meters long at the exit of the relevant right hand curve. The scuff mark was consistent with that of a bicycle.

Just to the west of the scuff mark, two unattended vehicles were parked legally in an easterly direction and on the northern side of the road.

Approximately 26 metres east of the tyre scuff mark were the presence of two gouge marks in the road that Constable Hall assessed as being caused by the crash. A further 2.7 metres south of the gouge marks was an amount of blood on the road surface.

Legally parked and unattended in the area of the blood and gouge marks was a blue Holden Nova hatch vehicle, parked facing east and on the northern side of the road. The blood on the road was located 1.3 metres east of the front of the Holden.

Constable Hall examined the Holden and, after speaking to the owner of the vehicle, was satisfied that it had not been struck by Mr Patmore's bicycle.

Constable Marisa Milazzo from Forensic Services attended the scene at 9.35am and took photographs and made observations. Once the scene was processed, Constables Tye and Wilson took Mr Patmore's bicycle to the police garage in Patrick Street, Hobart to enable further examination by a transport inspector.

On 11 September 2015, crash investigators Sergeant Rodney Carrick, Constable Hall and Constable Kelly Cordwell attended the scene for the purpose of conducting bicycle ride-through simulations by Constable Ralph Newton, an experienced mountain biker. The road was closed for the purpose of the simulations. Constable Newton had a GoPro recording device attached to the helmet he was wearing.

Constable Newton rode a bicycle that closely resembled that used by Mr Patmore on 29 July and travelled west to east on three separate occasions. Constable Newton took what can be described as a "racing line" on each occasion, riding close to the middle of the road to keep a tight line as he negotiated the right hand bend.

He rode the same course at three separate speeds – 50kmh, 55kmh and 60kmh. In his subsequent affidavit for the investigation, Constable Newton provided the opinion that Mr Patmore could have maintained control of his bicycle at each of those speeds. However, Constable Newton did not attempt to alter his course and noted that if he had done so, loss of control would have been possible.

Department of State Growth Transport Inspector, Noel Clarke, inspected Mr Patmore's bicycle on 4 September 2015. Mr Clarke stated that the quick release locking mechanism for the front wheel axle and hub assembly was not correctly adjusted, but could not say what effect this would have had on the handling characteristics of the bike. Constable Hall, in his affidavit, states that he was satisfied that this did not play a critical part in the crash due to the speed that the bicycle would have reached prior to the collision. Upon inspection of the remainder of the bicycle, Mr Clarke found no fault.

Constable Hall provided a comprehensive affidavit regarding his crash investigation. In the affidavit he stated that, after reviewing the evidence he had collected, he was satisfied that no other vehicles, stationary or mobile, were involved in the crash.

Constable Hall stated that it was possible that speed was a contributing factor in the crash, and if so the crash was most likely caused after Mr Patmore had passed Ms McKinnon's vehicle.

Constable Hall stated that the only physical evidence that speed may have been a factor is the scuff mark that was left at the scene where Mr Patmore would have applied the rear brake whilst negotiating the curve and leaving the scuff mark.

There was insufficient evidence however to calculate a speed of Mr Patmore's bike prior to the crash. It is realistic on the evidence of Constable Newton and the eye witnesses to conclude that he was likely to have been travelling in excess of 50kmh.

Submissions in relation to the holding of an inquest

Mr Gaggin, on behalf of the applicant, submitted that on the evidence as it stands there is a very real possibility that the vehicle driven by Ms McKinnon was, in some way, causative of the crash, whether by Ms McKinnon failing to keep a proper lookout, driving on the incorrect side of Rosehill Crescent, or driving at a speed excessive in the circumstances. In his letter to the Coroner's Office of 15 January 2016 he gave reasons for his submission as follows:

- Mr Patmore was an experienced rider with no record of accidents;
- The crash occurred shortly after Mr Patmore passed Ms McKinnon's vehicle;
- The markings on the road indicated that Mr Patmore was riding on his correct side;
- The accident occurred in close proximity to a corner on Rosehill Crescent;
- Ms McKinnon was not interviewed (presumably meaning a video interview); and
- There were no witnesses to the actual crash.

In subsequent submissions Mr Gaggin submitted that it appears clear from an independent assessment that this was a "two vehicle accident" not one involving only Mr Patmore's bike, even if there was no actual contact. In support of this conclusion, Mr Gaggin submitted that there was ambiguity in Ms McKinnon's initial police statement as to the location she referred to as the "left-hand bend" where she indicates that Mr Patmore passed her. He also submitted that the police investigation was inappropriate and inadequate. In this regard he cites a failure to properly remove or inspect Ms McKinnon's vehicle, a failure to adequately interview her, and a failure to investigate the impossibility of her viewing Mr Patmore in her rear vision mirror. He also submitted that Constables Tye and Hall appear to have acted on a preconceived view that Mr Patmore simply lost control of his bike.

He submitted, among other things, that if this matter proceeded to a public inquest it might well be found that Ms McKinnon was driving "slightly on the incorrect side" of Rosehill Crescent, forcing Mr Patmore to break and attempt to avoid a collision and thereby losing control, and therefore that her driving was a substantial cause of the crash.

He further submits that this matter could well attract recommendations regarding procedures for interviewing persons following similar fatal accidents and recommendations relating to full assessment of vehicles potentially involved in accidents to determine if there is any damage.

For all of these reasons, he submitted, a public inquest is required.

Ms Mackey, in opposing the application, submitted that Mr Patmore's death has already been the subject of competent investigation and that nothing further is to be served by holding a public inquest. She submitted that all crash analysis, reconstruction and collection of witness and physical evidence has been properly completed. Further, she submitted that her client's investigators have undertaken their own thorough factual investigation regarding the circumstances of the crash. In this regard the transcripts of the interviews with the main eye-witnesses were disclosed by the MAIB and were evidence in this application.

Ms Mackey submits that there is no evidence to suggest that Ms McKinnon's vehicle played any causative role in the crash, and in fact the evidence supports the contrary. Ms Mackey submits as follows:

> "Mr Patmore's bicycle was travelling at significant speed at the time he passed Ms McKinnon's vehicle as observed by Ms McKinnon. Mr Patmore was in control of his bike, albeit travelling very fast. No contact occurred between her vehicle and the bicycle and there is nothing to suggest that Mr Patmore took any evasive action regarding the car of Ms McKinnon either before or at that vehicle and indeed the accident occurred after the vehicle had passed.
>
> The car and the bicycle passed each other at, or just after, the left-hand curve in the road. Ms McKinnon's statement is that Mr Patmore passed her just short of the left-hand bend near her house. She looked in her rear vision mirror once he had passed and noted his bike to be wobbling as though he had lost control of it. He was travelling very fast. At the time that the bicycle passed her it was not in danger of crashing albeit travelling very fast. He did not look like he could stop the bike if he needed to. There is no evidence of the bicycle taking evasive action before or whilst passing Ms McKinnon's vehicle.
>
> There is evidence to suggest that Mr Patmore made an attempt to slow the speed of his bicycle at the accident, once he had passed Ms McKinnon's vehicle, leaving a scuffed tyre mark on the roadway of 1.8m in length. It is then that Mr Patmore lost control of the bicycle going over the handlebars and striking his head on the road surface and as a result, suffering a traumatic subarachnoid haemorrhage and diffuse brain injury from which he later died.
>
> There are many possible causes of Mr Patmore coming off his bicycle. Speed is perhaps the most likely one noting the consistent evidence of witnesses and the skid marks showing an attempt to slow the bicycle immediately prior to the fall. For an inquest to delve further into the possibility of either Ms McKinnon's vehicle or vehicles parked on the side of the road having any causative role would be pure speculation in light of the known facts and not in the public interest."

Ms Mackey further submits that the purpose of Mrs Patmore's application for an inquest is exposed by Mr Gaggin's correspondence to the Coroner's Office in which he submitted that the circumstances of the crash lead to the conclusion that it was a "motor accident" under

the *Motor Accidents (Liabilities & Compensation)* Act 1973. She submits that if the crash is considered by the applicant to be a motor accident, then the appropriate pathway is to pursue that issue in the Motor Accidents Compensation Tribunal for refusal to pay scheduled benefits upon the death of Mr Patmore; or, if negligence is asserted, in the Supreme Court of Tasmania under the *Fatal Accidents* Act 1934 for loss of dependency; or, if psychiatric injury is claimed, as a common law claim for damages for nervous shock.

Ms Mackey therefore submits, in summary, that the suggestion of a causative involvement by a motor vehicle (Ms McKinnon's or otherwise) is highly speculative, not based on fact and propelled by a desire to access benefits under the *Motor Accidents (Liabilities & Compensation)* Act 1973. In these circumstances, the costs and distress that would be occasioned by the holding of an inquest cannot be reasonably justified.

Conclusion

In my view, there is no foundation at all for the proposition that the circumstances leading to Mr Patmore's tragic death may be different in any material respect from those indicated by all of the evidence gained in the investigation. The evidence clearly points to Ms McKinnon driving her vehicle at the speed, location and manner stated coherently and consistently by her to both police and MAIB investigators. In summary, she was driving at a slow speed approaching the driveway to her house and on her correct side of the road when Mr Patmore passed her on his bike at speed.

Upon consideration of the independent statements of the NBN workers on Rosehill Crescent, it is to be noted that the conduct of Ms McKinnon demonstrated real concern for Mr Patmore whom she had seen lose control of his bike. Further, there was no suggestion that she conveyed to them by her words or behaviour that she considered that the presence of her vehicle was causative of Mr Patmore's crash, or that she had driven in a manner that may have contributed to it.

Consistently with the other evidence, Ms McKinnon's '000' call conveys her concern for Mr Patmore but not fault or involvement. I had the benefit of attending the crash scene with Constable Hall and a coroner's associate. At the left-hand curve where Ms McKinnon stated that she saw Mr Patmore pass her, it is plain that her rear vision would have allowed her to witness Mr Patmore losing control of his bike, particularly as her glance into the rear vision mirror was instantaneous after seeing Mr Patmore in front of her. There is no evidence from Constable Hall that Ms McKinnon could not have seen Mr Patmore as she described.

The evidence of Mr Patmore's very high speed in riding his bike down Rosehill Crescent is overwhelming. In the investigation, such evidence was provided by Ms McKinnon, Mr Triffitt and two other NBN workers interviewed by the MAIB, being Andrew Cordwell and Leigh Lovell. Mr Arnott's evidence of the heavy braking and skidding also supports Mr Patmore travelling at high speed with an associated loss of control. I particularly note that Mr Arnott did not hear any sounds of car tyres skidding or the sound of the collision into a car. There is no evidence of any other vehicles travelling on the road at the time apart from that of Ms McKinnon.

The scenario clearly conveyed by all witnesses, forensic evidence, ride-through simulations and opinion of the crash investigators is that of a loss of control by Mr Patmore whilst travelling at a high speed. In this regard I fully accept Ms Mackey's analysis in her submissions that I have previously set out.

On the evidence I could not rule out that Mr Patmore's loss of control might have been prompted by his reaction to seeing Ms McKinnon's vehicle travelling in the opposite direction even though Ms McKinnon was travelling on the correct side of the road and in other respects in accordance with her duty as a reasonable driver. However, the evidence indicates that Mr Patmore did not significantly change his line of travel whilst passing Ms McKinnon. Other possible causes of his loss of control at speed may have been his reaction to the parked cars on his left hand side of the road, a slight alteration in his line of travel, braking too hard or travelling onto a different part of the bitumen surface of the road. Unfortunately, errors in respect of speed or judgement with fatal consequences may be made by experienced riders with an otherwise good safety record.

I do not accept the applicant's submission that the circumstances of the crash were not appropriately or adequately investigated. The scene was secured in a timely manner and attended by properly qualified police officers who proceeded to competently investigate within their own areas of expertise. The important witnesses provided statutory declarations on the day of the crash. The fact that those statutory declarations were later sworn as coronial affidavits with identical content has no effect upon the quality of the evidence.

There should be no criticism of the fact that Ms McKinnon's vehicle was not seized for further examination to assess involvement in the accident. In hindsight, it may have been prudent for attending officers to specifically provide evidence as to the lack of damage to Ms McKinnon's vehicle and to photograph it. However, upon all of the evidence that they had efficiently accumulated from the scene, the conclusion that no contact with another vehicle had occurred was obvious. The decision not to video interview Ms McKinnon was also appropriate in the circumstances.

Attending officers did, appropriately, take the step of examining the parked Holden for damage and located its owner to confirm the lack of recent damage.

I do not consider that the minds of the investigating officers were closed to proper avenues of investigation. The decision to conduct the simulation is one example of ongoing, objective consideration of the cause or causes of the crash. The detailed affidavit of Constable Hall exposes logical and thorough reasoning and consideration of all relevant evidence to support his conclusion that no other vehicles were involved in the crash. I note that the applicant did not suggest that there were any further material witnesses who were relevant that had not been interviewed.

In all the circumstances I am satisfied that this is not a case where an inquest is warranted. The circumstances of Mr Patmore's death have been thoroughly investigated and are known as best as they are able to be known. The proposition that Ms McKinnon contributed to Mr Patmore's crash by driving in a manner contrary to that of a reasonably prudent driver is, at

best, hypothetical and against all of the evidence. Even if an inquest was held and some additional facts came to light, I am satisfied that they would not be such that the evidentiary conclusions would change.

In coming to the conclusion that no inquest should be held, I have had regard to other relevant factors as I have referred to earlier. In particular, it is apparent that one main reason for the applicant seeking an inquest is to assist in obtaining compensation in another forum. In his letter of 15 January 2016, Mr Gaggin stated "given the lack of witnesses, it is appropriate that full consideration be given as to whether Ms McKinnon was at fault. The ramifications legally for the deceased's widow are obvious". I observe that the coroner's role is not to determine fault but to investigate how death occurred. In assessment of causation for death, I accept that it may be necessary to consider the actions of any person involved in a particular death and whether those actions fell below a particular standard. However, there is no evidence at all that Ms McKinnon's actions were in this category. Secondly, the legal ramifications of a coronial finding for the applicant must not form part of the exercise of a coroner's discretion to hold or not to hold an inquest.

This is not a case where recommendations are likely to be made. This is not a case, as sad as it is, where public interest or community concern requires public ventilation. An inquest, if held, could not sensibly be limited to questioning of one or two main witnesses. All material witnesses would be required. This would necessarily involve significant preparation and resources that are currently scarce in the Coronial Division, particularly in light of the complex, mandatory inquests requiring listing.

For these reasons I do not consider that it is desirable to hold an inquest into the death of Mr Patmore.

Olivia McTaggart
Coroner