IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3898

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JACQUI HAWKINS, Coroner having investigated the death of STEVEN JOHN DOWS

without holding an inquest:
find that the identity of the deceased was STEVEN JOHN DOWS
born on 26 July 1973
and the death occurred on 19 August 2016
at Beechworth Wodonga Road, Wooragee, Victoria, 3747
from:

1 (a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER)

1. Steven Dows was 43 years old at the time of his death. He had recently moved into a new home in Yackandandah with his wife Magdalena (Maggie) Dows. Mr Dows had a young daughter, Stephanie from a previous marriage.

2. Mr Dows was described as a loving husband, father, son, brother and friend. He was also described as a positive person, who had a passion for life, a heart of gold and worked very hard towards he and his family's future.

3. Mr Dows was the owner of an engineering business which specialised in energy minimisation. The business involved the design and installation of energy saving and power reduction schemes for commercial and domestic users. Mr Dow's business was successful and steadily growing.

Mr Dows usually worked from home or from his office in Wangaratta but it was not unusual for him to travel frequently to visit customers and to follow potential leads on sales.

4. Mr Dows had no known medical or mental health conditions. According to his mother, Mrs Rosalie Dows, Mr Dows was fit and healthy.

5. Mr Dows' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability[1].

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Dow's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

8. In writing this Finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

Identity

9. Steven Dows was visually identified by his wife Maggie Dows on 19 August 2017. Identity was not in issue and required no further investigation.

Medical cause of death

10. On 23 August 2016, Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Dows and reviewed the post mortem computed tomography (CT) scan and the Form 83 Victoria Police Report of Death.

11. Dr Bouwer reported that at autopsy there were multiple injuries including head, chest, abdominal and pelvic injuries.

12. Toxicological analysis of post mortem blood did not detect any alcohol, common drugs or poisons.

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[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

13. Dr Bouwer provided an opinion that the medical cause of death was 1(a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER).

Circumstances in which the death occurred

14. On the morning of 19 August 2016, Mr and Mrs Dows woke at approximately 7am. During breakfast they discussed how they loved their new house. Mrs Dows left for work at approximately 8am and Mr Dows left some time after and was headed to his office in Wangaratta.

15. At approximately 9.15am, Mr Dows was driving south on the Beechworth Wodonga Road, on up an uphill section of the road known as the Rising Sun Hill, just north of 527 Wodonga Beechworth Road. At that particular location, Mr Dows would not be able to see over the crest of the hill, until he was approximately 117 metres away from it. At the same time Mr Dows was approaching the hill, another motorist Mr Thomas Hall, was travelling north along the same section of road, however he crossed the centre white lines, directly into the path of Mr Dows. Mr Dows attempted to take evasive action and avoid the collision by braking and steering to the left, but due to the steep terrain and the close proximity of trees on the outer edge of the road, could not steer out of the path of the oncoming vehicle and the two vehicles collided head on.

16. There were no witnesses to the accident, but several people arrived at the scene immediately after and contacted emergency services. Whilst the witnesses were waiting for the emergency services to arrive, they attempted to extract Mr Dows from his car and commenced cardiopulmonary resuscitation. Emergency services arrived and continued with resuscitation. Despite all best efforts, Mr Dows was unable to be resuscitated.

17. Mr Hall was also killed on impact.

Coronial investigation

18. Victoria police attended the scene and Leading Senior Constable Brian Tyler was tasked to commence a coronial investigation and compile a coronial brief.

19. According to witnesses, the first people at the scene stated that Mr Dows was wearing his seatbelt when they first saw him, and his seatbelt had been cut in an attempt to assist him.

20. Investigations revealed that Mr Dows was driving a blue Skoda Octavia sedan (Skoda), registration number 1CD 2DO. The Skoda had sustained catastrophic damage, which caused the engine and the transmission to become completely detached from the chassis.

21. The initial point of impact was identified by a deep gouge in the road surface, about midway across the south-bound lane between the centre line and the fog line, south of where the two vehicles involved in the crash had come to rest. Leading Senior Constable Tyler formed the opinion that the collision had occurred wholly within the southbound lane of the road. The collision reconstruction report from the Major Collision Investigation Unit confirmed this opinion.

22. The collision report found that Mr Hall had been travelling north at a speed in excess of 100 kilometres per hour, and had gradually crossed to the other side of the road, before colliding with the car driven by Mr Dows. The speed limit for the Beechworth Wodonga Road is 100 kilometres per hour. The report also concluded that Mr Dows was travelling at a speed of 80 kilometres per hour, and took evasive action to avoid the collision, by steering to the left and braking.

23. Leading Senior Constable Tyler determined that the Beechworth Wodonga Road was in good condition, and there was no evidence to suggest that the environment may have caused or contributed to the collision.

Investigations into Mr Hall's actions and subsequent death

24. Leading Senior Constable Tyler also investigated the circumstances of Mr Hall's death. Investigations revealed that Mr Hall was driving a white Mazda 2 (Mazda), registration XHA 581 north towards Yackandandah. Mr Hall was unlicensed at the time of the collision.

25. Senior Constable Nick Brickley, a mechanical investigator attached to the Mechanical Investigation Unit, carried out an inspection of the Mazda that was driven by Mr Hall. Senior Constable Brinkley found the car to be in a roadworthy condition prior to the impact. He noted that the front seat belt was taut and in a retracted position, which indicated that the pre-tensioner had activated whilst in this position. This suggested that Mr Hall was not wearing a seat belt at the time of the collision. Senior Constable Brickley did not identify any mechanical fault with the Mazda that would have caused or contributed to the crash.

Mr Hall's mental health

26. Mr Hall had suffered from schizophrenia for a number of years. His medical records indicate multiple admissions to hospital on an involuntary basis, as well as significant contact with community mental health services. Mr Hall was reported to be non-compliant with his medication. He did not have a history of violence or self-harm.

27. On 8 August 2016, Mr Hall was attended to by a caseworker, who administered his medication by way of 'depot' injection. Mr Hall expressed that he would be "*happier dead*" as his "*life was hell*", however he did not voice any plans or intent to commit suicide to the clinician, and at that time was not identified as being a risk to himself or others and therefore was unable to be involuntarily admitted to a mental health facility.

28. On the evening of Wednesday 17 August 2016, Mr Hall arrived unannounced at his mother's house, and stayed for two nights. Mrs Hall regularly attended a walking group on Fridays, and on Thursday evening they made arrangements for Mr Hall to accompany her the following day. She reported that in the days leading up to the incident, her son appeared calmer, which was illustrated by his acceptance of her invitation. On Friday 19 August 2016, Mr Hall decided that he no longer wished to accompany his mother on the walk, and indicated that he would prefer to stay in bed for a little longer instead.

29. When Mrs Hall returned from her walk, she found that her gate and her garage door had been left open, and her car missing. Mrs Hall reported that her son no longer drove, and that it was out of character for him to take her car. She indicated that Mr Hall had previously held a drivers licence, and had not renewed it, once it had expired due to his repeated hospitalisations.

Mr Hall's cause of death

30. On 24 August 2016, Dr Clare Hampson, Forensic Pathologist Registrar at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Hall.

31. Dr Hampson was not able to exclude the possibility of a cardiac arrhythmia as a contributing factor. Cardiac arrhythmia can present as a sudden loss of consciousness, seizures or sudden death. Mr Hall's risk factors for cardiac arrhythmia included coronary artery atherosclerosis and schizophrenia. Dr Hampson reported that it is recognised that people with schizophrenia have an increased risk of sudden death compared to the general population, presumed to be due to cardiac arrhythmia. In addition, schizophrenia is a disease that can affect mood, cognition, judgment and behaviour. Dr Hampson also stated that it was not possible to exclude Mr Hall's mental state as a contributing factor in this case.

32. Dr Hampson provided an opinion that the medical cause of death was 1a) INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER) IN A MAN WITH CORONARY ARTERY ATHEROSCLEROSIS AND SCHIZOPHRENIA.

Findings

33. Having considered the evidence I am satisfied that no further investigation is required.

34. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

35. I find that:

    a. the identity of the deceased was Steven John Dows born on 26 July 1973; and

    b. the Steven Dows died on 19 August 2016 from 1(a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER)

    c. in the circumstances described above.

36. I find that on 19 August 2016, Mr Thomas Hall drove a Mazda 2, head on into the vehicle driven by Mr Dows on the Beechworth Wodonga Road, Wooragee.

37. In determining whether or not Mr Hall intentionally caused Mr Dows' death, I have considered the background circumstances related to Mr Hall. Mr Hall had a medical history of schizophrenia, for which he received community mental health treatment. He had also recently expressed suicidal thoughts to his mental health case worker, 11 days prior to the collision, but was not found to meet the requirements of an involuntary admission to a mental health facility. On the other hand, the autopsy report could not exclude the possibility that Mr Hall may have suffered a cardiac arrhythmia. There is no presumption for or against a finding of suicide. Nevertheless, a finding that a person has deliberately taken his or her life can have long lasting ramifications for families and friends of that person. Therefore, it should only be made when there is clear and cogent evidence. Having considered all of the circumstances, and on the balance of probabilities, I am not comfortably satisfied as to whether or not Mr Hall's actions were the consequence of suicide or whether they are the result of a natural event, such as a cardiac arrhythmia.

38. I accept that this finding may not provide all of the answers that the family and friends of Mr Dows so desperately seek and I acknowledge the grief and devastation that you have endured as a result of your loss.

I direct that a copy of this finding be provided to the following:

The family of Mr Dows

Information recipients; and

Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 25 August 2017