IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 003899

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

(Amended pursuant to section 76 of the Coroners Act 2008 as at 13 July 2018)

I, JACQUI HAWKINS, Coroner having investigated the death of THOMAS EDWARD MACKENZIE HALL

without holding an inquest:

find that the identity of the deceased was THOMAS EDWARD MACKENZIE HALL

born on 19 November 1974

and the death occurred on 19 August 2016

at Beechworth Wodonga Road, Wooragee, Victoria, 3747

from:

1 (a) INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER) IN A MAN WITH CORONARY ATHEROSCLEROSIS AND SCHIZOPHRENIA

1. Mr Thomas Hall was 41 years old at the time of his death. He lived in Wangaratta, and was unemployed.

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

3. 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].

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

5. 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

6. Mr Hall was visually identified by his mother, Rosalyn Hall, on 19 August 2016. Identity was not in issue and required no further investigation.

Medical cause of death

7. On 24 August 2016, Dr Clare Hampson, Forensic Pathology Registrar at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Hall and reviewed the Form 83 Victoria Police Report of Death, the medical records of Mr Hall, obtained from the Docker Street Medical Centre, and the post mortem CT scan.

8. Dr Hampson found evidence of multiple traumatic injuries to the head, chest, abdomen, pelvis, and limbs. Dr Hampson reported that Mr Hall suffered unsurvivable injuries that would have rapidly resulted in death.

9. 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.

10. Toxicological analysis of post mortem blood retrieved on 20 August 2016 and 24 August 2016 detected the presence of hydroxyrisperidone and zuclopenthixol. Hydroxyrisperidone is a

[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.

metabolite of risperidone and zuclopenthixol, both of which were anti-psychotic medications that had been prescribed to Mr Hall. The level of zuclopenthixol was found to be mildly elevated above a therapeutic concentration, however, according to Dr Hampson this was not likely to be significant.

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

Circumstances in which the death occurred

12. Mr Hall's mother, Rosalyn Hall, reported that her son 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.

13. In April 2016, Mr Hall was subject to a twelve month community treatment order. Whilst being case managed by the Wangaratta Community Mental Health Service, he expressed paranoia around the provision of his medication. Mr Hall's management plan indicated that he did not have a history of violence, nor did he have a history of self injury.

14. On 26 May 2016, Mr Hall presented at the Wangaratta Emergency Department after calling an ambulance, stating that he was experiencing overwhelming thoughts of self-harm. Mr Hall was not assessed by a mental health clinician, and discharged himself that night.

15. On 30 May 2016, Mr Hall saw a general practitioner, where he asked that the doctor euthanise him. The general practitioner placed Mr Hall on an Assessment Order and arranged for him to be transferred to the Wodonga Emergency Department for assessment by the mental health team. Mr Hall was admitted to the Kerford Clinic as an involuntary patient that day, and was discharged on 1 August 2016. His discharge plan recommended that he move to a rehabilitation unit, however Mr Hall indicated that he would prefer to remain at home.

16. 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.

17. 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.

18. When Mrs Hall returned from her walk, she found that her gate and her garage door had been left open, and her white 2007 Mazda 2 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.

19. At approximately 9.15am, Mr Hall was driving north on the Beechworth Wodonga Road, on a section of the road known as the Rising Sun Hill, just north of 527 Wodonga Beechworth Road. At the same time, another motorist, Mr Steven Dows was driving a blue 2016 Skoda Octavia in the opposite direction, along the same section of road. It appears that Mr Hall 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.

20. 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, witnesses attempted to provide assistance to Mr Hall but it was apparent he was deceased.

21. Mr Dows also died at the scene.

Coronial investigation

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

23. Investigations revealed that Mr Hall was driving a white Mazda 2, registration XHA 581 north towards Yackandandah. Mr Hall was unlicensed at the time of the collision.

24. 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.

25. 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.

26. 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.

27. 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.

Findings

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

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

30. I find that:

    a. the identity of the deceased was Thomas Edward Mackenzie Hall born 19 November 1974; and

    b. Thomas Hall died on 19 August 2016 from 1(a) *injuries sustained in a motor vehicle incident (driver) in a man with coronary artery atherosclerosis and schizophrenia*;

    c. in the circumstances described above.

31. 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.

32. 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.

33. I wish to express my sincere condolences to Mr Hall's family. 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 Thomas Hall;
Information recipients; and
Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 25 August 2017