QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Troy Jason Howse**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO:	2010/1051
DELIVERED ON:	20 September 2012
DELIVERED AT:	Rockhampton
HEARING DATES:	29 & 30 May 2012, 8 August 2012
FINDINGS OF:	AM Hennessy, Coroner
CATCHWORDS:	Coroners: inquest, motor vehicle accident; identity of driver; refusal of doctors to allow a blood specimen to police during investigation of fatal accident; referral to Director of Public Prosecutions

REPRESENTATION:

Prosecutor Assisting:	Sgt D Dalton, Police Prosecutor
For Next of Kin:	Mr R Pack (instructed by AK Pack)
For Phillip HUDSON:	Mr B McGowran, Solicitor

These findings seek to explain, as far as possible, how the death of Troy Jason Howse occurred. Mr Howse died from head injuries sustained in a motor vehicle accident on the 28 March 2010 which occurred on Old Byfield Road, Cobraball, near Yeppoon. The only other occupant of the vehicle was Mr Howse's friend, Mr Phillip David Hudson. The primary issue investigated at the Inquest was which of the men were driving the vehicle at the time of the tragic accident.

THE CORONER'S JURISDICTION

1. The coronial jurisdiction was enlivened in this case due to the death falling within the category of "*violent death"* under the terms of the Act. A Coroner has jurisdiction to investigate the death under s 11(2), to inquire into the cause and the circumstances of a reportable death and an Inquest can be held pursuant to s 28.

2. A Coroner is required under s 45(2) of the Act when investigating a death, to find, if possible:-
   - the identity of the deceased,
   - how, when and where the death occurred, and
   - what caused the death.

3. An Inquest is an inquiry into the death of a person and findings in relation to each of the matters referred to in s 45 are delivered by the Coroner. The focus of an Inquest is on discovering what happened, informing the family and the public as to how the death occurred, but not on attributing blame or liability to any particular person or entity.

4. The Coroner also has a responsibility to examine the evidence with a view to reducing the likelihood of similar deaths. Section 46(1) of the Act, authorises a Coroner to "*comment on anything connected with a death investigated at an Inquest that relates to – (c) ways to prevent deaths from happening in similar circumstances in the future."* Further, the Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.

5. Due to the proceedings in a Coroner's court being by way of inquiry rather than trial, and being focused on fact finding rather than attributing guilt, the Act provides that the Court may inform itself in any appropriate way (section 37) and is not bound by the rules of evidence. The rules of natural justice and procedural fairness apply in an Inquest. The civil standard of proof, the balance of probabilities, is applied.

6. All interested parties can be given leave to appear, examine witnesses and be heard in relation to the issues in order to ensure compliance with the rules of natural justice. In this matter, the family of Mr Howse and Mr Hudson were represented at the Inquest.

7. I will summarise the evidence in this matter. All of the evidence presented during the course of the Inquest, exhibits tendered and

submissions made have been thoroughly considered even though all facts may not be specifically commented upon.

The Facts

8. At about 11.45pm on Sunday 28 March 2010, a single vehicle traffic crash occurred on Old Byfield Road, Cobraball, via Yeppoon. The crash involved a red Ford Falcon V8 Sedan (unregistered and uninsured) carrying Phillip Hudson (owner of vehicle) and Troy Howse. Mr Howse died in the crash from massive head injuries. Mr Hudson was injured and was transported to Rockhampton Hospital for treatment.

9. Mr Howse was born on 3 August 1975 and at the time of the accident was 34 years 7 months of age. He was a single man with no dependants and resided in Yeppoon. He was employed as a diesel fitter at a mine near Blackwater and at the time of his death was on days off.

10. During the morning of 28 March 2010, Mr Howse and Mr Hudson rode dirt bikes at the Yeppoon motorcross track. At the track they met a friend, Damian Lyle Baker. Conditions at the track were muddy and they left around lunchtime, and travelled to Mr Hudson's residence at 1642 Old Byfield Road, Lake Mary. Upon arriving at Mr Hudson's residence, Mr Hudson, Mr Baker and the deceased cleaned the dirt bikes and started drinking beer and rum which they mixed themselves. There was an unknown quantity of beer and at least two (2) 1125 millilitre bottles of rum.

11. Mr Hudson resided on the same road that the incident took place. Mr Hudson was the owner of the red 1981 Ford Falcon V8 sedan which he kept at his residence. The vehicle was unregistered and uninsured and Mr Hudson had fitted registration plates to it from a Commodore vehicle he and his mother owned. The registration for the Commodore vehicle expired in 2007.

12. Mr Hudson, Mr Baker and the deceased continued drinking throughout the afternoon and around 3.30pm decided to work on the Ford vehicle. The vehicle had not been driven or started for some time before this day. They eventually got it running and Mr Baker and Mr Hudson took it for a test drive. Mr Hudson drove the vehicle down the driveway onto Old Byfield Road before Mr Baker drove it back. Before taking the vehicle for a test drive Mr Baker consumed an unknown quantity of beer and between five and six plastic cups of rum which he mixed himself. He can recall Mr Hudson was mixing his own drinks and was drinking "*one for one*" with him.

13. Mr Hudson cannot recall working on the vehicle and denies taking it for a test drive. He later conceded his memory is not that good and Mr Baker's level of intoxication was not too bad so he might remember better.

14. After taking the vehicle for a test drive, it was parked in the shed and the drinking continued. Mr Hudson's mother made dinner for them around 7.00pm before receiving a call from Mr Baker's partner, Samantha Law, around 8.00pm who was upset because she was unwell and was expecting Mr Baker home.

15. Mr Baker eventually decided to walk home leaving Mr Hudson's residence somewhere between 8.00pm and 11.00pm. About five to ten minutes after Mr Baker left, Mr Hudson and Mr Howse decided to follow Mr Baker and see if he would return and continue drinking. Mr Hudson drove his Landcruiser vehicle and admits to being intoxicated at the time, having been drinking for most of the afternoon. They met with Mr Baker about a kilometre from Mr Hudson's residence. Mr Baker observed Mr Hudson driving his Landcruiser vehicle with the deceased in the passenger seat. He can recall Mr Hudson lunged at and chased him (in a friendly fashion) when he refused to return to Mr Hudson's residence. Mr Hudson and Mr Howse then returned to Mr Hudson's residence and continued drinking.

16. Later in the evening, Mr Hudson's mother was in bed at the premises and heard the engine of the Ford vehicle being revved and then idling down the driveway. The vehicle was driven a short distance down the road before it crashed.

17. Old Byfield Road, Cobraball is, at the scene of this incident, an unsealed gravel and dirt road without line markings. The road surface was in a good condition at the time of this incident and contained only a small amount of loose dirt and gravel. The road runs roughly east/west and is used mostly by local traffic. The road is about six metres wide with grass and dirt shoulders. There is no curbing or lighting due to the rural setting. There is a slight rise and gentle curve to the right at this section of roadway. The speed limit is 100 kilometres per hour (unsigned).

18. Police officers attended the incident on the night and investigated the crash. There was no evidence of another vehicle, person, animal or road condition that might have contributed to the crash. The weather was fine with only a light shower of rain just after the accident.

19. Police investigations determined that the vehicle was travelling in a westerly direction on Old Byfield Road when it went out of control and rolled onto its roof, coming to rest on the southern side of the road. Mr Howse was thrown from the vehicle and died from head injuries at the scene.

20. The first witnesses to the scene were the residents of a nearby house who heard a loud engine revving noise immediately before the crash. They were on the scene in a matter of minutes. Mr Hudson told them that he had been drinking and lost control but later changed his story to

say that Mr Howse was driving. Mr Hudson also told the witnesses that he had pulled Mr Howse out of the vehicle. There is contention on the evidence as to what Mr Hudson said and how it can be interpreted.

21. The vehicle sustained substantial damage to the passenger side front corner of the roof, the top of the guard on the same side and that side of the bonnet. That corner of the roof was crushed down into the passenger compartment. The front windscreen had been broken out and the front passenger side window had been smashed. The driver's window was wound down and was still intact.

22. A mechanical inspection of the vehicle found a number of defects but none such that they would have contributed to the crash. The driver's side seat belt had been tied up in an extension position, secured with a cable tie. The seat belt could not be retracted though the inertia reel function of the seat belt mechanism was still functional.

23. Mr Hudson was treated at the Rockhampton Hospital for a laceration to the left side of his head which was bleeding. He was seen to have some bruising or marks across his abdomen. All of the doctors who saw Mr Hudson were under the belief (from information from Mr Hudson and/or the ambulance officers) that he was the passenger in the vehicle.

24. It was clear from all of the evidence, witnesses at the scene, ambulance officers and doctors at the hospital that Mr Hudson was intoxicated. Mr Hudson also admitted that he had been drinking during the day to the same extent as Mr Howse and that he was intoxicated.

25. Police made a request of the medical personnel at the Hospital for a sample of blood from Mr Hudson given the likelihood of there being an investigation into whether he was the driver. This request was refused. The evidence is unclear and the medical notes not sufficiently documented as to how that request was handled and by whom. The evidence appears to indicate that Dr Gupta, the surgical registrar who consulted with Mr Hudson, refused the request. He has suggested this was on the basis that it could not be done immediately it was asked for due to the need for a head CT scan. The Police officers attending were under the impression that the refusal was definite but Dr Gupta seemed to be saying in his evidence that it was something which could wait. None of the medical personnel were of the retrospective opinion that Mr Hudson was not well enough to have blood taken for that purpose.

26. Section 80(10D)(a) of the *Transport Operations Road Use Management Act 1995 ("TORUM")* allows health care professionals to refuse a request by police for a blood sample. It is concerning that a request by police for a blood sample and the decision of medical staff including reasons were not documented by hospital staff. It is clear Mr Hudson was extremely intoxicated at the time of the accident. In the absence of a blood test, Mr Hudson's level of intoxication is based on

his admissions and the evidence of witnesses who observed his demeanour and alcohol consumption. A refusal for a request for a blood sample could have serious consequences for police investigating other matters because they might fall outside the time limit prescribed by section 80 of the TORUM.

27. Obviously this situation was less than optimal due to the unclearness surrounding which doctor was responsible for making the decision on the Police request (and the lack of recording of the matter), the need for compliance by Police with timeframes regarding testing for blood alcohol content, and the difference between what was communicated to Police and what the actual opinions of the doctors were.

28. Dr Buxton performed an autopsy on Mr Howse following the incident and was of the opinion that Mr Howse's injuries were consistent with him having been the driver. Mr Howse had a blood alcohol reading of .171%. He had gravel abrasions on the point of his right shoulder and no evidence that he was wearing a seat belt. He suffered a cerebral contusion and fractured skull which were catastrophic injuries and caused death quickly.

29. Sgt Stocker, QPS Senior Collision Analyst attached to the Forensic Crash Unit at Brisbane, compiled a collision analysis of the incident. He concluded that the vehicle was travelling at a minimum speed of 66 km/hr at the time it left the road. In the opinion of the Police Officer, the scene evidence indicated that Mr Hudson was the driver and Mr Howse the passenger. Due to the directly contrary medical evidence, Sgt Stocker was unable to determine which of the men was the driver of the vehicle.

ISSUES

30. The primary issue for determination at the Inquest is the identity of the driver at the time of the crash. The Family of Mr Howse have submitted that a finding should be made that Mr Hudson was the driver. Mr Hudson submitted it should be found that Mr Howse was driving.

Evidence against Phillip David Hudson being the driver

31. The evidence of Mr Hudson is that he recalls being in the passenger seat of the vehicle. In this regard, Mr Hudson relies on recollections of looking for a cigarette; telling Troy (Mr Howse) to slow down for a creek crossing; and a recollection of the Ford vehicle rolling out of the gate to his property. During the interview conducted by Police with Mr Hudson on the 31 March, Mr Hudson did make mention to a recollection of sitting in the passenger seat rolling out of the drive way and commenting for Troy to slow down for a crossing.

32. Mr Hudson advised QAS officers at the scene, Police and medical practitioners at the Hospital that he was the passenger. There were no witnesses who saw him driving at a time proximate to the crash. There

is some medical evidence in support of his contention that he was the passenger.

33. The Prosecutor Assisting submitted that it is noteworthy that Mr Hudson was unable to provide a detailed account of events at the time of these recollections which he described as flash backs. He could not comment for instance if he was wearing a seatbelt, or if he had a drink in his hand at that time. He also has made a comment that he believed he was located in the passenger seat of the car on the logic that he was flat out walking at that time due to alcohol consumption.

34. It was submitted that the credit which should be attached to such recollections is limited, particularly taking into account the fact that Mr Hudson was considerably intoxicated at the time of the motor vehicle accident.

Medical Notes – Hospital Chart

35. In the Rockhampton Hospital medical notes, Dr Roach has referred to Mr Hudson as a passenger of vehicle. This information appears to have emanated from either Mr Hudson himself or ambulance staff. Similarly Drs Gupta and Kumar stated in their notes that Mr Hudson was the passenger and that were derived from secondary sources such as Mr Hudson and Ambulance officers.

36. Mr Hudson had bruising to the left hip which, it is submitted is consistent with his coming into contact with the passenger side door which was bowed out during the incident.

Evidence of marks on Mr Hudson's abdomen

37. Various doctors gave evidence of marks or bruising to Mr Hudson which may relate to the wearing of a seat belt. Dr Roach gave evidence that her diagram which shows a mark across Mr Hudson's abdomen, extending from the left upper quadrant, diagonally across the central abdomen to the lower quadrant, may suggest he was sitting in the passenger side of the vehicle. The Doctor's diagram drawn in progress notes shows a mark below the navel level. Doctor Roach would not draw conclusions as to whether the mark was formed by the lap strap or sash strap of a seat belt, stating "*it would be difficult to comment given the bruising marks are just across the abdomen. So without knowledge of their – the nature of the – the crash and the forces involved, it would be difficult to comment from a medical perspective. I'm not expert in seatbelt marks.*" The Doctor was hesitant to comment if a loose fitting lap belt may be able to create marks in the opposition direction, without knowing the forces involved. The doctor formed her opinion as to Mr Hudson being the passenger from the information she was told and based on her examination of the injuries. The other doctors who dealt with Mr Hudson were not able to add to the evidence in this regard. Dr Gupta, who sighted Dr Roach's diagram, suggested that the mark would be from the lap strap and said that with such marks you can not tell whether the patient might be the

passenger or driver. Dr Gupta also stated that the mark to the abdomen could have been caused by something besides a seatbelt, suggesting a host of things, including a steering wheel could not be excluded as the cause. Dr Gupta did not resile from his position that Mr Hudson was the passenger. Dr Roach's evidence is uncertain at best and inexpert to the extent that she had little experience with seatbelt markings at the time of the treatment of Mr Hudson.

38. Sergeant Stocker provided evidence that a loose fitting seat belt could cause the direction of the seat belt injury to change, stating, "*yes I would agree that a person could move relative to the seat belt straps up until it came into contact with them*."

DNA Evidence

39. Amanda Reeves, a scientist with QFSS, gave evidence that a DNA swab taken from the steering wheel of the vehicle matched the DNA profile of Troy Howse. Ms Reeves accepted that the presence of DNA does not establish that a person touched that location, making reference to the possibility of secondary transfer of the DNA material. Similarly, a time frame for the deposit of the DNA sample was not able to be ascertained due to the number of variables involved.

41. The DNA of samples swabbed from the ground outside the driver's window and the driver's seat belt buckle were found to have a high probability of originating from Philip Hudson. Sergeant Stocker stated, "*from my opinion its either he (Hudson) made contract with the seatbelt with blood or the seatbelt has come into contact with his blood".*

42. Given Mr Hudson had a head injury which was bleeding, and he extricated himself from the vehicle (not being able to remember how he exited the vehicle), the presence of blood/ DNA on the driver's seatbelt buckle and outside the drivers door does not allow a conclusive inference to be drawn as to how the samples may have come to be there. Any conclusions over who was driving associated with the location of DNA would seem very limited.

Opinion of Dr Buxton

43. Dr Buxton opined that Mr Howse was the driver of the vehicle at the time of the accident. This opinion takes into account that most of the injuries sustained by Mr Howse are to the right side of the head. Further lacerations running across the forehead, and on the left side, were said by Dr Buxton to be consistent with the head coming into contact with the upper surround of a windscreen. Marks on the right side of the body were consistent with contact with the door or perhaps occurred during eviction from the vehicle.

44. Dr Buxton was asked whether Mr Howse's head injuries could have occurred whilst he was in the passenger side and partially ejected from the vehicle, as the roof / passenger side A pillar came into contact with the ground during the roll over. The Doctor stated that if that was the

case "*with that coming down I'd expect more extensive injuries to the– left side of his head*." Dr Buxton considered it most likely that Mr Howse was ejected from the driver's side window during the crash.

45. Dr Buxton was of the opinion that Mr Howse's head injuries were not caused after he was ejected from the vehicle, stating, "*You get fairly messy injuries where they hit the ground and you get more tearing rather than cutting. This was a – the main injury to the right side of the head was more of a linear laceration*", such as might be consistent with hitting a door or window frame.

Evidence in favour of Phillip David Hudson being the driver

46. Counsel for the Family submits that there is a larger body of evidence that supports the finding that Mr Hudson was the driver.

Driving History

47. Mr Hudson has a poor traffic history with a preponderance of the offences being speeding. He was also convicted of a drink driving offence shortly before the accident.

Earlier acts of driving

48. Mr Hudson agreed he drove a Toyota utility motor vehicle along Old Byfield Road to find Damian Baker only hours before the fatal crash. Damien Baker places Mr Hudson driving the red XD Ford Falcon along the driveway and along Old Byfield Road earlier during the day when they were working on the vehicle.

49. Whilst limited conclusions may be drawn, that Mr Hudson was driving at earlier points in time during this day, even when intoxicated, some inference can be drawn that Mr Hudson is more likely to have been driving at this later point in time.

Comments contained on OOO Phone call

50. During the OOO Phone call made by Malinda Vaughan, Mr Hudson states, "*Fucking killed him. Fucking killed him*." Mr Hudson is placed as stating, "*All I remember …fucking corner*." Malinda Vaughan explained that there is a bend in the road only two car lengths in front of the crash site. "*Fucking killed him …..fucking had my ….*"

51. At 4 minutes and 40 seconds Officer Warby's evidence is that Mr Hudson states, "*It's my fault?*"

52. It was submitted that the above comments all allow an inference to be drawn that Mr Hudson was the driver. The contrary position is that Dr Gupta accepted as possible that people who had gone through incidents like car crashes, may have very little memory of what happened.

Comments at the scene supporting Mr Hudson being the driver.

53. Mr Hudson was very upset when the witnesses arrived on the scene. He was also probably in shock. His memory of the incident is likely to be poor due to his intoxication, injuries (including a head injury), his upset over his good friend dying in front of him and the possibility of shock. The reliability of his statements at the scene would therefore potentially be subject to limited weight being attached to them on an evidentiary basis.

54. Melinda Vaughan, one of the first witnesses at the scene, says Mr Hudson stated something like, "*I tried to get it under control, I couldn't handle it*". She said "He continued to talk. He said something like "*its not ok, I'm sorry. I'm in shock, I couldn't get it under control. Its not ok, Troy is dead*".

55. Kira Leahy's evidence during the inquest was to the effect that "*When we were trying to ask him questions, he wouldn't really answer them, he'd avoid them and just say I – I tried to control it and that was – and then we'd ask him, "What did you try and control?", and he wouldn't really answer*."

56. During the inquest Mr Hudson did not recall making the comments, offering that he was intoxicated, and had a bang on his head. He feels that he could have said anything.

57. Malinda Vaughan provided evidence that Mr Hudson when asked who was driving stated, "*I was*", and then Jayden started talking to him and then he said, *No , I wasn't*."

58. Jaydon Leahy's evidence was that Mr Hudson stated at the scene that "*I was driving, I tried to keep the car under control,*" as opposed to "*keep it under control.*" He gave his opinion to the Police and arguably interpreted what he thought Mr Hudson had said. It is submitted on Mr Hudson's behalf that he was holding the body of his friend when the witnesses arrived. Mr Howse was bleeding from the head (and onto Mr Hudson) around the time that he was heard to say "*I tried to get it under control"*. This interpretation of the events was not put to the witnesses for their comment.

59. Most of the statements of Mr Hudson were said to be made during one or more of the witnesses being on the phone to 000 but the transcript of that call does not accord completely with the versions given to Police of the comments of Mr Hudson.

Opinion of Collision Analyst

60. Sergeant Stocker concludes that the scene evidence indicates that Hudson was the driver and Howse was the passenger in the vehicle at the time of the crash.

61. The Sergeant explained this opinion, "*So from the way the vehicle has rotated, the most likely person to have been in the passenger seat was the one that was found in front of the vehicle and also, because of the crushing to the roof, is also consistent, I suppose, with the head injuries sustained by the front seat passenger as well*."

62. Sergeant Stocker's evidence seemed to be that the point of impact to the vehicle was the left hand part of the vehicle, the roof section which came into contact with the ground first. Occupants would have been thrown towards the direction of the passenger window during the course of the accident. In the Sergeants opinion the most likely ejection portal of the vehicle was the front left (passenger) window.

63. Stocker explained, "*to me what I'm trying to say is that I believe that the – that the passenger was either partially ejected or ejected at the time that the vehicle struck the ground.*"

64. In the Sergeants opinion it would be unlikely for the driver to be ejected through the front passenger window as the drivers body would need to get past the passenger.

65. The solicitor representing Mr Hudson submitted that the conclusion reached by Sgt Stocker that Mr Howse was the passenger (and was ejected from the vehicle) thus putting Mr Hudson in the driver's seat, is utterly inconsistent with the medical evidence as a whole.

Mr Hudson's movement in the vehicle

66. Mr Hudson told the first witnesses to the scene that he had dragged his friend from the car. This does not accord with the other evidence that Mr Howse was thrown from the vehicle during the accident. If he wasn't thrown clear and was the driver, then that scenario does not accord with Mr Hudson's version either on the basis that he could not have crawled out of the driver's side window (as he said) over the body of Mr Howse and could not have pulled him from the vehicle either.

67. Counsel for the family has submitted that the absence of blood inside the vehicle from Mr Hudson's injuries, especially from the head laceration and taking into account that , if he was the passenger, he had to crawl into the drivers seat to exit the vehicle by the driver's side window points to him being the driver. Sgt Stocker found this unusual given the circumstances of the accident.

The Deceased

68. Counsel for the Family submitted that it would have been uncharacteristic for Mr Howse to drive after he had been drinking. He had no drink driving history since 1999 but did have periodic speeding offences. He had a chance to test drive the vehicle earlier in the day but had opted not to. He did not drive in the earlier pursuit of Mr Baker and was therefore unlikely to have driven later.

Conclusion

69. The expert evidence in this matter of Dr Buxton and Sergeant Stocker conflicts on the likely ejection portal. These witnesses also differ on the grounds upon which they offer as supporting their conclusions. Ultimately both witnesses offer opinion evidence in relation to who was the driver of the motor vehicle, at the time of the crash.

70. Evidence from medical practitioners concerning a mark across Mr Hudson's abdomen does not seem to offer considerable assistance on this point. The evidence seems to establish that the mark was from a seat belt and not a steering wheel or other item. That the mark was likely caused by the lap belt offers little assistance if the person was wearing a passenger or drivers seatbelt. In any event in this instance with the driver's side seat belt having a cable tie and being loose fitting, no assistance can really be obtained from this evidence.

71. I found the witnesses Melinda Vaughan and Jaydon Leahy to be credible witnesses. Both witnesses were challenged and were adamant that Mr Hudson made comments consistent with being the driver and later retracted those statements. In particular these witnesses seem to describe Mr Hudson realising the seriousness of the situation, before changing his version of who was driving. This is consistent with comment such as *"I am in trouble"*. In combination with comments contained on the 000 recording in which Mr Hudson makes comments, an inference could be drawn that he was the driver of the motor vehicle.

72. When considering the evidence of these witnesses in combination with the factors affecting the weight which could be attached to Mr Hudson's statement, I am satisfied there is sufficient cogency in the evidence to rely on it. Dr Buxton's contrary opinion was formed without the benefit of the knowledge of the mechanics of the crash (which the Police really should have briefed him on once the circumstances were known and before seeking an opinion) and while the evidence is, in itself, reliable, this circumstance affects the weight attaching to his opinion. Sgt Stocker's evidence is quite compelling.

73. **On the balance of probabilities** considering the whole of the evidence before me, I am satisfied that Mr Hudson was the driver of the motor vehicle at the time of the accident.

FINDINGS required by s 45(2)

74. I am required to find, so far as has been proved on the evidence, who the deceased person was and when, where and how he came by his death. After consideration of all of the evidence and exhibited material, I make the following findings:

Identity of the deceased person– The deceased person was Troy Jason Howse.

Date of Death – Mr Howse died on the 28 March 2010.

Place of death – Mr Howse died at Old Byfield Road, Cobraball near Yeppoon, Qld.

Cause of death – Mr Howse's death was as a result of cerebral destruction; fractured skull sustained when he was involved in a motor vehicle accident during which the vehicle in which he was travelling left a gravel road and rolled, coming to land on its roof. Mr Howse was ejected from the motor vehicle during the crash. There is conflicting evidence as to whether Mr Howse or the other occupant of the vehicle was the driver at the time of the crash but on the balance of probabilities I am satisfied that Mr Hudson was driving.

Referral under section 48

75. Section 48(2) *Coroners Act 2003* provides that a Coroner who, from information received in investigating a death, reasonably suspects that a person has committed an offence, must give the information to the appropriate prosecution agency for consideration.

76. I consider there is sufficient evidence upon which to refer Mr Hudson to the Office of the Director of Public Prosecutions in relation to the death of Mr Howse and I will do so.

Coronial Comment

77. Section 46(1) of the Coroners Act 2003 empowers the Coroner to comment, whenever appropriate, on anything connected with the death that relates to public health and safety or the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. Recent Queensland authority supports a broader than direct connection between any matter on which comment is made and the death under investigation.

I make the following comment/recommendation:

That Queensland Health ensure it has appropriate guidelines dealing with a request under section 80 TORUM for a blood sample request and should ensure that all requests are documented.

A M Hennessy
Coroner
20 September 2012