CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of Mary Louise Nelson and Rowan Nelson
Hearing dates:	23 June 2022
Date of findings:	23 June 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Carolyn Huntsman, Deputy State Coroner
Catchwords:	CORONIAL LAW – motor vehicle collision, cause and manner of death
File number:	2020/00014961 and 2020/14914
Representation:	Senior Constable Howard Mullen, Solicitor and Coronial Advocate assisting the Coroner

Findings:

I make the following findings in relation to the death of Louise Mary Nelson, pursuant to s81 of the Coroners Act 2009 NSW:

Identity: Louise Mary Nelson

Date - The date of death of Louise Mary Nelson was 15 January 2020.

Place - The place of death was Pacific Motorway (M1) Pimlico NSW.

Cause of death - The cause of death was Multiple Injuries

Manner of death - The manner of death was Misadventure (Motor Vehicle Accident)

I make the following findings in relation to the death of Rowan Nelson, pursuant to s81 of the Coroners Act 2009 NSW:

Identity – Mr Rowan Nelson

Date – The date of the death of Mr Rowan Nelson was 15 January 2020.

Place - The place of death was Pacific Motorway (M1) Pimlico NSW.

Cause of death – The cause of death was Multiple Injuries

Manner of death - The manner of death was Misadventure (Motor Vehicle Accident)

Recommendations Nil

Non-publication orders: Nil

JUDGMENT

1 This inquest was an inquiry into the death of two people, Louise Nelson and Rowan Nelson, both of whom were dearly loved by family and friends. The two inquests are being heard together because the deaths are related, having occurred during the same motor vehicle collision. For this reason joint reasons for decision are published.

2 Louise Nelson is Rowan's mother. Very sadly, Louise and Rowan lost their lives on 15 January 2020, when their motor vehicle collided with a freightliner coming in the opposite direction. Rowan was driving the vehicle and Louise was a passenger.

3 I would like to begin these reasons for decision by expressing my deep condolences to the family and friends of Louise and Rowan for their loss. Louise and Rowan's close family members include Louise's daughter/Rowan's sister, Mikayla, and Louise's sisters, Maree and Elizabeth (Libby), and Terese, and Louise's mother/Rowan's grandmother, Marjorie.

4 It is important to acknowledge that such sudden and tragic deaths continue to be felt by family members for several years, with considerable impact on the lives of the deceaseds' loved ones. While not directly a part of this inquest, I note that Mr Scott Nelson (father of Rowan and husband of Louise) passed away in September 2021, and while his death is not directly related to the matters being examined by this inquest, I acknowledge that the Nelson family have endured great tragedy. I offer my condolences for their loss, particularly to Ms Mikalya Nelson, who has suffered what can only be described as tremendous and heartbreaking loss over the last year.

The Coroner's role

5 Under the *Coroners Act 2009* (the Act), a Coroner has the responsibility to investigate all reportable deaths. Reportable deaths are defined under

Section 6 of the Act and include deaths which have not occurred naturally, such as in the present case.

6 The coronial investigation is conducted primarily to make formal findings as to the following five aspects of death pursuant to s81 of the Act: (1) the identity of the person who died; (2) the date and (3) place they died, and what was the (4) cause and the (5) manner of that person's death. The inquest investigates the facts and circumstances of a death, places them on the public record, and in certain cases will examine changes that could be made to prevent similar deaths in the future.

7 It is important to recognise that the coronial process represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. Even the with the passage of time, it is expected that families will wish to grieve and attempt to cope with their enormous loss in private. An unfortunate aspect of the coronial process and inquest is that it can require a family to re-live distressing memories, and to do so in public. Given the loss of two beloved family members this inquest is particularly distressing for the family of Louise and Rowan, and I again express my condolences for their loss.

8 A coronial inquest can contain elements of adversarial and inquisitorial process, however it is investigation and inquiry which are at its core. It is not a forum where the Coroner sets out to prove any allegation or proposition. Rather, the inquest is an inquisitorial exercise in fact finding, aimed at discovering what occurred, and it is this principle that steers the approach taken by a Coroner in evidentiary and procedural matters.

The evidence

9 A coronial investigation precedes the inquest. During the investigation considerable evidence, in form of witness statements, expert opinions/reports, photographic evidence, are obtained by, and provided, to the Coroner. Reports as to the cause of death are provided by forensic pathologists (autopsy reports). In the case of the investigation into the deaths

of Louise and Rowan Nelson, extensive evidence was obtained and contained within the brief.

10 The evidence in the brief of evidence was very clear and did not require questioning of witnesses. For this reason, the officer in charge of the police investigation, Detective Sergeant Michael Smith, was the only witness required to give oral evidence at the inquest. His statement summarised the evidence in the brief, and he also provided his opinion, after consideration of all the evidence including mechanical examination of the motor vehicle and expert examination of the crash site, as to the cause of the motor vehicle collision, this will be further detailed below.

Background/History

11 Mrs Louise Mary Nelson was born on 19 October 1966. She is the daughter of Marjorie Kelly and sister to Maree, Elizabeth, and Terese. Louise was married to Mr Scott Nelson, and they were together for 28 years, having spent the last 20 of those residing at Pimlico, NSW. As a result of this marriage, Louise had two children and is the mother of Rowan and Mikayla Nelson.

12 Louise is described as a very intelligent person, who worked as a physiotherapist. Friends report that she was a great support to all her family members. She was friendly and well-liked by those who knew her. It was reported to police that Louise was respected in the community. Louise's sister tells police that Louise was a gently protective mother, she was also the main financial support and managed the family. Louise was generous with her time, and she would attend her mother's house twice a week to assist with chores. It is abundantly clear that Louise was very loved and is dearly missed. Louise was only 53 years old at the time of her death.

13 Rowan Nelson was born on 25 September 1997. He is described as a quiet and gentle young man. He was intelligent, having topped all of his subjects at school, and also being named a co-school captain. Upon completion of school Rowan went to Europe, where he spent time working in a boarding

school. Rowan had most recently been studying at the Australian National University, in Canberra. It is again, abundantly clear that Rowan was loved and is dearly missed. At the time of his death he was 22 years old.

14 Rowan was a young man who suffered from mental health issues. Medical records obtain during the investigation reflect that Rowan had been dealing with mental health issues since he was younger, and particularly in 2017 and 2019. Rowan had been receiving treatment and was on medication to assist him. There are notes, obtained from a clinical Psychologist that he was seeing in 2017, which reflect Rowan had reported random thoughts of suicide, however it also stated that he did not take these seriously, nor did he have a plan in relation to these, and at that time he was assessed as low risk. However, is clear that Rowan struggled with his mental health. In order to understand the circumstances of Louise and Rowan's deaths, it is important that Rowan' s mental health issues are examined.

15 An extensive investigation was undertaken with respect to the deaths of Rowan and Louise, and a number of Rowan's friends provided statements.

16 Mr Callum Shaw, a friend of Rowan's, whom he had met while studying at ANU and who he subsequently resided with, stated that when he initially met Rowan, he was a happy outgoing guy, who seemed happy with his university lifestyle. Callum says that at the beginning of their second year at university he became aware that Rowan began to struggle with the competing demands of university, study and work. Callum noted that in the later parts of 2018 Rowan's mood changed. He states that Rowan seemed depressed and would not leave his room, he recalls Rowan telling him he was seeking treatment with regards to his depression, and that he noticed an increase in the amount of marijuana that Rowan was smoking.

17 In November 2019, Rowan and some of his friends took a trip to Tasmania. Whilst they were on holiday, Rowan had discussed his mental health and disclosed that he had been struggling, however, he also stated that the holiday was what he needed, and that he was feeling a lot better.

December 2019 Incidents

18 Mr Callum Shaw recalls an incident on 19 December 2019 and told police:

> "About 11:30pm that night Rowan came into my room and woke me up. He seemed pretty out of it. He was crying and seemed really sad. He didn't say much but to me but just told me that he needed to go to Hospital for his mental health and asked if I could drive him to the Hospital".

19 Callum told police that he had never seen Rowan like that before. He drove Rowan to the Calvary Hospital in Belconnen and took him to the Emergency Department.

20 It is clear from the actions of Callum, that Rowan had people around him who really cared for him.

21 At the Calvary Hospital on 19 December 2019 Rowan was assessed as having suicidal ideation, reported to be vague plan, in the context of substance dependency (cannabis primarily) with underlying depressive like symptoms. It was noted that he had ceased anti-depressant medication some 6 months prior. He was medically cleared and discharged - with discharge planning including referral to GP for mental health care plan, referral for follow up in community, in particular for medication review. He told clinicians that he had supportive friends – that this was so is evidenced by the witness statements obtained during the coronial investigation.

22 On 20 December 2019, Callum states he received a phone call from Rowan's parents, who informed him that they could not locate Rowan at the Hospital. As a result of this phone call, Callum entered the bedroom of Rowan and located a note on his pillow which read: "It's too much I am sorry everyone". Callum drove to the Hospital where he located Rowan in the emergency department. He said Rowan seemed tired and showed him a large booklet on Mental Health that he had been given by the hospital. A couple of hours later Callum received a phone call to collect Rowan from the hospital and did so around 11.30am on 20 December 2019.

23 Sometime that afternoon (20 December 2019), Rowan was at home on the veranda using his laptop. Rowan then walked inside and returned with a large kitchen knife. Callum and Rowan spoke for about an hour, seated outside in the garden, on garden seats, and during this conversation Rowan was saying things like “It’s just not worth it” and “I don’t want to be here anymore.” Whilst he was saying this, Rowan was holding the knife and there was a can of petrol near him. Callum states that he managed to get the knife off Rowan and throw it across the garden, he also removed the can of petrol and says he convinced Rowan to go to Hospital.

24 At this time Callum has gone inside the house to get his car keys, upon his return he was unable to locate Rowan. By now there were other people at the location. Rowan had managed to get on the roof of the property and had the knife in his hand and was yelling “It’s just not worth it, I’m gunna stab myself.” As a result of this, Callum called ‘000’ he then went back outside and tried to talk Rowan into coming down off the roof. Callum saw Rowan lay down on the roof and proceeded to stab himself, initially, in the calf and then in the chest. Callum was able to access the roof, remove the knife and coax Rowan down. Police and Ambulance then took over.

25 Another friend, Casey, was present at the house on 20 December and gave police a similar account to that provided by Callum.

26 About 3:30pm on 20 December 2019, ACT police were called in response to a ‘check welfare’ which reported that a male was on the roof of the house holding a knife threatening to kill himself. Senior Constable Serena Wong and Constable Andrew Bishop from City Police, Australian Capital Territory attended. Statements from both officers were obtained by the OIC in this matter. Senior Constable Wong describes arriving at the house, being met by Callum and shortly thereafter Rowan appearing at the door. She states that Rowan had blood on his hands and was wearing a black coloured t-shirt which had fresh wet blood seeping through the centre of the chest. Senior Constable Wong recalls Rowan lifting his t-shirt and seeing a small stab wound around his sternum approximately 4 millimetres wide.

27 Rowan was subsequently assessed and transported to hospital by the ACT Ambulance Service. On 20 December 2019, medical notes indicate that clinical staff had real concerns for Rowan's wellbeing, finding:

> "This 22 year old man presents with diagnostic uncertainty in the context of a very significant suicide attempt, preparing with multiple methods. His differential diagnosis include a first episode psychotic disorder and a mood disorder. The major shift in clinical presentation when seen this morning at Calvary and on presentation to TCH this evening is of great concern in terms of the predictability of his risk". [Given this assessment of risk he was admitted to hospital for further observation and assessment].

28 Rowan spent some time in the Mental Health Ward at Canberra Hospital, from 20 December through to early January 2020, when he was discharged into the care of his parents, who had driven from the far North coast of NSW to Canberra to be with Rowan. The medical records reflect that Rowan had been responding to the treatment. He was discharged on antidepressant medication (Loxalate "Escitolopram oxalate').

29 Upon his discharge, Rowan returned to his family house in northern NSW and remained living with his parents until the date of the collision. Mr Scott Nelson told police that he and Louise collected Rowan upon discharge from hospital in Canberra and drove him home a few days after New Year. Mr Scott Nelson told police that Rowan appeared to have been fine since his return, and that Rowan was on a low dose of medication to assist with his mental health. Mr Scott Nelson reported that on the evening prior to the collision, Rowan seemed a bit sad and was trying to work out what to do with his future. Mr Scott Nelson also said that on the morning of 15 January 2020 Rowan seemed fine when he woke up, and as a spur of the moment thing, Rowan and Louise decided to go to the beach.

30 A friend, Lyster, told police that he spoke with Louise Nelson on 14 January 2020 who told him that Rowan was doing well, and that Rowan was thinking of going to a local University and getting a job in the area. He says Louise told him that Rowan's doctor said he was going well, and there had been no further threats of self harm.

31 Lyster told police that he did not believe that Rowan would intentionally harm his mother, in the course of his driving, and there must have been another cause of the accident other than an intentional act. He raised the issue of the presence of traffic cones on the road.

32 Callum also told police that, in conversations with Rowan by telephone, after his move back home with his parents, Rowan seemed much happier, and he told Calum that he had been hanging out with his mother a lot, and was thinking of resuming University study.

33 If use of cannabis had exacerbated Rowan's mental health at the time of his admission in the ACT, the results of drug and alcohol testing conducted after the collision, indicate that at the time of his death Rowan was not using cannabis. Nor was any cannabis detected in post mortem testing of blood or urine. Therefore, any risk of deterioration in his mental health, linked to cannabis use, would have been reduced. In addition, Rowan was taking medication prescribed for his mental health and was well supported by family. The evidence, including in the notes of the psychologist of 2017, indicates that Rowan was close to his mother and got on well with her.

Day of Collision

34 On the morning of 15 January 2020, Rowan woke up and seemed fine. It was apparently a spur of the moment decision for Rowan and Louise to visit Louise's mother, Marjorie that morning. According to Scott Nelson it was a spur of the moment decision to go to the beach that day.

35 Mr Scott Nelson stated that Rowan and Louise left the residence at Pimlico at about 10:30am, getting into a Silver coloured Toyota Yaris, a car Louise had owned for six to seven years. Louise's sister reports that they arrived at Marjorie's house at around 10.30am and left to have a swim at around 11.30am. At about 12:30pm, Louise rang Scott Nelson and said "we are just leaving the beach, we'll be home in about half an hour."

36 Mrs Maree O'Brien, sister of Louise, was at Marjorie's house when Rowan and Louise attended. Maree tells police that she did not notice anything unusual about Rowan's behaviour. Maree states that Rowan did appear to be very affectionate, that he hugged her, his mother and Marjorie, a number of times. Maree stated that Rowan was an affectionate person and would generally hug goodbye, however on this occasion she considered that Rowan hugged more than usual. She told police that she saw nothing on 15 January 2020 to indicate Rowan was suicidal.

37 When Rowan and Louise left Marjorie's house, Louise was heard to ask Rowan who was driving, to which Rowan answered "me". This was the last time that anyone spoke to Rowan or Louise. They left with Rowan driving the Toyota Yaris which was owned by Louise.

38 There were a number of witnesses to the accident, who provided statements to police. From the evidence obtained, it appears that the car, being driven by Rowan, was heading South on the Pacific Motorway (M1). Shortly after the Pimlico Rd exit, where Rowan and Louise would have turned off to head home, the car crossed over to the Northbound lanes and collided head on with a semi-trailer. The semi trailer, a Freightliner Prime Mover with an unladen trailer, was at the time travelling north on the M1 Motorway. At a point approximately 900m south of the intersection of Pimlico Road and the Pacific Highway both vehicles have collided heavily in the northbound lanes. Both Rowan and Louise suffered catastrophic injuries and died instantly. Louise and Rowan were transported from the scene to Lismore Base Hospital.

39 The collision and deaths were actively investigated by Ballina Detectives under 'Strikeforce Montpelier'. The Officer in Charge of the police investigation, Detective Sergeant Michael Smith, attended the site of the collision soon after the collision occurred (he arrived within approximately 10 minutes). On arrival he saw the Prime Mover was stationary in the breakdown lane, and on fire, and the Toyota Yaris was in the breakdown lane with extensive damage to the front of the vehicle. The driver of the

Prime Mover was interviewed at the scene, he was shaken but did advise police that he did not see anything until the last moment and that the other car, the Yaris, appeared to come out of nowhere.

40 Arrangements were made for the attendance of Crime Scene examiners from the Forensic Services Group, and also crime scene officers from Lismore Crime Scene unit attended, and documented the collision scene. Senior Constable Rehwinkle from the Far North Coast Crash Investigation Unit attended the collision scene and his investigation included drone footage of the collision scene, which was used also in mapping the scene as part of the investigation.

41 Witnesses included the driver and passenger of a car that was just passing the Prime Mover around the time of the collision – those witnesses said that they saw the Nelson's vehicle travel directly into the path of the Prime Mover. They told police that the Prime Mover managed to regain control of the truck after the collision and pulled over, and the truck then caught fire. They observed the truck to be travelling at about 98 km/hour (in the 110 zone for cars), and thought the Toyota Yaris was going quite fast. It is clear that both these witnesses had a good view of both vehicles at the time of the collision. Indeed, the passenger said that the Yaris crossed their path before impacting with the Prime Mover. Witnesses in another vehicle, which was travelling southbound at the time, also saw the collision and provided their dash cam footage to police. Other witnesses who observed the collision or its aftermath provided statements to police.

42 There was some contention in relation to road works on the Highway, specifically at the Pimlico Rd exit. Mr Lyster Hart, who was the neighbour to Rowan and Louise, believed that there had been traffic cones at the Pimlico Rd exit, which may have contributed to Rowan not turning off the motorway. Dashcam footage has been reviewed and it is clear that although there are roadwork signs (a sign "Roadworks on side road" was located about 100 metres from the intersection) there are no traffic cones on the roadway at the intersection, nor blocking the roadway. On the median strip at the start of the

U-turn Bay is a sign indicating “No U-turn Police and NRMA Roads & Maritime Vehicles excepted’.

43 Sergeant Derick Fenton, from the Forensic Evidence and Technical Support Command, provided an expert statement in relation to an analysis of the collision. Although he did not attend the scene, he based his opinion on the evidence - including evidence provided by crime scene investigation officers who comprehensively documented, measured and photographed the road and surrounding area. After reviewing the images captured at the scene, Sergeant Fenton is of the opinion that the road is unremarkable. He further states that after reviewing the material available, he is of the opinion that the road did not contribute to the collision occurring, in terms of construction, geometry, topography or condition.

44 Documents were received from Transport for NSW which stated that on Pimlico Road, Quickway were carrying out drainage work which required short term traffic control. It also states that there was no short-term traffic control in place around the emergency U-turn area. The road was operating as per final design. There were no traffic cones at the U-turn bay.

45 The vehicle driven by Rowan was examined by Crime Scene Officer, Daniel Smith. Mr Smith provided an expert certificate, in which he gives the opinion that the examination revealed no mechanical defects or component failure, which may have contributed to the collision occurring and all the damage detected on the vehicle was consistent with collision impact.

46 In relation to this aspect Sergeant Fenton also states in his statement, that there was no physical evidence at the scene typically associated with a sudden mechanical failure, nor is there any other evidence which tends to suggest that the driver was fighting for control of his vehicle.

47 The investigation also reviewed the possibility of driver inattention/incapacitation or intoxication. Both Rowan and Louise’s phones

were examined, there is no evidence to suggest that either of them was using their phones at the time of the collision.

48 Blood and Urine was also examined and there was no detection of alcohol or illicit drug in either sample.

49 Sgt Fenton makes the following remarks in relation to driver inattention/incapacitation or intoxication:

> "While the Toyota moved in a righthand direction across the median strip and into the northbound lanes, I am not satisfied that this is definitive evidence of steering input on behalf of the driver. The shallowest possible path would not require any meaningful steering input and could possibly be achieved by a vehicle that was left to its own devices."

50 He then goes onto remark that:

> "In the same regard, this report assume that the Toyota crossed the median strip at the constructed U turn bay. If this is true, it is tempting to suggest that the driver utilising the provided U turn bay is evidence that he must have been conscious and in control of the vehicle. While this possibly true, and it would seem rather coincidental or unlikely that an out of control vehicle with an unconscious driver would cross the median strip at the most convenient place, it is not beyond the scope of possibility.

51 Sergeant Fenton noted that physical evidence from the scene does not identify the driver's intention. He states that whilst there are circumstances that may indicate an intentional act by the driver, equally there is no evidence which indicates it was an intentional act. Evidence suggests that the likely speed of the Yaris was between 90 km/h and 135 km/h as it moved across the median strip and into the path of the Prime Mover. The distance travelled by the Toyota as it crossed the median strip to impact was between 100 and 150 metres, depending on trajectory.

52 It should also be noted that there is no evidence from any of the witnesses, nor any physical marks on the roadway, such as skid marks, that would suggest that the Toyota was braking or taking evasive action in trying to avoid the freightliner.

53 Sergeant Fenton notes that there is no definitive evidence of steering input by the driver (the car could have just moved in the path of the Prime Mover – it is not clear there was any conscious steering in that direction). Sergeant Fenton stated that he cannot exclude lack of consciousness on the part of the driver given the lack of any evidence of the driver consciously operating the controls of the car (steering, braking etc).

Cause of Death

54 On 22 January 2020, a post-mortem was conducted on Ms Louise Nelson, by Dr Donovan Paul LOOTS, with the direct cause of death being determined to be Multiple Injuries.

55 On 22 January 2020, a post-mortem was conducted on Mr Rowan Nelson, by Dr Donovan Paul LOOTS, with the direct cause of death being determined to be Multiple Injuries.

Findings

56 As Coroner I must make the formal findings required under s81 of the Act as to identity of the deceased, place and date of the death, cause and manner of the death. The findings that I make on these matters are as detailed below.

57 In relation to Mr Rowan Nelson, the evidence indicates that he was a young man who struggled with his mental health. This raises the issue of whether he drove the car with intention to take his own life. This issue is also raised by the absence of any evidence of the driver (Rowan) taking action to avoid the accident, such as braking or swerving. It is noted that the officer in charge of the police investigation formed the view that the collision was likely caused by an intentional act by the driver, as set out in the statement he provided in the brief.

58 A difficulty implicit in consideration of this issue, is that the evidence is very clear that Rowan was aware of the presence of a passenger in the car, his

much loved mother, Louise. The evidence about both Rowan and Louise, and their family members and friends, supports the conclusion that this was a family who loved and supported each other; and the evidence also supports the conclusion that Rowan knew he was he loved and cared for, by friends as well as family.

59 Whilst as a lone driver, the issue of suicide may arise, it is another matter altogether where the driver has a passenger in the car whom he cares for. In this context it must also be acknowledged that Rowan himself was loved and supported by family and friends. It must also be acknowledged that there were no reports of deterioration in Rowan's mental health, no reported use of cannabis, and there was reported compliance with prescribed medication. Those who knew Rowan well, such as Callum, reported him to be presenting as much happier. His mother, Louise, reported to Lyster just the day before the collision, that Rowan was going well, had future plans, and there were no further reports of self harm incidents or thoughts. As such there is an absence of any evidence of deteriorating mental state, or suicidal intent.

60 I also note that his aunt, Maree, who saw him on the morning of the collision, did not observe any behaviour indicating suicidal thoughts, and his father, Scott, also reported that Rowan seemed fine.

61 Before a finding of suicide can be made, a coroner should be "comfortably satisfied" on the balance of probabilities to the Briginshaw standard, that this is the appropriate finding.

62 In relation to the Briginshaw standard, in order to satisfy this standard, the evidence should be clear and cogent.

63 It is noted that the Briginshaw standard is a rule of evidence which flows from a High Court decision by that name. It has been reflected in s140 of the Evidence Act 1995 NSW which provides

> 140 Civil proceedings: standard of proof
> (1) In a civil proceeding, the court must find the case of a party proved if it is satisfied that the case has been proved on the balance of probabilities.
> (2) Without limiting the matters that the court may take into account in deciding whether it is so satisfied, it is to take into account—
> (a) the nature of the cause of action or defence, and
> (b) the nature of the subject-matter of the proceeding, and
> (c) the gravity of the matters alleged.

64 Whilst Coronial proceedings apply the civil standard of proof, making findings on the balance of probabilities, s 58 of the Coroners Act 2009 provides that a coroner in coronial proceedings is not bound to observe the rules of procedure and evidence that are applicable to proceedings before a court of law. However, while Coronial proceedings are not bound by the strict rules of evidence, regard must be had to those evidentiary rules. In particular, when it comes to fact finding, the applicable standard of proof must be applied, and findings must be made on the balance of probabilities, applying the Briginshaw standard as required – and as reflected in the Evidence Act. The Briginshaw standard applies to making a serious finding about the manner of death.

65 While on the face of the evidence, one may suspect that Rowan took his own life, it is difficult to find that he would also disregard his mother's well-being. In addition, there are two matters that should be assessed.

66 The first is the evidence of Sergeant Fenton, who while commenting on driver inattention/incapacity states:

> "There is much about this incident that lends itself to the suggestion that it was an intentional act, and I have not been presented with any information which eliminates this as a possibility. However, equally, I have not been presented with any physical evidence which definitively confirms that this collision occurred as a result of a deliberate act on behalf of the driver of the Toyota."

67 The second matter are the views of the Nelson family, who knew both Rowan and Louise very well, and knew of Rowan and Louise's love and support of each other. While I note they accept that Rowan suffered from metal health issues, they do not believe that Rowan would have intentionally taken

Louise's life. This must be given weight in this matter in the light of all the evidence about the care this family displays for its members.

68 Based on the evidence provided, and in noting the two matters I have just detailed, I cannot reasonably exclude the hypothesis that Rowan was incapacitated at the time of the collision, and I cannot exclude the possibility that the collision *was not* a deliberate act. In this context I note the evidence of family and friends, as detailed above, that Rowan did not present at that time as mentally unwell, nor was he expressing suicidal thoughts. There was no evidence indicating deterioration in his mental health, rather, as set out above, the evidence indicates improvement in his mental health and stability. Nor, on all the evidence, was there any reason for Rowan to show disregard for his mother's life and well-being, which would have been required if his act of driving was intentional collision.

69 For all the above reasons I am not satisfied that the evidence establishes that the collision was deliberate. I therefore find that the collision was accidental. Given this finding then the manner of death for both Rowan and Louise Nelson is misadventure.

Mrs Louise Nelson – formal findings:

Identity - the person who died was Mrs Louise Mary Nelson

Date - Louise Mary Nelson died on 15 January 2020.

Place - the place of death was Pacific Motorway (M1) Pimlico NSW.

Cause of death - the cause of death was Multiple Injuries

Manner of death - the manner of death was Misadventure (Motor Vehicle Accident)

Rowan Nelson – formal findings:

Identity – the deceased was Mr Rowan Nelson

Date – The date of the death of Rowan Nelson was 15 January 2020.

Place - the place of death was Pacific Motorway (M1) Pimlico NSW.

Cause of death – the cause of death was Multiple Injuries

Manner of death - the manner of death was Misadventure (Motor Vehicle Accident)

Closing

70 I acknowledge and express my gratitude to the Coronial Advocate and Solicitor Assisting the Coroner, Senior Constable Howard Mullen, for his assistance both before and during the inquest. I also thank the investigating Police Officers, and in particular the Officer in Charge, Detective Sergeant Michael Smith, for his work in the Police investigation and compiling the evidence for the inquest.

71 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family of Louise and Rowan Nelson.

I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales

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