IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002111

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of HARLEY JAMES SMITH

Findings of:	AUDREY JAMIESON, Coroner
Delivered on:	27 August 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006
Hearing dates:	27 August 2025
Representation:	None
Counsel assisting the Coroner:	Ms Kelly McKay of Counsel

I, AUDREY JAMIESON, Coroner, having investigated the death of HARLEY JAMES SMITH

AND having held a Summary Inquest in relation to this death on 27 August 2025

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was HARLEY JAMES SMITH

born on 12 July 2016

and the death occurred on 14 April 2024

at Willow Grove Road, Trafalgar, Victoria 3824

from:

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

in the following summary of circumstances:

HARLEY JAMES SMITH died at the age of 7 years when the vehicle he was a passenger in collided with a truck, in circumstances where it appeared the driver of the vehicle, his father Conan Smith, intended to take their lives. At the time of his death, Harley lived in Longwarry with Conan. His mother, Amy Galea, sadly predeceased him having died from cancer three days prior.

BACKGROUND CIRCUMSTANCES

1. Harley was the only child to Conan Smith and Amy Galea. Harley is remembered as a lovable, beautiful and cheeky boy. He loved toy trucks and cars and was particularly fond of his Sonic the Hedgehog toy which brought him great comfort.

2. Harley lived with his parents in Longwarry, having moved there around two years prior to the fatal collision. Conan and Amy had separated around a year prior to the fatal collision but continued living together to provide consistency for Harley.

Schooling and supports

3. Harley was formally diagnosed in November 2022 with intellectual disability, Autism Spectrum Disorder level 2, Developmental Language Disorder and ADHD. He had previously been medicated on the recommendation of his Paediatrician but his parents did not want him to take medication and so this was ceased.

4. Harley was a recipient of NDIS funding, administered by Windermere Child and Family Services. He and his parents first met with NDIS Support Coordinator Suzanne in May 2022. Suzanne noted that Conan and Amy seemed *"receptive but overwhelmed"*, and *"had their own issues with understanding"*. She set about organising supports though appeared to have difficulty due to Covid and the fact that Conan would not allow any supports to attend the home, reportedly as he was concerned that someone would make a complaint to Child Protection.

5. Harley was subsequently engaged with a Paediatrician, Behavioural Specialist, Occupational Therapist and Speech Therapist. Conan was the main parent engaged with the NDIS and these services.

6. The evidence of each of these services is that Harley's attendance was sporadic, the family were difficult to engage, and they were unable to see Harley in his home due to unrestrained animals making it an unsafe environment. Conan and Amy appeared to disagree on aspects of Harley's care such as returning to school and medication, which Amy wanted to explore but Conan did not. Notwithstanding this, Suzanne felt that Conan was quite invested in finding the right supports for Harley.

7. Harley had attended Longwarry Primary School, with adjustments being made to the delivery of his education and his contact hours to best support him. His school day went for 2 hours and ended at recess because Harley would tire easily from the effort of participating in the activities set for him.

8. In approximately July of 2023, Harley was withdrawn from Longwarry Primary School to be home schooled by Conan. The reason given to some was that Harley was repeatedly getting sick at school, and this was making Conan sick. Conan told his friend, Brooke, that

he wanted to home school Harley because his intellectual disability meant that he "*wouldn't understand if people were taking advantage of him or being rude to him*"

9. Following the commencement of home schooling, Harley's support team noticed an increase in his behaviours of concern such as verbal aggression and making threats, physical aggression, violence predominantly towards women, and expressing wanting to die and asking his parents to kill him. His violence was almost always directed towards Amy and not Conan.

10. In October 2023, Harley's service providers met to discuss Harley in the context of his concerning behaviours. As a result of this meeting, Conan requested a new NDIS Support Coordinator as he *"didn't like the fact that the providers and [Suzanne] had spoken about Harley."* Suzanne subsequently handed the file to NDIS Support Coordinator Jessica.

11. Jessica recalled having discussions with Conan about homeschooling and was concerned that Conan had openly stated he did not have a curriculum planned and instead engaged in activities such as going for walks and counting mailboxes. She noted that Conan was hesitant for Harley to receive help and *"every time new ideas were brought up in regard to Harley's care, Amy was willing to look outside the box and try things. Conan always shut them down."*

12. Between July 2023 and October 2023 Harley was not attending school at all. In the period immediately before Amy became ill and was diagnosed with cancer (in March 2024), Harley was being home schooled by Conan and was also attending Longwarry Primary School intermittently for social interactions and to maintain peer connections. However, from approximately mid-March 2024, when Amy was admitted to hospital, Harley and Conan spent their days travelling backwards and forwards to the hospital to visit Amy daily.

13. At the time of the fatal collision, the family were not actively engaged with any services as Conan had withdrawn Harley from those supports.

14. In reflecting on her engagement with the family, Jessica recalled *"I always had the underlying feeling that something was going on and I had the impression that Conan and Amy stretched the truth with me because they were scared I would report them to DFFH."*

Family violence

15. There is competing evidence as to whether Conan perpetrated family violence towards Harley.

16. Several witness statements indicate that Conan loved being a father, absolutely loved Harley and wanted what was best for him. Brooke noted that *"Before Amy was unwell, Conan was always happy."* She considered him to be a *"really good dad … just really wanted the best for Harley."* Another friend, Shanika, noted that *"Conan and Amy were both brilliant with Harley"*, though they often took things personally and took comments regarding Harley's health to mean they were not parenting correctly. According to Suzanne *"Conan absolutely adored Harley".*

17. To the contrary, acquaintance Patrick recalled *"When Conan was gone, Harley and I spoke normally. He spoke without any fear and totally normal. I couldn't believe the difference when he was with Conan."*

18. On the week of Amy's death, Patrick went to their home to take Conan and Harley to the hospital. He recalled hearing Conan screaming *"if you were any bigger, you little [expletive][1], I'd bash ya".* He observed Harley *"sitting on the couch and his eyes were wide, like a deer. He was in terror."* Around this time, a neighbour recalled hearing Conan yelling and Harley crying. Amy's manager Rafaella also recalled seeing Conan *"hit [Harley] on the bum pretty hard"* before picking him up and sitting him on a seat, which was *"like a smack down".*

19. According to Leanne, a palliative care nurse at Monash Health had told her she was going to report Conan's treatment of Harley to her boss as she was concerned. This has not been substantiated and hospital social worker Madeleine noted in her statement to the Court that no one in her team had raised that issue, nor had she seen any documentation advising of the same. She had later been advised by a nurse that Conan had been distressed regarding visitor limitations, but no behaviour concerns were raised.

[1] I consider the effect of the sentence can be read without my needing to repeat the expletive in question.

20. It appears that, to the extent that there may have been any family violence perpetrated by Conan towards Harley, it occurred at a time when Conan was under significant stress because of Amy's illness and imminent passing.

21. The available evidence indicates that Conan perpetrated family violence towards Amy. The Victoria Police database lists two incidents with Conan as the Respondent and Amy as the Affected Family member. Both incidents involved verbal arguments, and one incident involved Conan damaging property, following which a Family Violence Intervention Order was issued.

22. According to Amy's family, Conan began isolating Amy from them around the time Harley was born. He prevented her family from contacting her and from seeing Harley and would break or confiscate her phone. He often locked her out of the house, and Amy's mother Leanne further recalled that he had admitted to taking an axe to the bonnet of Amy's car because of his temper. Amy regularly called Leanne crying because of Conan's actions. Conan would also send text messages to Leanne with words to the effect of *"come and get your fat, lazy daughter."*

23. Leanne also detailed that Amy often needed money for groceries and that she initially gave money to Amy, but she eventually took to buying the groceries for Amy because she knew that Amy was giving the money to Conan and she didn't know what the money was being spent on. According to Amy's manager Raffaela, she had to immediately withdraw cash for rent when she received her salary, to ensure the rent was paid *"before Conan could take the rest."* When she asked Amy why she did not move out, noting that her impression was that Amy was uncomfortable living with Conan, she said *"I'm not sure what will happen if I leave"* and *"he has no one else."*

24. NDIS Support Coordinator Jessica had suspicions that Amy was unsafe at home but did not have evidence to support this. She stated *"I recall a phone call with Amy … Afterward, I felt something wasn't right … I then called her just before she started [work] and asked her "are you safe?" she told me everything was okay and I had no evidence to go on. It was part of my underlying suspicions that something was going on, that she wouldn't talk."*

Child protection involvement

25. Harley was subject to seven reports to Child Protection between July 2016 and February 2024. Six reports were closed at the intake phase. One report progressed to protective intervention before being closed two months later, when it was assessed that there were insufficient grounds to enforce compliance with parenting services.

26. The reports related to Conan being agitated and aggressive towards health staff, lack of engagement with services, family violence perpetrated by Conan towards Amy, Harley displaying violent behaviour at school, allegations of neglect and allegations that Conan was hitting Harley. Conan and Amy were provided support and advice on parentcraft by practitioners, though it was noted that Conan was often agitated and unhappy during the appointments.

27. Child Protection were not involved with the family at the time of the fatal collision.

28. Conan was also known to Child Protection as a child and was subject to eleven reports between November 1989 and December 1998.

THE CORONIAL INVESTIGATION

Jurisdiction

29. Harley's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

30. The Act recognises that it is in the public interest to hold a public hearing when a person causes the death of another: it is mandatory for the coroner to hold an inquest if the death occurred in Victoria, the coroner suspects the death was the result of homicide, and no person or persons have been charged with an indictable offence in respect of the death.[2]

[2] Section 52(2)(a); section 52(3)(b) of the Act.

31. The circumstances suggest that Conan caused the death of Harley and in doing so, also took his own life. Accordingly, I determined that an Inquest should be held and given both deaths occurred in the same circumstance it was appropriate to hold one hearing encompassing both cases.

32. Having considered the available evidence, I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 27 August 2025.

Purpose of a coronial investigation

33. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[3]

34. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

35. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[5]

36. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including

[3] Section 67(1) of the Act.
[4] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[5] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as "implicit".

public health or safety or the administration of justice.[6] These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.[7]

37. The Coroners Court of Victoria is an inquisitorial jurisdiction.[8] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[9]

Sources of evidence

38. This Finding is based on the totality of the material produced by the coronial investigation into the deaths of Conan James Smith and Harley James Smith. That is, the Court File and Coronial Briefs of evidence compiled by Detective Senior Constable Lauren Grech.

39. The Briefs will remain on the Court File, together with the Inquest transcript.[10] In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

40. I am also grateful for the summary of circumstances prepared by Counsel Assisting, Ms McKay.

Standard of proof

41. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect

[6] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[7] See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[8] Section 89(4) of the Act.
[9] Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.
[10] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

to the principles enunciated in *Briginshaw v Briginshaw*[11]. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to
    - the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

IMMEDIATE CIRCUMSTANCES OF DEATH

42. In mid-March 2024, Amy presented to West Gippsland Hospital with severe and debilitating lower back pain and a persistent cough, and sudden onset left-sided facial droop. She was later transferred to Moorabbin Hospital, and on 27 March 2024 to the Monash Medical Centre. Amy was diagnosed with metastatic adenocarcinoma and given a very short prognosis.

43. Conan was extremely distressed by Amy's unexpected diagnosis and short prognosis, described by Brooke as *"a mess … down and out"*. She stated that stated that she "*knew that he was so fragile and distressed and worried, he had already said that to me in person"*

44. Conan and Harley visited Amy in hospital daily, often travelling by public transport as they did not have a car. Conan was well engaged with Monash Health Social Worker Madeleine

[11] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. at 362-363: *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

and accepting of services and supports. Madeleine liaised with Harley's NDIS Support Coordinator, Jessica, to best provide support for the family.

45. During her admission, Amy did not raise any concerns with Madeleine regarding Harley's care with Conan, or his ability to care for Harley, and nor did she raise concerns about her relationship with Conan or any harmful behaviours or risks. Amy's family told Madeleine that they had difficulties communicating with Conan and did not trust him but did not elaborate on this.

46. Madeleine observed Conan to be attentive to Harley; he was able to balance being a father despite being distressed about Amy's pain and discomfort and struggling with her deterioration. She observed Harley to be very talkative, though more *"tired and sad"* closer to the day of Amy's death. Harley did not express any concerns about care from Conan or disclose any information about risks.

47. Conan had expressed to Madeleine that he was worried about how he would cope as a single father, both financially and as Harley's caregiver. He similarly told Brooke *"I'm not sure if I can do this on my own"* and spoke of feeling alone and wishing he had people around him.

48. Amy sadly died in hospital on 11 April 2024, surrounded by her family.

49. On 12 April 2024, Leanne and her partner Tony visited Conan and Harley at their home. Tony and Conan spoke about Conan's car, a Holden Rodeo which was unable to be driven. They offered assistance, including the use of Amy's superannuation to pay for her funeral, and noted that Conan *"seemed alright ... he was taking things pretty well."*

50. The same day, Conan contacted his friend Scott and asked for his assistance to purchase a car. They exchanged several messages, in which Conan *"sounded like he was struggling and not coping".* Conan said he wanted a car quickly as he was moving away with Harley immediately after Amy's funeral. When asked where he was moving, Conan replied *"Not sure yet just drive until whenever we end up got too many memories around here".*

51. Conan sent a Facebook message to Chase, who had advertised his car for sale on Facebook Marketplace two days prior. The car was a white 1999 Subaru Impreza. Conan and Chase

spoke on the phone and Conan told him he *"wasn't doing so well",* disclosing *"my girlfriend died yesterday".* He sounded choked up and said *"I have to go"* before hanging up.

52. That afternoon, Conan sent Chase a message saying *"I'll call ya today mate I just need to get my head together but yeah keen on the car".* After several messages over the following day, they made arrangements to meet in Longwarry at 10am on 14 April 2024 so that Conan could purchase the car.

53. Conan then messaged Scott and told him he found a car to purchase and sent a photo of the Subaru he arranged to purchase from Chase. Scott told him *"Subarus are good but you have to really maintain them"*, to which Conan replied *"everything will be fine mate".*

54. On the morning of 14 April 2024, Conan and Chase met as arranged. Conan introduced Harley as his *"little one"* and disclosed that Amy had wanted Harley to be the beneficiary of her superannuation, but her family wanted the money, and that her family were not willing to pay for the funeral. Chase felt *"a bit awkward"* and did not know how to respond. He recalled *"the whole time I could tell he was very down, his pain was obvious. He seemed like a broken man and had a really washed out look on his face. You could tell he was hurting a lot, I assumed that was about the recent death of his partner".*

55. Between 1 and 2pm, Murtaza arrived at Conan's residence to purchase his bronze Holden Rodeo that had been posted for sale on Facebook Marketplace the previous day. Murtaza recalled that Conan *"seemed quite agitated ... He told me about how his girlfriend had recently passed away".* Murtaza paid $400 cash and left with the Holden.

56. At 3:26pm, Mark, owner of Neilsen Funerals called Conan after he had contacted their office. Mark asked Conan how he was doing, to which he replied *"we're doing okay"*. Conan wanted to meet Mark that day to give him some things, including jewellery for Amy. Mark was not available so told him to bring the items in the following day, when they had a scheduled appointment. Conan said it had to be done that day, because he was going to buy a car the following day. He acknowledged he had called out of the blue and told Mark he would call again tomorrow. Mark advised that they had a secure drop box at the front of their office.

57. At an unknown time before 3:40pm, Conan set about burning items in a bathtub located in their backyard. He then set the house alight, before leaving the property with Harley and their pet dogs. Upon noticing the fire, bystanders immediately called Triple Zero and some entered the property and began attempting to extinguish the fire. They observed a separate fire in a bathtub in the back yard.

58. The Country Fire Authority and Fire Rescue Victoria attended and extinguished the fire. FRV personnel, now aware that Conan and Harley resided at the house, conducted a thorough search and confirmed that there was nobody within the house.

59. At 4:22pm, Scott received a voice-to-text message from Conan saying *"Scott, I'm sorry mate. I've just threw a bag over your fence. It's a white cooler bag with Amy's stuff in it".*

60. At 4:24pm, Conan sent Scott a text message saying *"I threw a cooler bag over your fence with Amy's things and $6000 please give it to mark at Neilsons funeral service in Warragul. Sorry Scott".* Conan posted the same message to Facebook and tagged Scott. Scott attempted to call Conan a few times, but his phone appeared to be off.

61. At 4:33pm, Scott called Neilsen Funerals and explained the situation to a member of staff. She advised that Conan was supposed to be attending the following day to arrange Amy's funeral, and that no one had been able to contact him to confirm the appointment, and she was worried because his house was on fire.

62. At around 5:22pm, the truck driver[12] was driving northbound on Willow Grove Road in Trafalgar. They were driving a Kenworth Prime Mover connected to a tri-axle cattle trailer. They recalled travelling at around 85-95 km/h despite the 100 km/h speed limit, as the *"road is a bit rough just near there".* They observed a white car, later identified to be Conan's newly-purchased Subaru, driving southbound in the opposite lane, *"driving normally on the road".*

63. Suddenly, the Subaru veered into the northbound lane. The truck driver remembers "*Seeing it come towards me and the next thing it was in front of me".* The truck driver was unable

[12] The name of the truck driver is known to the Court, however I do not deem it necessary to identify them for the purposes of my Finding.

to take any evasive action, and the vehicles collided head-on. The truck pushed the Subaru back some 55 metres before both came to rest off the side of the road.

64. Witnesses to the collision immediately called Triple Zero and attempted to render assistance, though *"it was obvious there was no one alive in the car."*

65. Emergency services personnel observed a man, young boy and two dogs deceased in the vehicle. Through communications between emergency services personnel in the local area, it was determined that it was likely that the occupants of the vehicle were Conan and Harley Smith and their two dogs, but substantial damage to the vehicle made identification impossible at that time.

66. On the morning of 15 April 2024, the Disaster Victim Identification Unit and the State Emergency Service attended and completed the extraction of Conan and Harley from the vehicle.

INVESTIGATION PRECEDING THE INQUEST

Identification

67. On 23 April 2024, the nuclear DNA profile of the deceased was compared with the nuclear DNA profile of Conan Smith, Harley Smith's father. The results of the DNA analysis supported a view that the deceased was a child of Conan Smith.

68. On the same date, Coroner Leveasque Peterson considered the available evidence and determined that the cogency and consistency of all evidence relevant to the identification of the deceased support a finding that the deceased was Harley James Smith, born 12 July 2016. Accordingly, she signed a Determination by Coroner of Identity of Deceased (Form 8).

Medical cause of death

69. On 18 April 2024, Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Harley Smith and provided a written report of her findings dated 30 May 2024. At the time of compiling her report, Dr Ho had available to her the following materials:

- Victoria Police Report of Death (Form 83)
- VIFM preliminary examination form
- VIFM contact log
- Victoria Police Section 27: Request for Immediate Autopsy and subsequent withdrawal
- DFFH response to Notification of Child Death
- Twenty-two (22) scene photographs
- Post mortem computed tomography (**CT**) scan
- Post mortem CT report from the Royal Children's Hospital

70. The autopsy showed extensive traumatic injury to the head resulting in shattered and fragmented skull vault and brain. Dr Ho commented that these injuries would have been fatal. Several fractures, right haemothorax, haemoperitoneum and multiple liver and splenic lacerations were also identified.

71. The autopsy also showed an external anal injury comprising of bruising and lacerations that Dr Ho identified were the result of blunt force and penetrating trauma. Dr Ho commented that these may have occurred secondary to the motor vehicle incident and given the extent of the injuries sustained, there is no equivocal way of determining pre-existing injuries or injuries that may have been sustained immediately prior to the collision.

Toxicology

72. Toxicological analysis of post-mortem samples did not identify the presence of ethanol or common drugs or poisons.

Forensic pathology opinion

73. Dr Ho provided an opinion that the medical cause of death was 1 (a) multiple injuries sustained in a motor vehicle incident (passenger).

House fire

74. Arson Chemist John Kelleher of the Victoria Police Forensic Services Centre identified that there had been two fires in the house, as well as a fire in the backyard.

75. There had been a fire in the western corner of the house in the third bedroom, which had consumed the combustible components of the mattress and any bedding. The fire had spread to the bedside tables and the wardrobe, burning the furniture and contents. The fire extended through the roof space over the adjoining rooms, with some limited spread of the fire along the hallway.

76. There had been a second fire in the front entry hallway, where the contents of a large cupboard (mainly clothing and shoes) were spread across the floor and badly burnt. The fire extended through the roof space above the kitchen and lounge room, causing collapse of large parts of the ceiling.

77. The damage was not indicative of flammable liquid spread through the house, and none was detected in testing.

78. There had also been a fire in the backyard, in an old bathtub. The bathtub was filled with a mixture partly burnt timber, grass and weeds, and what appeared to have been DVDs.

79. Mr Kelleher concluded that the cause of the fire in each case was the ignition of combustible material. In the third bedroom, this was the mattress and/or bedding. In the front hallway, it was clothing and/or other readily ignitable material from the cupboard. He was unable to

determine the source of ignition but in the absence of any obvious source of accidental ignition and given the presence of two distinct and separate fires, considered it was probably a match or cigarette lighter.

Fatal collision

80. Willow Grove Road at the collision location is a two-lane carriageway with bitumen lanes separated by a divided white line. The speed limit is default to the national speed limit of 100 km/h due to being a country road. At the time of the collision the road surface was dry and in good condition. The weather was fine and clear.

81. Detective Sergeant Robert Hay of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit calculated that the speed of the truck when it struck Conan's vehicle was a minimum of 104 km/h, based on an assumed 100% braking efficiency of the truck involved. He noted that if the brakes were less than 100 percent efficient then the speed would be lower.

82. D/Sgt Hay was unable to calculate the speed of the Subaru.

83. Samples of the truck driver's blood were taken at hospital at 7pm on the night of the fatal collision. An analysis of these samples did not detect the presence of ethanol or any unprescribed drugs or poisons. Morphine and Ondansetron were detected, but police confirmed that these drugs were administered to them by paramedics after the collision occurred.

84. There was no evidence to suggest that the driver of the truck contributed to the collision through any action or inaction. All available evidence indicates that Conan deliberately drove the vehicle into the path of the truck at such a time that the truck driver was unable to take any evasive action.

85. Dr Jason Schreiber of the VIFM was asked to provide an opinion regarding the involvement of drugs in the fatal collision.

86. Dr Schreiber noted that Conan had THC and mirtazapine (an antidepressant) in post-mortem blood samples three days following the fatal collision. Although the detected THC blood

concentration was on a level that appeared high and indicated recent cannabis use, positive redistribution after death does not allow for a reliable estimation of the THC level before death.

87. He opined that Conan's sudden veering into the opposite lane may be explained by the impairing effects of THC, probably in combination with mirtazapine. However, he was unable to rule out suicidal behaviour, tiredness or a medical condition as the cause of such behaviour, also in view of Conan being treated with an antidepressant.

FINDINGS AND CONCLUSION

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Harley James Smith, born 12 July 2016, died on 14 April 2024 at Willow Grove Road, Trafalgar, Victoria 3824.

2. I accept and adopt the medical cause of death ascribed by Dr Joanne Ho, and I find that Harley James Smith died from multiple injuries sustained in a motor vehicle collision in which he was the passenger.

3. I find that Harley James Smith's death was caused by the intentional act of Conan James Smith, who intended to also take his own life.

4. I find, on the evidence available to me, that the main precipitating factor influencing Conan James Smith to adopt the course of action he chose was the sudden deterioration and death of his partner, Amy Galea, on a background of his diagnosed and treated mental ill-health.

5. AND, although with the benefit of hindsight, there were several concerning aspects to Harley James Smith's short life, there was no substantive evidence and no overt behaviours of Conan James Smith to have caused anyone to envisage that he would so violently end his son's life.

I convey my sincere condolences to Harley's family for their loss.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

DISTRIBUTION OF FINDING

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

Leanne Bennett, Senior Next of Kin

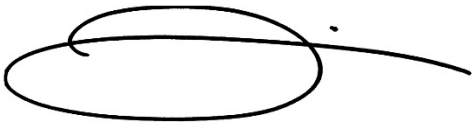
Philip Smith, Senior Next of Kin

Transport Accident Commission

Commission for Children and Young People

Detective Senior Constable Lauren Grech

Signature:



AUDREY JAMIESON
CORONER

Date: 27 August 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.