MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Leigh John Williams

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

a) The identity of the deceased is Leigh John Williams;

b) Mr Williams died as a result of severe trauma associated with a single motor vehicle crash at the intersection of Manana Road and East Wickham Road, Yambacoona, King Island;

c) Mr Williams died on 8 February 2015 at King Island District Hospital, King Island in Tasmania; and

d) Mr Williams was born in Clayton, Victoria on 3 March 1988 and was aged 26 years; he was in a de facto relationship with two sons, and was employed as a farm worker.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Williams' death. The evidence comprises a detailed report by crash investigators; an opinion of the State Forensic Pathologist as to cause of death; relevant police and witness affidavits; medical records and reports; and forensic evidence.

I make the following further findings, based upon the evidence, as to how Mr Williams' death occurred.

At 10.16pm on 7 February 2015 Mr Williams was the driver and sole occupant of a Mazda Utility when he crashed into a power pole at the intersection of Manana Road and East Wickham Road, Yambacoona, King Island.

During the evening before the crash Mr Williams had been in company with a friend, Clint Russell, at Counsel Hill. They were in separate vehicles. They drove from Counsel Hill towards the intended destination, being the home of Mr Russell at Haines Road, Egg Lagoon. Although travelling together, witnesses stated that their vehicles were approximately 500 metres apart. Mr Williams led the way from the junction of Reekara Road and Manana Road. At 10.16pm Mr Williams' vehicle collided with a power pole on East Wickham Road at the 'T' junction of Manana Road. Both roads at the crash location were gravel.

Mr Williams was alive at the scene and assisted by witnesses and by ambulance. He was seated in the driver's position and had his seatbelt fastened at the time of impact. Mr Williams showed signs of serious head injuries. During his extraction from the vehicle, it

became apparent that he had sustained severe damage to his legs. Mr Williams was taken to King Island District Hospital by ambulance, but tragically he did not survive his injuries and was pronounced deceased at 2.27am Sunday 8 February 2015.

Results of toxicological testing enable me to conclude that Mr Williams had alcohol in an elevated quantity in his blood at the time of driving. This result is consistent with the evidence that he had consumed alcohol during the evening. Analysis of his mobile telephone indicates a strong possibility that he was using it close to the time of the crash. If this is the case he may have taken his eyes off the road. Further, eyewitness evidence indicates that Mr Williams was travelling at a speed too high to safely take the corner at the T-junction.

Comments and Recommendations:

I extend my appreciation to Senior Constable Fiona Russell for her high quality investigation and report.

I also acknowledge the dedicated efforts of volunteer ambulance, fire and emergency personnel in attending to Mr Williams at the crash scene.

The tragic death of Mr Williams is yet another example of the risk posed by the combination of speed and alcohol consumption when driving.

The circumstances surrounding this matter do not require me to make any recommendations pursuant to section 28 of *Coroners Act* 1995.

In concluding, I convey my sincere condolences to Mr Williams' family and loved ones.

Dated: 3 March 2016 at Hobart in the state of Tasmania.

Olivia McTaggart
Coroner