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 Mark Norman Wright

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

a) The identity of the deceased is Mark Norman Wright;
b) Mr Wright died as a result of injuries sustained in a single motor vehicle crash in which he was the driver and sole occupant of his vehicle;
c) The cause of Mr Wright's death was the combined effects of traumatic injuries of the head and neck and positional asphyxia;
d) Mr Wright died on 25 April 2016 at the Southern Outlet slip lane on the Huon Highway, Kingston in Tasmania; and
e) Mr Wright was born in Darwin, Northern Territory on 26 August 1969; he was aged 46 years.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mark Norman Wright's death. The evidence comprises a detailed report by the crash investigator; an opinion of the forensic pathologist who conducted the autopsy; 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 Wright's death occurred.

On 24 April 2016 Mr Wright travelled to the home of his friend, Phillip Page, in Geeveston to assist him with some building work. Mr Page and Mr Wright spent the day together from 10.30am until 7.30pm. They consumed alcohol throughout the day. Mr Page stated that Mr Wright would not normally drive his vehicle home after consuming alcohol. Despite the attempts of Mr Page on this occasion to dissuade Mr Wright from driving, he drove to the Geeveston RSL Club.

At 9.00pm Mr Wright was located at the RSL Club by his partner, Roslyn Hiscox. In her affidavit for the investigation, Ms Hiscox stated that he appeared affected by alcohol but was in good spirits and was not ready to leave. Ms Hiscox left, presuming that Mr Wright would telephone her later for a lift home.

The barman at the RSL Club, Samuel Hohne, stated in his affidavit that Mr Wright left the venue at closing time, being around 10.40pm. Prior to leaving, Mr Wright purchased a bottle of vodka and said that he may go to the Lady Franklin Hotel. The evidence indicates that the Lady Franklin Hotel had closed at 8.30pm on that evening. It is unknown as to exactly where Mr Wright went after leaving the RSL Club.

At 1.26am on 25 April 2016 Mr Wright's vehicle, a white Toyota Camry sedan D82WS, was located in the north western slip lane joining the Huon Highway and the Southern Outlet at Kingston by passing motorists who called police. The vehicle was on its roof with the front of the vehicle facing into an embankment and Mr Wright inside.

Police officers arrived at the scene at 1.43am and ambulance personnel arrived shortly thereafter. Mr Wright was located by Constable Timothy Meech unresponsive in the driver's seat of the vehicle. He was wearing his seatbelt.

The passenger side of the Camry was crushed, indicating that the vehicle had rolled over during the incident. The driver's door and frame were also crushed and the vehicle could only be accessed via the driver's side rear door.

Constable Meech and volunteer ambulance officer, Frances Velnaar, entered the vehicle and cut Mr Wright free from his seatbelt. They attempted to remove him from the vehicle but were unable to do so.

With the assistance of ambulance officers, Mr Wright was extricated from the vehicle. The ambulance officers commenced resuscitation attempts upon Mr Wright. These were unsuccessful and ceased at 2.22am. Mr Wright was then determined to be deceased.

Sergeant Rod Carrick, Senior Crash Investigator, attended and examined the scene, assisted by an officer from Forensic Services.

A quantity of cannabis was located in the front of the vehicle. Two unopened cans of UDL Vodka were also located. The bottle of vodka purchased by Mr Wright was not located in the car.

Sergeant Carrick's examination of the scene revealed that the vehicle's movements before the crash occurred as follows:

Mr Wright's vehicle left the sealed road surface and the right side of his vehicle travelled on an unsealed portion of the road's edge. Mr Wright then over-corrected and swerved to the left where the left side tyres travelled on an uneven gravel and grass verge. The vehicle continued on where it contacted the embankment. This caused the vehicle to straighten towards, and ultimately strike, the embankment where its momentum caused it to become airborne and roll over toward the driver's side. It finally came to rest on its roof against a road sign on the northwest side of the slip lane. There was no indication that the vehicle was under brakes during the incident. Mr Wright was travelling at approximately 80km/h at the time of the crash, being in excess of the advisory sign of 65km/h for that portion of the road.

Mr Wright's mobile phone was located at the scene and examined. There is no evidence to suggest that he was using his mobile phone at the time of the crash.

The examination of Mr Wright's vehicle was carried out by transport inspector, Mr Peter Moses. His examination revealed that the damage to the vehicle was consistent with an impact and rollover incident. The brake system and steering components were functioning normally at the time of the crash and the tyres were in good condition. The driver's side airbag did not deploy during the crash. Mr Moses concluded that the vehicle was in good condition and had been well maintained prior to the crash. I accept his opinion.

Dr Donald Ritchey, forensic pathologist, performed an autopsy on Mr Wright. He determined that the cause of Mr Wright's death was traumatic injuries to the head and neck together with positional asphyxia. The finding of positional asphyxia arose due to Mr Wright having been suspended upside-down in the driver's seat by his seatbelt with the weight of his body on his head and neck. I accept Dr Ritchey's opinion as to cause of death.

Toxicological testing of Mr Wright's blood subsequent to death revealed a blood alcohol reading of 0.165g/100ml of blood, more than three times the legal permitted limit. The presence of desmethylvenlafaxine and THC (cannabis) were also detected in higher than therapeutic levels. Desmethylvenlafaxine is the active ingredient of Pristiq, a medication that Mr Wright was prescribed at the time of his death.

The evidence of the forensic scientist in the investigation is that drivers with elevated levels of alcohol are at increased risk of being involved in a motor vehicle crash. A reading between 0.140 and 0.180 increases the risk of a crash between 20 and 50 times. A combination of high alcohol concentration and THC may severely impact driving performance by increasing reaction time and reducing perceptive and reactive abilities.

I find that the combination of the high level of alcohol and THC in Mr Wright's system severely impaired his judgement and reactions whilst driving on a portion of road that required careful attention and reduced speed. Such impairment rendered him unable to adequately control his motor vehicle resulting in the crash that caused his death.

I am satisfied that Mr Wright's crash was not a result of any deliberate action taken on his part to harm himself. I am further satisfied that no other person or vehicle was involved in the crash that caused Mr Wright's death.

Comments and Recommendations:

I extend my appreciation to investigating officer, Sergeant Gerry King, and crash investigator, Sergeant Rod Carrick, for their investigation and reports.

I acknowledge the efforts of all who attended at the crash scene to assist Mr Wright.

I convey my sincere condolences to the family and loved ones of Mark Norman Wright.

Dated: 28 April 2017 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner