MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Rod Chandler, Coroner, having investigated the death of Trent Terrence Hill

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

a) The identity of the deceased is Trent Terrence Hill;
b) Mr Hill was born in Launceston on 15 September 1993 and was aged 24 years;
c) Mr Hill died on 27 November 2017 on Meander Valley Road at Travellers Rest in Tasmania; and
d) The cause of Mr Hill's death was fatal injuries involving the brain, cervical spine and lung all sustained in a motor vehicle crash.

Background

Mr Hill was single. He did not have children. He had casual employment at Entally near Hadspen. He enjoyed good health. He was the owner of a Ford sedan.

Circumstances Surrounding the Death

At about 10.05pm on 27 November 2017 Mr Hill was driving his Ford on Meander Valley Road in an easterly direction towards Prospect. He was alone. In the vicinity of Travellers Rest the Ford was negotiating a slight right hand bend when it left the roadway, overturned and collided with a gum tree. Mr Hill sustained serious injuries in the crash and was found deceased inside his vehicle.

Post-Mortem Examination

This was carried out by pathologist, Dr Ruchira Fernando. In her opinion the cause of Mr Hill's death was fatal injuries involving the brain, cervical spine and lung all sustained in a motor vehicle crash. I accept this opinion.

Investigation

This was overseen by First Class Constable Nigel Housego, a crash analyst attached to the Crash Investigation Section of Tasmania Police.

His investigation satisfies me that:

1. Mr Hill was issued a driving licence in 2010. The licence was later cancelled and Mr Hill was unlicensed at the time of the crash.
2. The Ford was in a roadworthy condition save that its left hand rear tyre had a non-compliant tread depth. This defect did not cause or contribute to the crash.
3. Mr Hill was not wearing a seat belt at the time of the crash.
4. The road surface in the area of the crash was dry and in a good condition.
5. The area of the crash was subject to a 100kph speed limit. Mr Hill's Ford was calculated to be travelling at a minimum speed of 118kph just prior to the crash.
6. Mr Hill had been drinking alcohol prior to the crash. His post-mortem blood alcohol reading was 0.126 g/100ml.
7. Excessive speed coupled with an excessive level of alcohol caused Mr Hill to lose control of his vehicle. In all likelihood his injuries were compounded by his failure to wear a seat belt.

Findings, Comments and Recommendations

For decades road safety authorities in this State have been reminding road users of the perils of driving too fast, consuming too much alcohol and not wearing a seat belt. Sadly Mr Hill did not heed these warnings and his needless death is the result. It is to be hoped that it reminds others that driving can be a life threatening activity if these fundamental rules are ignored.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act* 1999. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Mr Hill's family and loved ones.

Dated: 20 September 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner