MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Andrew McKee, Coroner, having investigated the death of Wayne Phillip Dennis,

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

a) The identity of the deceased is Wayne Phillip Dennis;
b) Mr Dennis died as a result of injuries he suffered in a single vehicle crash;
c) Mr Dennis' cause of death was exsanguination due to multiple fractures; and
d) Mr Dennis died on 15 February 2019 on Port Sorell Road, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Dennis' death. That evidence is comprised of the following:

a) An opinion of the pathologist who conducted the autopsy;
b) The Police Report of Death for the Coroner;
c) Relevant police and witness affidavits;
d) Toxicology report prepared by Forensic Science Services Tasmania;
e) An affidavit of Mr A Fitzpatrick, a Transport Inspector employed by the Department of State Growth;
f) A report and an affidavit of Senior Constable S Mason, a crash scene investigator;
g) Medical records and reports; and
h) Forensic evidence.

Mr Dennis was born in Tasmania on 4 May 1987 and was aged 31 years at the date of his death. He was a single man having separated from his partner. The relationship produced one child. Mr Dennis had regular contact with his child.

At the date of his death he was employed as a barman at the Shearwater Resort and he resided in East Devonport. He had a number of health issues and numerous witnesses indicated that he suffered from depression.

Circumstances Surrounding Mr Dennis' Death

A consideration of the sworn affidavits of the various witnesses, and the materials obtained during the coronial investigation, enables me to make the following findings of fact regarding Mr Dennis' movements and activities on the day of his death, along with the manner of his driving shortly prior to his vehicle leaving the roadway.

Mr Dennis attended work on Thursday, 14 February 2019. He was rostered to work as a barman between midday and 5.00pm. At 5.00pm, Mr D Aitken and Mr R Elstone commenced their shift at the Shearwater Resort Tavern, effectively taking over bar duties from Mr Dennis.

Mr Aitken was working behind the bar and observed Mr Dennis, from the conclusion of Mr Dennis' shift until Mr Dennis left the Shearwater Resort Tavern, with a group of friends around midnight. The group of friends included fellow employees of the Tavern. Mr Aitken was aware the group intended on travelling to the home of Mr J Lewis. Mr Aitken offered to drive the group to Mr Lewis' home as Mr Lewis only lived a short distance from the Shearwater Resort Tavern. It was Mr Aitken's intention to join the group at Mr Lewis' home.

Mr Aitken noted that Mr Dennis became progressively more intoxicated throughout the evening.

At around midnight the group who had been socialising at the Shearwater Resort Tavern travelled to Mr Lewis' home. Mr Lewis obtained a lift to his house with a person he only identified as Janine. Ms Clark, another employee of the Tavern, along with others walked to Mr Lewis' home.

Around 12.35am to 12.40am Mr Aitken and Mr Elstone arrived at Mr Lewis' home. A short time later Mr Dennis contacted Mr Lewis and stated that he was lost. Mr Aitken said that he would go and look for Mr Dennis. He located Mr Dennis outside of Mr Lewis' home sitting in the gutter near his vehicle. He enquired of Mr Dennis how he had travelled to Mr Lewis' home and Mr Dennis indicated that he had driven his motor vehicle.

Mr Aitken in his affidavit dated 20 February 2019 indicated that he *"read him [Mr Dennis] the Riot Act because I had already offered him a ride once that night."*

Mr Aitken attempted to obtain Mr Dennis' car keys from him but was unsuccessful. Mr Aitken left Mr Lewis' home at 1.15am and once again offered Mr Dennis a lift, but he declined.

Mr Elstone left Mr Lewis' premises at around 2.00am. He offered Mr Dennis a lift home but he declined.

Whilst at Mr Lewis' home Mr Dennis continued to consume alcohol. On numerous occasions Mr Lewis indicated that Mr Dennis was welcome to spend the night at his home. Mr Lewis described Mr Dennis as "pretty drunk". Others present attempted to take Mr Dennis' keys from him but they were unsuccessful.

Mr Lewis recalls that sometime between 2.30am and 2.45am Mr Dennis disappeared. He presumed that he had snuck away and gone home.

The Collision

After leaving Mr Lewis' premises Mr Dennis attempted to call Mr Lewis on his mobile phone at 2.47am. At 3.13am Constables Lincolne and Bester, whilst travelling west on Port Sorell Road at Wesley Vale, observed a white Toyota Camry off to the right-hand side of the roadway. Given the condition of the vehicle it was obvious it had been involved in a collision.

The vehicle had suffered substantial damage and was lodged against a tree. A male person from a neighbouring property was at the scene and advised Constables Lincolne and Bester that he had heard the collision.

Mr Dennis was located at the front of the vehicle. Constable Lincolne and Constable Bester noted Mr Dennis appeared deceased but requested attendance of an ambulance and Tasmanian Fire Service.

Paramedics attended. Mr Dennis was unresponsive and was declared deceased at the scene.

Condition of Mr Dennis' Vehicle Prior to the Collision

After the collision Mr Dennis' vehicle was inspected by transport inspector, Mr A Fitzpatrick. The vehicle driven by Mr Dennis was found to be in an unroadworthy condition due to the driver's seat belt webbing being frayed. I find that the defect identified by Mr Fitzpatrick did not cause or contribute to the collision.

Crash Investigation

A thorough investigation of the collision was conducted by Senior Constable S Mason.

Based on Senior Constable Mason's affidavit and report to the coroner, I find that Mr Dennis was travelling towards Wesley Vale from the Shearwater direction. Mr Dennis was travelling at an excessive speed, namely 120 km/h in an area clearly signposted with a speed limit of 80 km/h. The front lights of the vehicle were only on park and not low or high beam. Mr Dennis had just travelled on a short straight of some 550 metres in length and was about to negotiate a slight right curve when his vehicle went into a yaw. The vehicle slid sideways, passenger side

first, across both lanes of the road before travelling over a grass verge on the western side of the road, colliding with a hidden rotten tree stump.

The vehicle continued on for 9.5 metres, sliding passenger side first into a tree. Upon impact the vehicle also tipped up, crushing the roof as it wrapped around the tree trunk. The vehicle then rotated between 90 and 180° around the tree, coming to rest against it, facing an easterly direction.

At some stage during the crash sequence, Mr Dennis was ejected from the vehicle coming to land 2.3 metres from the edge line and directly in front of the vehicle itself. I am satisfied based on Senior Constable Mason's investigations that at the time of the collision Mr Dennis was not wearing his seatbelt.

Prevailing weather conditions and the condition of the roadway did not cause or contribute to Mr Dennis' vehicle leaving the roadway.

Senior Constable Mason concluded that the cause of Mr Dennis' vehicle leaving the roadway and his subsequent death was a combination of excessive speed, Mr Dennis failing to wear a seatbelt and driving a motor vehicle whilst exceeding the prescribed blood alcohol limit of 0.05 g/100ml.

Post-Mortem and Toxicology Report

A post-mortem examination was undertaken by pathologist Dr Terence Brain. Dr Brain opined that the cause of Mr Dennis' death was exsanguination due to multiple fractures received in a single vehicle crash. I accept Dr Brain's opinion as to Mr Dennis' cause of death.

Toxicology testing of samples obtained at the autopsy revealed the presence of alcohol in Mr Dennis' blood. That report indicates that Mr Dennis had alcohol in his blood at 0.261 g/100ml.

The author of that report made the following comments regarding Mr Dennis' elevated blood alcohol reading:

> "*A blood alcohol concentration of 0.261 g /100ml of blood would significantly impair driving performance to the point of being unable to properly control a motor vehicle. It has been estimated that the relative risk of a driver with a blood alcohol concentration of 0.180 g/100ml being involved in a crash is approximately 50 times that of a driver with nil blood alcohol. It is therefore expected that a blood alcohol concentration higher than this would be associated with an even greater risk of crash involvement.*"

I am satisfied based on the toxicology report that Mr Dennis' capacity to safely control a motor vehicle and respond in an emergency situation was significantly impaired.

In summary, I find that Mr Dennis' motor vehicle has left the roadway, collided with a hidden stump and then travelled further until it collided with a tree. During that process Mr Dennis was ejected from the vehicle. I find that it was a combination of speed and his decision to drive a motor vehicle with a blood alcohol reading of 0.261 g/100ml that led to his vehicle leaving the roadway.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Mason for his investigation and report.

The circumstances of Mr Dennis' death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I wish to comment that this collision would not have occurred had Mr Dennis not been exceeding the applicable speed limit for the portion of roadway that he was travelling upon and driving a motor vehicle with a blood alcohol level of 0.261 g/100ml.

As a result of consuming alcohol, his driving performance was significantly impaired to the point of being unable to properly control a motor vehicle.

This case is just one further example of the consequences that flow from an individual's decision to drive a motor vehicle whilst exceeding the prescribed alcohol limit of 0.05g of alcohol per 100ml of blood and exceeding the applicable speed limit.

I further note that this was yet another collision that exposed first responders, namely police officers and paramedics and a member of the public to another fatal collision.

Dated: 15 May 2020 at Hobart Coroners Court in the State of Tasmania.

Andrew McKee
Coroner