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 Melissa Joan Wilton

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

a) The identity of the deceased is Melissa Joan Wilton;
b) Ms Wilton died as a result of multiple blunt trauma injuries she sustained in a collision between a vehicle driven by herself and another motor vehicle;
c) Ms Wilton's cause of death was multiple blunt trauma injuries; and
d) Ms Wilton died on 31 March 2019 at Orford, Tasmania.

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

- An opinion of the forensic pathologist who conducted the autopsy;
- Affidavit of Senior Constable A Hall, a crash scene investigator;
- Relevant police and witness affidavits;
- Affidavit of Mr Clark, a Transport Inspector employed by the Department of State Growth;
- Medical records and reports;
- Toxicology reports prepared by Forensic Science Services Tasmania; and
- Forensic evidence.

Ms Wilton was born on 4 July 1982 and was 36 years of age at the date of her death. At the date of her death Ms Wilton was engaged to be married. She had been in previous relationships and was the mother of two children, a son and daughter. Ms Wilton's daughter resided with her father. Pursuant to a Court order, Ms Wilton had contact with her daughter every alternate weekend.

Ms Wilton resided in Triabunna with her stepmother. She held casual employment at Spring Bay Seafoods as a seafood processor and at the fish van on the Triabunna wharf.

Circumstances Surrounding the Death

A consideration of the evidence obtained in the coronial investigation enables me to make the following findings regarding Ms Wilton's activities on the day of her death and the manner of her driving shortly prior to the collision.

On the morning of 31 March 2019 Ms Wilton travelled from her home in Triabunna to South Arm to spend the day with her fiancé. Ms Wilton and her fiancé, along with her daughter, had planned to attend a family day at the South Arm RSL.

Ms Wilton, her fiancé and daughter arrived at the South Arm RSL at approximately 11.00am. They left the RSL at approximately 4.00pm. During the course of the day Ms Wilton consumed approximately five to six cans of Cascade Draught beer.

Ms Wilton's fiancé encouraged her to spend the night at his home. Ms Wilton declined because she had arranged to return her daughter to her father at the conclusion of contact. Ms Wilton had arranged to meet with her daughter's father at the Foreshore Tavern, Lauderdale at approximately 4.30pm.

Ms Wilton travelled from South Arm to the Foreshore Tavern in her Nissan Pulsar motor vehicle. Ms Wilton arrived at the Foreshore Tavern at approximately 5.20pm. Ms Wilton left her daughter in her father's care, left the Foreshore Tavern and travelled to the BWS bottle shop at Sorell.

At 5.36pm Ms Wilton was observed on CCTV footage to enter the BWS bottle shop at Sorell. She purchased a six pack of Cascade Draught beer cans from the bottle shop. At 5.38pm Ms Wilton was captured on CCTV footage leaving the bottle shop, entering her vehicle and placing the six pack of beer on the floor behind the passenger seat of the vehicle. The vehicle was then observed leaving the BWS bottle shop.

Ms Wilton was then observed by Mr Sullivan leaving the BWS bottle shop and travelling in the direction of Station Street, Sorell towards Triabunna. Ms Wilton was known to Mr Sullivan.

The next person to observe Ms Wilton's vehicle was Ms Brain who was travelling north on the Tasman Highway just north of Brinktop Road. This was at approximately 5.50pm. Ms Wilton's vehicle overtook Ms Brain's vehicle. Due to the nature of the overtaking manoeuvre Ms Brain was required to slow her vehicle in order to enable Ms Wilton to safely complete the overtaking manoeuvre and avoid a collision. Ms Brain observed Ms Wilton's vehicle to

accelerate after the overtaking manoeuvre, and in her view, Ms Wilton's vehicle was travelling well in excess of the 100 km/h speed limit as she soon lost sight of Ms Wilton's vehicle.

The next person to observe Ms Wilton's vehicle was Mr Keal, who was travelling as a passenger in a motor vehicle being driven by his wife heading northbound on the Tasman Highway up Bust-Me-Gall-Hill. This was at approximately 6.00pm. Mr Keal observed Ms Wilton's vehicle overtake the vehicle being driven by his wife. Mr Keal estimates that Ms Wilton's vehicle was travelling in excess of 100 km/h as Ms Wilton's vehicle was out of sight in a very short distance. Mrs Keal's observations of Ms Wilton's overtaking manoeuvre and the speed at which she estimates Ms Wilton's vehicle to be travelling are consistent with the observations of Mr Keal.

Ms Wilton's vehicle was observed by a Mr Strune as he was driving his motor vehicle southbound towards Sorell. He was approximately 3 to 4 km south of Buckland. Mr Strune's attention was drawn to Ms Wilton's vehicle due to its speed which he estimated to be between 120 to 130 km/h.

The Collision

At approximately 6.15pm Mr Mark Dance was driving his Nissan Navara utility (towing a tandem box trailer) south on the Tasman Highway heading towards Buckland. Mrs Naomi Dance was a passenger in the motor vehicle.

Mr Dance's vehicle was being followed by another vehicle being driven by Mr Tie. A Ms Menezies was a passenger in Mr Tie's vehicle.

At the same time Ms Wilton was travelling in a northerly direction towards Orford.

The observations of Mr Dance, Mr Tie and Ms Menezies as to the movements of Ms Wilton's vehicle prior to and up until the collision are consistent. Mrs Dance has no recollection of the collision.

Ms Wilton's vehicle has drifted off the left hand side of the road into the gravel verge. Ms Wilton has lost control of the vehicle and has swerved from one side of the roadway to the other in an attempt to regain control of the vehicle. This occurred on three or four occasions.

Mr Dance applied his breaks but was unable to avoid a collision.

Immediately after the collision Mr Dance and other passing motorists, including an off duty fireman, policeman and a doctor, have provided assistance to Ms Wilton. An ambulance was

called and attended the scene of the collision. Unfortunately Ms Wilton was pronounced dead at the scene.

Condition of Vehicles Prior to Collision

Both vehicles were inspected after the collision by Mr Clark, Transport Inspector. Both vehicles were in a roadworthy condition prior to the collision. As to the trailer being towed by Mr Dance, Mr Clark found that the trailer was not in a roadworthy condition prior to the collision due the following defects:

a) Two of the tyres fitted did not comply with the vehicle standard rim/tyre requirements. Non-compliance was due only to cracks in the sidewalls;
b) Numberplate light not fitted; and
c) Brake assemblies not correctly assembled.

Mr Clark expressed the opinion that the brake assemblies were operational however as to the total efficiency of the brake system he was unable to draw any conclusion.

Based on the evidence before me (namely the expert opinion of Senior Constable Hall) I am satisfied that the defects noted by Mr Clark did not contribute to the collision.

Crash Investigation

A thorough investigation of the collision was conducted by Senior Constable Adam Hall, an experienced crash scene investigator. Senior Constable Hall completed a comprehensive report for the Coroner and has sworn an affidavit dated 14 October 2019.

Crash reconstruction and analysis indicated that approximately 8 km north of the township of Buckland, Ms Wilton has become distracted, most likely seeking to retrieve a cigarette from her handbag, and her vehicle has veered to the left and has entered the gravel verge at the end of a straight section of the roadway.

Ms Wilton has applied excessive right hand steering input in an attempt to correct the position of the vehicle on the roadway. Excessive steering input has caused the vehicle to cross to the incorrect side of the road. In an attempt to regain control of the vehicle, Ms Wilton has continued to apply right and left hand steering inputs causing the vehicle to swerve from one side of the roadway to the other. Her vehicle has continued northbound out of control in the southbound lane.

The rear of her vehicle has begun to side slide around its centre axis, resulting in her vehicle rotating in an anti-clockwise direction. Ms Wilton's vehicle has then crossed back to the correct side of the roadway.

Mr Dance has observed Ms Wilton's out-of-control vehicle prior to the collision. He slowed his vehicle and steered his vehicle to the right. As Ms Wilton's vehicle has continued to rotate around its centre of mass, it has crossed back onto the correct side of the road and in that process has collided head on with Mr Dance's vehicle.

Senior Constable Hall was aware of the views expressed by Transport Inspector Mr Clark, in particular that the trailer being towed by Mr Dance was in an unroadworthy condition. Senior Constable Hall expressed the opinion that the unroadworthy condition of the trailer was not a contributing factor in the cause of the collision. I accept his opinion.

I also note from Senior Constable Hall's investigation that Ms Wilton held an L2 learner licence.

I also note that inspection of Ms Wilton's vehicle after the collision identified two of the six beer cans purchased at the Sorell bottle shop had been opened. The empty cans were located within the front passenger foot well. I am satisfied on the balance of probabilities that Ms Wilton had consumed the two cans of beer whilst travelling between Sorell and the scene of the collision. The consumption of the two cans of beer were in addition to the alcohol she had consumed throughout the day at South Arm.

Senior Constable Hall in his report to the Coroner expressed the following opinions:

a) Mr Dance played no part in the cause of the collision as he was abiding by the Road Rules;
b) Mr Dance had insufficient time to avoid a collision with Ms Wilton's out of control vehicle;
c) The collision was caused solely by Ms Wilton's judgment and driving ability being affected by her consumption of alcohol; and
d) That there is evidence to suggest Ms Wilton's attention was drawn from the road prior to losing control of her vehicle. That evidence is Ms Wilton's open handbag being found in her lap and a number of lose cigarettes being found in the vehicle. (Senior Constable Hall believed Ms Wilton was attempting to retrieve cigarettes from her handbag when she lost control of her vehicle.)

I am satisfied that Senior Constable Hall is qualified to express the opinions expressed in his report. I accept the opinions expressed by Senior Constable Hall as to the cause of the collision.

Post-Mortem Examination and Toxicology Report

A post-mortem examination was undertaken by forensic pathologist, Dr Donald Ritchey.

Dr Ritchey opined that the cause of Ms Wilton's death was multiple blunt injuries sustained in a motor vehicle crash. I accept his opinion as to the cause of death.

Toxicology testing of samples obtained at autopsy revealed the presence of cannabis and alcohol in Ms Wilton's blood. The toxicology report showed a blood alcohol level of 0.196 g/100mL.

The author of the report made the following comment regarding the effect of alcohol consumption on driving ability:

> *"A blood alcohol concentration of 0.196 g per 100 mL 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 0.18 g/100 mL 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 relative risk of crash involvement. Ethanol is a central nervous system (CNS) depressant. In general, the effects of ethanol on the CNS are proportional to its concentration in the blood and cognitive sensory and motor disturbances (e.g. mild degrees of muscular incoordination, slowed reaction times, visual impairment) increase as the blood alcohol concentration increases. At higher concentrations, there is loss of critical judgement, incoordination, reduced perception and awareness, impaired balance, decrease in activity including sedation and sleep, nausea and vomiting, reduce responsiveness and decreased intellectual performance. When alcohol is used by drivers, there are delayed and impaired reactions to driving situations which are caused by the depression of psychomotor and cognitive function. There is also increased risk taking and increased speed. Alcohol has acute effects on body systems other than the CNS causing a feeling of warmth through dilation of blood vessels (but a loss of body heat to cold environments), irritation to the gastrointestinal track, increased urine formation, and damage to the liver."*

The author of the report made the following comment on the effect of cannabis ingestion on driving ability:

> *"THC was identified in the specimen, indicating the possible recent use of cannabis by the deceased. It should be noted however, that a proportion of the THC identified may be due to the post-mortem release of this drug from tissues and therefore may not reflect the concentration at the time of death. Studies have demonstrated that the combination of alcohol and THC may severely impede driving performance. The combined use of alcohol and THC increases reaction time, impairs visual search frequency, and leads to reduced ability to perceive and/or respond to changes in relative speeds of other vehicles and therefore adjust vehicle speed as appropriate. Individuals under the influence of THC may potentially have a reduced capacity to avoid collisions if confronted with a sudden need for evasive action."*

Given the blood alcohol concentration of Ms Wilton I am satisfied that the effects of alcohol upon drivers, identified in the toxicology report above, would have been applicable to Ms Wilton. I am further satisfied that her ability to safely control a vehicle would have been affected by her consumption of cannabis.

In summary, I find that Ms Wilton's attention was drawn from the roadway, more probable than not whilst attempting to retrieve a cigarette from her handbag, causing her to drift off the bitumen portion of the road way into the gravel verge, whereupon she has lost control of her motor vehicle as a result of excessive steering input. I find that her judgement and ability to safely drive a motor vehicle would have been impaired by the alcohol and cannabis she had consumed.

Comments and Recommendations

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

The circumstances of Ms Wilton's 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 Ms Wilton been concentrating on the task of driving her motor vehicle and had not been driving a motor vehicle with a blood alcohol level of 0.196 g/100 mL. Her ability to safely control a motor vehicle and respond appropriately in an emergency situation was compromised. She posed a significant risk to herself and other persons lawfully using the roadway.

I note that Mr and Mrs Dance suffered injuries as a result of the collision. Mr Dance a fractured sternum and bruising to his ribs. Mrs Dance a fractured collar bone.

I also note that members of the public were exposed to the aftermath of the collision when they stopped to render assistance.

I further note that this is yet another collision that exposed first responders, namely police officers and paramedics, to another fatal collision.

This case is just one further example of the consequences that flow from an individual's decision to drive a motor vehicle with a high blood alcohol level.

I convey my sincere condolences to the family and loved ones of Ms Wilton.

Dated: 5 March 2020 at Hobart Coroners Court in the State of Tasmania.

Andrew McKee
Coroner