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 Justin Thomas Groves

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

a) The identity of the deceased is Justin Thomas Groves;
b) Mr Groves died as a result of injuries sustained in a motor vehicle crash;
c) Mr Groves' cause of death was blunt trauma injury to the head; and
d) Mr Groves died on 18 August 2019 at Lemont, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Justin Thomas Groves' death. The evidence includes the following:

- The Police Report of Death;
- Affidavits verifying identification and life extinct;
- An opinion of the forensic pathologist who conducted the post-mortem examination;
- Crash investigation report;
- Police, family and witness affidavits;
- Medical records and reports; and
- Forensic evidence.

Mr Groves was born on 6 April 1999 and was 20 years of age at the date of his death. He was the only child of Matthew and Kim Groves. At the date of his death Mr Groves was single and resided with his parents.

Mr Groves was educated at Oatlands School. He completed his formal education at the end of year 10. At the conclusion of his schooling he commenced a livestock traineeship with Roberts at Bridgewater. He was employed as an auctioneer conducting livestock sales state-wide. He was also responsible for the purchase of livestock.

Circumstances Leading to Mr Groves' Death

On Saturday, 17 August 2019, Mr Groves had spent the afternoon at home washing his Ford Ranger utility (registration D 27 TG). He advised his father that he intended to travel to Campbell Town with Mr Luke Foster to watch some friends play football. He and Mr Foster then intended travelling to a property at Tooms Lake to stay the night.

Ms L Dillon, Ms A Massie and Mr J Watson have all sworn affidavits as part of the Coronial investigation into the death of Mr Groves. It is their observations which provide details as to the movements of Mr Groves in the hours preceding his death.

According to Ms Dillon, a weekend away had been organised to occur at a Tooms Lake property over the weekend of 16-17 August 2019. On the evening of 17 August a fire was lit and a number of young persons attended the property. They socialised together with the vast majority of attendees consuming alcohol. A significant number of attendees were camping at the property overnight.

Mr Groves contacted Mr Watson between 8.00 and 9.00pm. At that time he was at Campbell Town. Mr Groves and Mr Foster arrived at Mr Watson's parents' home at 700 Stonehouse Road at approximately 10.30pm.

Mr Groves and Mr Foster then travelled from Mr Watson's home to the property at Tooms Lake. Mr Watson followed behind them in his ute. Mr Watson did not intend spending the night at Tooms Lake and he left the property at 12.30am with Ms B Fisher and returned to his parents' home.

Upon arrival at the Tooms Lake property Mr Groves and Mr Foster were observed to consume Great Northern Beer. In the early hours of Sunday morning at approximately 2.00am. Mr Groves and Mr Foster decided to leave the Tooms Lake property and return to Mr Watson's parents' home. Ms Massie decided to travel with Mr Groves and Mr Foster to Mr Watson's parents' home. This was despite the fact she initially told Mr Groves not to go for a drive when he mentioned his intention to do so.

Ms Dillon attempted to persuade Mr Groves and the others not to leave the Tooms Lake property. According to Ms Dillon the group left at around 2.30am.

The group arrived at Mr Watson's parents' home at approximately 3.00am. Mr Groves and Mr Foster entered Mr Watson's bedroom and encouraged him to continue to consume alcohol. Mr Watson described both men as intoxicated but capable of walking. Mr Watson indicated that they were all welcome to stay at his parent's property. Ms Massie accepted the invitation to stay the night.

Ms Massie observed Mr Groves and Mr Foster leaving Mr Watson's parents' property. Mr Foster was driving Mr Groves' Ford Ranger. Ms Massie observed Mr Groves on the outside of the vehicle, standing on the side step holding onto the cab as the vehicle was driven away from the property by Mr Foster. Ms Massie assumed Mr Groves and Mr Foster were returning to Mr Groves' home. Ms Massie asked Mr Groves to message her when he arrived home. Ms Massie then went to sleep.

The Crash

A 000 call was made by Mr Foster at 4.27am. Mr Foster advised the 000 operator that he and a 'mate' had been involved in a car crash on York Plains Road. He advised the 000 operator that the vehicle had rolled and that he had performed CPR.

He was unable to give a precise location of the crash or a phone number to the operator. The phone call then cut out. The operator was having difficulty hearing Mr Foster and he was dropping out. Emergency Services comprising Police, Fire, Ambulance and the SES were dispatched to the scene.

Mr Groves' utility was located on Stonehouse Road approximately 3.6 km north from York Plains Road.

Ambulance Tasmania arrived on scene at 5.10am. Mr Groves was noted by paramedics to be breathing but taking agonal breaths. Appropriate treatment was provided to Mr Groves. Unfortunately he was unable to be resuscitated and was declared deceased at the scene.

Mr Groves was identified at the scene and transported to the mortuary.

Mr Foster was transported to the Royal Hobart Hospital for assessment. At the scene he had admitted to being the driver of the utility. At the Hospital a sample of his blood was taken for analysis pursuant to the *Road Safety Alcohol and Drugs Act* 1970.

Post-Mortem Examination

A post-mortem examination was conducted by forensic pathologist, Dr Donald Ritchey. Dr Ritchey opined that Mr Groves' cause of death was blunt trauma injury to the head sustained in a motor vehicle crash. I accept Dr Ritchey's opinion.

An analysis of samples taken at autopsy confirmed that Mr Groves had alcohol present in his system. The results were as follows:

a) Blood.075g/100mL;
b) Vitreous humour .078g/100mL; and
c) Urine .101 g/100mL.

Crash Investigation Report

A comprehensive crash investigation report was prepared by Senior Constable Adam Hall. I am satisfied that Senior Constable Hall is qualified to express the opinions contained in the Crash Investigation Report. He also provided a subject report.

On 18 August he attended and inspected the scene of the crash at Stonehouse Road, Lemont He undertook a number of investigations at the scene.

As a result of those investigations, Senior Constable Hall concluded that the utility was travelling in an easterly direction along Stonehouse Road. As Mr Foster negotiated a right hand corner on Stonehouse Road he lost control, causing the vehicle to rotate clockwise around its centre of mass before over-steering counter clockwise causing the vehicle to broadside and overturn.

The vehicle has rolled driver's side first and rolled at least one full rotation before coming to rest on its driver's side on the northern side of the road.

The vehicle came to rest 113 meters from the point in which it first lost control.

Senior Constable Hall conducted a critical curve speed analysis for the right hand curve. He concluded an eastbound vehicle could safely negotiate the right hand curve at a speed up to 70km/h. He concluded a speed above 70km/h would result in a loss of control.

Senior Constable Hall conducted a speed analysis and concluded the vehicle was travelling at 78 km/h when it first lost control.

At some stage through the rollover Mr Groves was ejected through the passenger side window. Mr Groves was not wearing his seatbelt.

As a result of being ejected from the vehicle Mr Groves sustained the injuries outlined in the post-mortem report prepared by Dr Ritchey.

Inspection of Ford Ranger

The Ford Ranger vehicle was inspected after the crash by Mr P Wells, a transport inspector employed by the Department of State Growth. Mr Wells swore an affidavit as part of the Coronial investigation and provided an opinion that the vehicle had been well maintained prior

to the crash. He expressed the view the vehicle was in an un-roadworthy condition due to the fitment of aftermarket wheel spacers to both rear wheels. I am satisfied Mr Wells is qualified to express the opinions contained in his affidavit and I accept his opinion.

I note that Senior Constable Hall has expressed the opinion the fitment on the wheel spacers did not cause or contribute to the crash. I accept his opinion on this issue.

Prosecution of Mr Foster

Mr Foster was charged with and pleaded guilty to the following offences on complaint 40/20:

1) Cause the death of another person by negligent driving in breach of Section 32(2A) of the *Traffic Act* 1925;
2) Drive a motor vehicle whilst exceeding the prescribed alcohol limit in breach of Section 6(1) of the *Road Safety (Alcohol and Drugs) Act* 1970;
3) A person mentioned in Section 6(3) in breach of Section 6(20 of the *Road Safety (Alcohol and Drugs) Act* 1970 [a provisional licence holder with alcohol in his body]; and
4) Fail to comply with a condition of a driver's licence in breach of Section 12(1) of the *Vehicle and Traffic Act* 1999 [Mr Foster was driving a manual vehicle when he was only licenced to drive an automatic vehicle.]

Mr Foster was convicted of counts 1, 3 and 4 on the complaint. In accordance with usual sentencing practices count 2 was subsumed and dismissed.

On counts 1 and 3 Mr Foster was sentenced to a home detention order of eight months. He was made the subject of a Community Corrections order for a period of 30 months and fined the sum of $1500. On count 1 he was disqualified from holding or obtaining a driver's licence for a period of 15 months. On count 3 he was disqualified from holding or obtaining a driver's licence for a period of 3 months. That disqualification was ordered to commence on 15 December 2020.

It is apparent from Mr Foster's pleas of guilty that he was driving a manual vehicle when he was only licenced to drive an automatic vehicle. At the time of the crash he was a P2 licence holder. He was required to have a zero blood alcohol level. An analysis of a blood sample taken after the crash indicated that Mr Foster had a blood alcohol reading of 0.072 g of alcohol per 100 m/l of blood. This sample was taken approximately four hours after the crash.

A report has been prepared which would indicate that Mr Foster's blood alcohol level would have been greater at the time of the crash.

Senior Constable Hall has expressed the opinion that the following factors contributed to the crash:

a) The speed at which Mr Foster negotiated the corner, which Senior Constable Hall described as excessive;
b) The effect that the consumption of alcohol would have had upon a relatively inexperienced driver's judgement and driving ability; and
c) Mr Foster's inexperience in driving a manual car.

I accept Senior Constable Hall's opinion.

I also note that Senior Constable Hall has expressed the opinion that had Mr Groves been wearing his seat belt he would have survived the crash. I accept his opinion on this issue.

Comments and Recommendations

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

The circumstances of Mr Justin Groves' 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 fatal crash is another example of the tragic consequences of persons driving motor vehicles at excessive speed for the prevailing driving conditions, whilst affected by alcohol.

The case also serves as a timely reminder of the tragic consequences that can flow as a result of individuals failing to wear seat belts.

I convey my sincere condolences to the family and loved ones of Mr Groves.

Dated: 23 August 2021 at Hobart Coroners Court in the State of Tasmania.

Andrew McKee
Coroner