MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Dean Moses Rapana

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

a) The identity of the deceased is Dean Moses Rapana;

b) Mr Rapana died from chest injuries sustained as a passenger in a single motor vehicle collision;

c) The cause of Mr Rapana's death was a transected thoracic aorta; chest injuries; and

d) Mr Rapana died on 29 July 2021 at Currie, King Island Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Rapana's death.

The evidence includes:

- Tasmania Police Report of Death,
- Affidavits establishing identity and life extinct;
- Report – Dr Christopher Lawrence, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Results – Blood Analysis, Ms Angela Kym Bull;
- Affidavit – Mr Philip Evans, Transport Safety and Investigation Officer, sworn 30 August 2021;
- Records – Ambulance Tasmania;
- Affidavit – Ms Edith Rapana, sworn 1 September 2021;
- Affidavit – Mr Gary Johnson, sworn 1 September 2021;
- Affidavit – Ms Deanne Lee, sworn 23 September 2021;
- Affidavit – Ms Demi Forrest, sworn 18 August 2021;
- Affidavit – Ms Jenna Cook, sworn 10 August 2021;

- Affidavit – Ms Sarah McRae-Gilmour, sworn 7 August 2021;
- Affidavit – Sergeant Mark Lopez, sworn 10 August 2021;
- Affidavit – Constable Robert Oberrauter, sworn to September 2021 (and photographs);
- Affidavit – Senior Constable Adam Lloyd, sworn 26 December 2021; and
- Collision Analysis Report – Senior Constable Adam Lloyd, Western District Crash Investigation Services.

Mr Rapana died as a result of injuries sustained by him in a single vehicle motor vehicle crash which occurred at Main Street, Currie on King Island. The injuries he sustained in the crash, when the vehicle left the road, skidded and hit an embankment, would not have been sustained if he had been wearing a seatbelt. Mr Rapana was thrown around in the cabin striking his chest, which transected his aorta causing his death. It hardly needs to be pointed out that he would not have been thrown around in the cabin of the vehicle if he had been wearing a seatbelt.

The evidence is that the driver of the vehicle, his partner Ms Angela Bull, was driving with a blood alcohol level well over twice that permitted by law.

The vehicle involved in the crash, a Subaru Forester station wagon had no mechanical defects which caused or contributed to the happening of the crash. I note that it was fitted with front seat belts which were fully operational. There was no impediment to them being worn.

Comments and Recommendations

The circumstances of Mr Rapana's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995. I do however **comment** that the wearing of seat belts in vehicles in Tasmania became mandatory approximately 50 years ago. It is little short of astonishing that people still die in motor vehicle crashes in this state as a result of injuries which would have been prevented had they been wearing seat belts.

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

Dated: 20 July 2022 at Hobart in the State of Tasmania.

Simon Cooper
Coroner