



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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### Record of Investigation into Death (Without Inquest)

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Yu Qian Wang

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

- a) The identity of the deceased is Yu Qian Wang;
- b) Ms Wang died as a result of injuries sustained by her as a passenger in a motor vehicle crash;
- c) The cause of Ms Wang's death was abdominal injuries due to single motor vehicle collision; and
- d) Ms Wang died on 12 October 2015 at Launceston General Hospital, Charles Street, Launceston in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Wang's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; the results of toxicological analysis of samples taken at autopsy; affidavits of a transport inspector and the Tasmania Police crash investigator and affidavits of witnesses, including other passengers in the vehicle in which Ms Wang was travelling.

The evidence satisfies me that Ms Wang was a rear seat passenger in a rented Kia 'Carnival' vehicle being driven west on the Esk Main Road by her friend Ms Wen Li Zhu. The evidence of the transport inspector satisfies me that the vehicle was roadworthy prior to the crash.

I am satisfied that the crash which claimed Ms Wang's life occurred when Ms Zhu lost control of the Kia as she attempted to overtake a prime mover towing a box trailer. The vehicle left the road and collided with a tree.

Neither alcohol nor drugs were a factor in the happening of the crash and a subsequent crash reconstruction satisfies me that neither was speed.

It is however apparent that the crash occurred as a result of driver inexperience.

In addition, the evidence satisfies me that Ms Wang did not have her seatbelt correctly fastened at the time of the crash; it was fastened under her arm rather than over her shoulder. As a

consequence the seatbelt was unable to operate as designed. I note that the other rear seat passenger suffered serious neck injuries in the crash; she was stretched out in the seat, not sitting upright, at the time of the crash and thus her seatbelt was unable to operate correctly either. In contrast, the driver and front seat passenger, both of whom had their seatbelts correctly fastened, suffered only minor injuries.

Ms Wang was conscious after the crash. She was rushed by ambulance to the Launceston General Hospital where her condition deteriorated and she died later the same day.

After formal identification Ms Wang's body was transported to the mortuary at the Royal Hobart Hospital. There an autopsy was carried out by Dr Christopher Hamilton Lawrence, the State Forensic Pathologist. Dr Lawrence identified that Ms Wang had suffered multiple fatal injuries including abdominal injuries, which relevantly included a lap-type seatbelt mark on her abdomen.

Toxicological analysis of samples taken at autopsy was unremarkable.

I am satisfied that Ms Wang died in the circumstances outlined above. I am also satisfied that had she been wearing her seatbelt correctly it is likely she would have survived the crash.

#### **Comments and recommendations**

I comment that it seems remarkable that deaths and serious injuries in motor vehicle crashes still result from a failure to either wear a seatbelt or wear a correctly fastened seatbelt. Sadly, that is precisely the case in relation to Ms Wang's death.

I conclude by extending my sincere condolences to the family of Ms Wang on their loss.

**Dated** 23 October 2017 at Hobart in Tasmania

**Simon Cooper**  
**Coroner**