Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Chloe Michelle Walsh

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

a) The identity of the deceased is Chloe Michelle Walsh;
b) Miss Walsh died as a result of injuries sustained by her as a passenger in a motor vehicle crash;
c) The cause of Miss Walsh’s death was multiple blunt traumatic injuries; and
d) Miss Walsh died on 3 October 2014 at The Esplanade, Strahan, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Miss Walsh’s death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; forensic and photographic evidence; and the detailed report of a Tasmania Police Crash Investigator.

Shortly after 11.00pm on Friday, 3 October 2014 Miss Walsh, aged just 15, was killed when the vehicle she was a rear seat passenger in left a street in Strahan, travelled through orange safety mesh and plunged over an embankment. The vehicle, driven by 20 year old Aaron Samuel Henrick, which he had owned for only 7 days, landed bonnet first at the base of the embankment. Miss Walsh was not wearing a seatbelt because the clasp of the belt was not accessible and could not be worn. She was propelled through the windscreen of the vehicle and suffered injuries to her head and neck which resulted in her almost instantaneous death.

The vehicle came to rest on her body. Police and members of the public were quick to lift the vehicle from her body but found nothing could be done for her.

Mr Henrick was taken to hospital after the crash and a sample of his blood taken. The sample revealed a blood alcohol concentration of 0.121 g of alcohol per 100 mL of blood and a concentration of 5 µg of cannabis per litre of blood.
I am satisfied that the alcohol and cannabis would have significantly impaired his ability to properly control the vehicle.

The vehicle – a repairable but written-off 14 year old Mitsubishi Magna VRX - was unregistered. A subsequent examination of it by a Transport Inspector found numerous deficiencies including in relation to tyres, brakes and a seatbelt which meant that the vehicle was not roadworthy.

At the time of the crash Mr Henrick did not hold the appropriate licence to drive, being the holder only of a learner’s drivers licence. He should not have been driving at all.

Mr Henrick was subsequently charged with and pleaded guilty to, *inter alia*, causing the death of Miss Walsh by dangerous driving contrary to section 167A of the *Criminal Code*. He was sentenced to 4 years imprisonment for that crime as well as two counts of causing grievous bodily harm by dangerous driving in relation to 2 other passengers.

It is clear that Mr Henrick drove in a reckless and dangerous manner for a short period of time over a short distance but just long enough to cause Miss Walsh’s death.

I note that all other persons in the vehicle survived the crash and it is quite possible that had Miss Walsh been wearing a properly fitted seatbelt as the others in the vehicle were she may well have survived.

**Comments and Recommendations**

The circumstances of Miss Walsh’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 once again alcohol, drugs and the failure to wear a seatbelt have all been significant factors in this death.

I convey my sincere condolences to the family and loved ones of Miss Walsh.

**Dated** 18 October 2018 at Hobart, Tasmania.

**Simon Cooper**

**Coroner**