



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Ethan Phillip Chugg

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

- a) The identity of the deceased is Ethan Phillip Chugg (“Ethan”);
- b) Ethan died in the circumstances set out in this finding;
- c) The cause of death was head and chest injuries sustained in a single motor vehicle crash; and
- d) Ethan died on 3 December 2020 at Burnie in Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Ethan’s death. The evidence includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Post-mortem report of Dr Christopher Lawrence, forensic pathologist;
- Toxicological reports of Mr Neil McLachlan-Troup, forensic scientist;
- Transport inspection report of Mr Alan Fitzpatrick, transport inspector;
- General practitioner records for Ethan Chugg;
- Ambulance records for Kyle Rogers;
- Ambulance records for Ethan Chugg;

- Affidavit of Diarne Rogers, mother of Ethan Chugg;
- Affidavit of Boden Rogers, front passenger in the collision;
- Affidavit of Leigh Hardstaff, witness at the scene;
- Affidavit of Emma Alderson, witness at the scene;
- Affidavits of Senior Constables Sven Mason and Thomas Donnellan, attending police officers;
- Affidavit and photographs of First Class Constable Dean Walker;
- Affidavit and photographs of First Class Constable Mark Johnston;
- Affidavit, photographs, and speed analysis report of Senior Constable Adam Lloyd, crash investigator;
- Video interviews of Timothy Pyke (nearby resident) and Kyle Rogers; and
- Phone records of Kyle Rogers.

Ethan Phillip Chugg (“Ethan”) was born on 6 November 1999 and was aged 21 years at his death. He is the son of Diarne Rogers and Phillip Chugg and is survived by his twin brother, Hayden. At the time of his death, Ethan was employed as a diamond driller in Rosebery. He had recently moved back to Tasmania after the Covid-19 pandemic affected his ability to work as a ‘fly-in fly-out’ worker interstate. He was fit and healthy, law-abiding, and enjoyed outdoor activities.

On the evening of 2 December 2020, Ethan met his friend, Boden Rogers (“Boden”), at the Wharf Hotel in Wynyard. They were shortly joined by Ethan’s uncle, Kyle Rogers (“Kyle”). They socialised together and consumed alcohol, mostly beer. At some time after 8.00pm, they left the hotel in Kyle’s vehicle, a Hyundai Excel Sprint hatchback. Kyle drove them to a friend’s residence where they consumed further alcoholic drinks. They all remained there until 11.15pm, at which time they left in Kyle’s vehicle, with Kyle driving. Boden was the front seat passenger and Ethan was seated in the rear passenger side seat behind Boden. Kyle was intending to drive Boden home to his house in Calder Road, about 15 minutes away.

Kyle was travelling in a general southerly direction along Calder Road, a two lane bitumen road in good condition with a speed limit of 100km/h. Kyle had navigated a right-hand curve

on Calder Road before moving onto a stretch of straight road. At this point, the crash investigator's analysis showed that the vehicle, travelling at 102km/h, swerved to the left with the passenger side tyres leaving the sealed road but the driver's side tyres remaining on the road surface. The vehicle then entered a yaw as a result of the sudden swerve before re-entering the road and hitting a lip which caused it to become airborne for a short distance. It then skidded across a grass verge, hit a fence and rolled before coming to final rest upside down in a grass culvert-type drain.

Ethan, the only occupant of the vehicle not wearing a seatbelt, was ejected from the vehicle during the rotation. He was located unconscious under the rear of the vehicle and was extricated. Ambulance paramedics arrived, provided medical assistance and conveyed him to the North West Regional Hospital. Tragically, he died early in the morning of 3 December due to the severity of his injuries.

Kyle and Boden were treated for non-life threatening injuries at the North West Regional Hospital.

Boden told police officers that he observed a white Labrador dog "standing or slowly walking around in the middle of the road" and that Kyle took evasive action and swerved to the left in order to miss the dog. Kyle also told police officers at the scene that he had swerved to avoid a dog that came onto the road in front of him, but when he was formally interviewed by police two months later he had a poor recollection of events surrounding the crash, and did not recall the presence of the dog. The crash investigator, Senior Constable Lloyd, stated in his report that the tyre marks at the scene were most consistent with swerving to avoid an obstruction on the road, rather than simply inattention. He also noted that the driver had negotiated the prior curve correctly. He also stated that most drivers, when confronted with an animal on the road, tend to swerve to avoid the animal rather than hit it. Upon all of the evidence, I find that Kyle swerved and lost control of the vehicle in response to the presence of a dog on the roadway. Upon the evidence, there were several dogs belonging to the occupants of nearby residences that could plausibly answer Boden's description of the dog. Therefore, I cannot identify the dog in question.

Before the crash, Kyle had consumed a significant quantity of alcohol, returning a blood alcohol reading two hours after the crash of 0.113 grams/100mL. This level of alcohol would have affected his capacity to drive. However, Senior Constable Lloyd determined that Kyle's reaction time in response to the presence of the dog was within that expected of a reasonable driver in these circumstances. It is speculation to suggest that, had Kyle not been affected by alcohol, he may have seen the dog earlier and controlled his vehicle.

The evidence allows me to find that the weather conditions and condition of the vehicle played no part in the crash. I am further satisfied that Kyle was not using his mobile phone whilst driving at any relevant time.

On 21 September 2021, Kyle was convicted in the Magistrates Court of Tasmania of several driving offences occurring upon the evening of the crash, including driving whilst exceeding the prescribed concentration of alcohol. He was disqualified from driving, fined, and ordered to perform community service orders. He was not charged with causing Ethan's death by negligent driving.

An operational seatbelt belt was available for Ethan to wear, but he did not do so. It is most likely that Ethan would have survived if he had been wearing his seat belt.

Comments and Recommendations

The circumstances of Ethan's death are not such as to require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act 1995*.

I thank Senior Constable Adam Lloyd for his competent investigation.

I convey my sincere condolences to Ethan's family and loved ones.

Dated 31 January 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner