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 Gordon James Horsham

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

a) The identity of the deceased is Gordon James Horsham;
b) Mr Horsham died as a result of injuries sustained by him in a single motor vehicle crash;
c) The cause of Mr Horsham's death was a complete transection of his body; and
d) Mr Horsham died on 15 October 2017 near the Rubicon River Bridge, part of the Frankford Highway, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Horsham's death. The evidence comprises an opinion of the pathologist who conducted the autopsy; medical records; the report of a specialist police traffic crash investigator; a report from a Transport Inspector; an affidavit from Mr Horsham's senior next of kin, his niece; and forensic and photographic evidence.

Gordon James Horsham, 78 years of age at the time of his death, died when he lost control of the vehicle he was driving far too fast west on the Frankford Highway.

The evidence satisfies me that at the time Mr Horsham lost control of his vehicle (a 2004 model Hyundai Sante Fe Wagon) it was travelling at least 148 km an hour in a 100 km an hour zone. Tyre marks identified at the scene show that Mr Horsham drifted into the gravel on the left side of the road, travelled for 37 metres on the gravel shoulder, yawed back to the right for a further 10.3 metres onto the road, entered the wrong lane, skidded again and travelled back off to the left hand side of the road for approximately 50 metres before leaving the road all together, rolling up and over a wire fence and landing in a paddock next to the highway.

After landing in the paddock the Hyundai continued to roll for a further 56 metres until it came to rest.

Although Mr Horsham was wearing a seatbelt, he was not wearing it correctly. The sash was under his arm rather than over his shoulder. This caused the lap section of the seatbelt to act in effect as a guillotine so that as the vehicle rolled and skidded after it left the highway his body was cut in half at the waist and then ejected from the vehicle in pieces.

Attending police officers and fire fighters found parts of his body scattered over a large area in a paddock. His torso and the lower part of his body were found 4 metres apart. Most of the wrecked Hyundai was 25 metres past where the lower half of Mr Horsham's body was located. It would appear from a blood stain on the roof of the vehicle that it had rolled on a part or parts of Mr Horsham's body after it was ejected in pieces from the cab of the vehicle.

Mr Horsham's body was removed from the scene and transported by mortuary ambulance to the mortuary at the Launceston General Hospital. At the mortuary an autopsy was carried out which confirmed that Mr Horsham had suffered shocking injuries including that his body had been completely severed in the middle. Toxicological analysis of samples taken at autopsy did not detect the presence of alcohol. Over-the-counter and prescription drugs were identified as being present in those samples but in low levels. At autopsy it was noted that Mr Horsham was suffering from chronic kidney disease. Other history obtained from his medical records indicated that Mr Horsham had a past history of ulcerative colitis and colectomy. He was also a diabetic patient with renal failure. In short, Mr Horsham was in poor health with a likely compromised ability to control a motor vehicle at all, let alone at the speed at which he was driving in the immediate lead up to his fatal crash.

The wreck of Mr Horsham's Hyundai was subsequently examined by a Transport Inspector. The inspector, a qualified motor mechanic with a number of years' experience in the motor trade, expressed the opinion that prior to, and at the time of the crash, Mr Horsham's vehicle was both mechanically sound and roadworthy. Specifically, the inspection did not reveal any fault that could have caused or contributed to the happening of the crash.

I am also satisfied on the basis of the material obtained in the investigation that neither weather nor road conditions caused or contributed to the happening of the crash.

There is no evidence Mr Horsham was distracted by the use of a mobile phone in the immediate lead up to the crash.

Although Mr Horsham was wearing a seatbelt as has already been noted he was not wearing it correctly. Senior Constable Mason expressed the opinion, which I accept, that after Mr Horsham lost control of his vehicle and as he was thrown around inside it, the lap section of the belt continually tightened around his waist and cut him in half. Senior Constable Mason went on to say that had the belt been worn correctly, that is with the sash covering his shoulder and chest area, Mr Horsham may have survived the crash.

Quite why Mr Horsham was driving at the speed he was can only be guessed at.

I observe that it is fortunate indeed that no other vehicle or vehicles were caught up in the crash.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Mason for the very professional manner in which he approached this investigation and for the comprehensive report he provided.

Mr Horsham's death was, like virtually all deaths in motor vehicle crashes, completely avoidable. As should be very clear from this finding, excessive speed and a failure to wear a seatbelt properly were the causes of Mr Horsham's death. I **comment** that for seat belts to be effective it is imperative that they be worn correctly.

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

Dated 27 August 2018 at Hobart, Tasmania.

Simon Cooper
Coroner