



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 Timothy David Bryan

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

- a) The identity of the deceased is Timothy David Bryan;
- b) Mr Timothy David Bryan died in the circumstances set out below;
- c) Mr Bryan's cause of death was chest and abdominal injuries sustained in a single motor vehicle crash; and
- d) Mr Bryan died on 26 September 2016 at Forthside Road, Forthside, in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Bryan's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; results of toxicological analysis of samples taken at autopsy; a detailed report from an experienced Tasmania Police Crash Investigator (which included a speed analysis); relevant police and witness affidavits; a report from a transport inspector; and forensic and photographic evidence.

The evidence satisfies me that a Holden Rodeo flat tray vehicle driven by Mr Bryan, failed to negotiate a corner, crossed onto the wrong side of the road, across a gravel verge, through a fence and rolled, coming to rest on its roof in a paddock. Mr Bryan was ejected from the cab of the vehicle in the crash. His left arm was trapped under the vehicle. Both his passenger, Mr Proud, and a bystander report Mr Bryan was talking immediately after the crash, he died very soon after its happening. Although emergency services were quickly on the scene after the happening of the crash, there was nothing that could be done for Mr Bryan.

The evidence satisfies me that Mr Bryan had consumed a considerable amount of alcohol before the crash. Toxicological analysis of samples taken at autopsy indicate that Mr Bryan had a blood alcohol level of 0.185 g of alcohol in 100 mL of blood at the time of the crash.

Mr Bryan had also consumed cannabis some time prior to driving. The same toxicological analysis indicated the presence of significant levels of cannabis in Mr Bryan's system.

Evidence from Miriam Connor, Forensic Scientist at Forensic Science Service Tasmania, was that:

“Studies have demonstrated that the combination of alcohol and [cannabis] may severely impede driving performance. The combined use of alcohol and [cannabis] increases reaction time, impairs visual search frequency, and leads to reduced ability to perceive and/or respond to changes in relative speed of other vehicles and therefore adjust vehicle speed as appropriate.”

The evidence satisfies me, beyond any doubt, that neither Mr Bryan nor Mr Proud were wearing seatbelts at the time of the crash.

A subsequent speed analysis satisfies me that speed was not a factor in the occurrence of the crash. Similarly, the evidence satisfies me that the vehicle Mr Bryan was driving was mechanically sound at the time of the crash, although it was carrying a heavy fuel pod on the tray and this doubtlessly affected in a negative way the handling of the vehicle.

However, Mr Bryan's death occurred as a result of him driving a vehicle when significantly impaired by alcohol and cannabis. This caused him to lose control of the vehicle, leave the road and roll. As noted above neither he, nor his passenger, was wearing a seatbelt. The passenger is fortunate to be alive.

Comments and Recommendations

The circumstances of Mr Bryan'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 it is a matter of significant regret that fatalities still regularly occur in motor vehicle crashes as a result of alcohol and drug use and the failure to wear seat belts.

I convey my condolences to the family of Mr Bryan.

Dated 29 January 2018 at Hobart in Tasmania.

Simon Cooper
Coroner