



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 Michael Lawrence

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

- a) The identity of the deceased is Timothy Michael Lawrence;
 - b) Mr Lawrence died as a result of a Personal Water Craft (PWC) crash;
 - c) The cause of Mr Lawrence's death was multiple injuries; and
 - d) Mr Lawrence died on 22 October 2017 at Marion Bay, Tasmania.
- I. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Lawrence's death. The evidence includes:
- an opinion of the forensic pathologist who conducted the autopsy;
 - the results of toxicological analysis of samples taken at autopsy;
 - a report from a marine surveyor;
 - affidavit of Peter Hopkins, General Manager, Recreational Boating and Marine Facilities, Marine and Safety Tasmania (MAST) sworn 16 November 2017;
 - Tasmania Police Report of Death for the Coroner;
 - affidavit of Michael Lawrence sworn 15 November 2017;
 - affidavit of Katelyn Williams sworn 9 November 2017
 - affidavit of Sam Kingston sworn 21 November 2017;
 - affidavit of Daniel Griffith sworn 20 November 2017;
 - affidavit of James Castle sworn 4 December 2017;
 - affidavit of Matthew Pepper sworn 6 November 2017;
 - affidavit of Joshua Piesse sworn 7 November 2017;
 - affidavit of Jake Murray sworn 7 November 2017;
 - affidavit of Emily Collins sworn 17 November 2017;
 - affidavit of Meegan Doyle sworn 21 November 2017;
 - affidavits of investigating police;
 - medical records and reports; and
 - forensic and photographic evidence.

Background

2. Mr Lawrence was born on 15 August 1985. Described as happy and positive, he was educated in Hobart and then employed in a variety of occupations until he settled into a career as a builder - in which he excelled. He and his partner, Ms Katelyn Williams, lived in the home they owned together at Carlton.
3. An athletic and fit man, Mr Lawrence was very much at home in, on and around water, being a surfer and highly competent swimmer.
4. On 28 October 2014, Mr Lawrence bought a blue Yamaha VX deluxe model PWC.¹ The PWC was registered and Mr Lawrence was appropriately licenced, and experienced in riding it.²

Circumstances of Death

5. On 21 October 2017, Mr Lawrence, along with Ms Williams, was part of a group at a shack at Little Chinaman's Bay, north east of Dunalley, near the Marion Narrows. The group had come to together to celebrate the 26th birthday of Mr Sam Kingston.³ The shack belonged to Mr Kingston's family.
6. Between 4.00 and 5.00pm, Mr Lawrence and Ms Williams arrived at the Boomer Bay boat ramp in order to travel across to the shack. Mr Lawrence rode his PWC across and Ms Williams travelled in a dinghy with Mr Jake Kingston and another friend, Mr Will Brearley.⁴
7. The evening seems to have been what might be described as a normal social gathering. The group drank alcohol, listened to music, socialised, had a barbecue dinner and generally had an enjoyable time around a campfire and inside the shack. During the course of the evening Mr Lawrence drank mid strength beer and "a couple of shots of Jim Beam or something similar".⁵ Reportedly, he also had "a puff on a joint of cannabis".⁶
8. At one stage during the evening a witness saw Mr Lawrence fall off his chair.⁷

¹ PWCs are also known as "jet skis".

² See affidavit of Peter Hopkins, MAST- Mr Lawrence held motor boat licence 162209, with a PWC endorsement, which was current at the time of his death.

³ See affidavit of Sam Kingston, page 1.

⁴ See affidavit of Katelyn Williams, page 1 of 4.

⁵ See affidavit of Daniel Griffiths, page 2.

⁶ *Supra*.

⁷ See affidavit of Jake Murray, page 2.

9. The sequence of events which led to Mr Lawrence's death and, in particular, timings, are difficult to determine with precision. Nonetheless, the evidence satisfies me that sometime between 10.00 and 11.00pm three men - Mr Daniel Griffiths, Mr James Castle and Mr Matthew Pepper - drove to the spit at Marion Bay and were picked up from there and transported by dinghy across to the shack, a short distance away.
10. About an hour or so after their arrival, the three men decided to leave the gathering at the shack. A conversation ensued as to how they would get back across to the spit. Mr Lawrence was present at the time and a party to the conversation. It is unclear, on the evidence, who else was involved in the conversation. In any event it is clear enough that Mr Lawrence offered to ferry Mr Griffiths, Mr Castle and Mr Pepper to the Marion Spit on his PWC. Accordingly, Mr Lawrence put on his PFD and then took Mr Griffiths first.
11. Mr Griffiths described Mr Lawrence as sitting on his seat with Mr Griffiths standing, and behind him, straddling the PWC's seat. Mr Griffiths had a waterproof esky between his knees and was holding his socks and phone in his hand (so they did not get wet). Mr Griffiths said Mr Lawrence had a beer in one hand. Both men had head torches. The night was described as "really dark". There was no moon.
12. Mr Lawrence successfully delivered Mr Griffiths to the beach on the other side of the narrows at Marion Spit, a distance of no more than 400 metres.
13. Mr Griffiths described what happened next:

"Tim said he would go back to get [Mr Pepper] and told me to flash my head torch at him when I heard him coming back so that he would know where I was. Tim then took off, laughed and accelerated on the beach next to me, in a joke that he was going to spray me with his propeller [sic]. After he initially accelerated, he then pattered off slowly and it looked like he was heading straight towards the lights of the shack on the other side.

I was listening to where he was going and was looking at my phone as I only had 2% battery left. I was also trying to put my wet feet back into my socks and shoes in the dark. I heard the [PWC] going at a normal idling pace for a couple of minutes and then heard it accelerate and take off. It sounded like it was doing figure eights or something like that. I thought maybe Tim had picked up [Mr Pepper] and one of them was being stupid on the [PWC]. I heard the [PWC] going flat out for about 30 seconds and then it

stopped. It was like it hit something and stopped, but there wasn't any loud bang or splashing, but I knew something really bad had just happened".⁸

14. Mr Griffiths entered the water and swam to where he thought the PWC had been. The current forced him back to the beach. He used his phone to call Mr Pepper. He told him something had gone wrong. About 10 minutes later, Mr Pepper and Mr Castle arrived in a dinghy and with Mr Griffiths began searching the waterway. Between 10 and 20 minutes after the searching commenced, they found the PWC floating in the middle of the bay.⁹ The three men noted that it had extensive damage to its left front side. They could not find Mr Lawrence so continued to search for him.
15. Just after 1.00am, Mr Pepper telephoned police and outlined what had occurred. He spoke to the on-call Dunalley Police Officer, Senior Constable Keenan. Mr Pepper was only able to provide very vague information to Senior Constable Keenan, appearing heavily intoxicated and extremely stressed. Senior Constable Keenan knew a social gathering was occurring at the shack and contacted the property owner to confirm some details. Because of that conversation Tasmania Police Marine and Rescue Services, the Police Rescue helicopter and additional police officer from Nubeena, Constable Etherington, were all called out.
16. Meanwhile, the search continued. A second dinghy entered the water with Mr Jake Kingston, his partner, Ms Emily Collins, and Ms Williams in it. They also found the PWC (now sitting on rocks in Little Chinaman's Bay) and saw damage to its front left hand side. Mr Sam Kingston and Mr Rob Westland joined the search in Mr Westland's boat.
17. About 50 metres from shore Mr Lawrence was found lying face down in the water by the occupants of the second dinghy. He was pulled into the dinghy by Mr Jake Kingston who noted he was unconscious and not breathing.¹⁰ Mr Kingston commenced CPR. Mr Griffiths immediately came over to assist and (apparently a lifeguard) took over CPR.¹¹ He attempted to feel for a pulse but could not locate one. Nonetheless, he commenced and continued CPR. The best estimate is that Mr Griffiths continued with CPR for approximately one hour until the rescue helicopter arrived.

⁸ See affidavit of Daniel Griffiths, *supra*, generally.

⁹ See affidavit of Matthew Pepper at page 2 who says the PWC was found 20 minutes after the search started and that of Daniel Griffiths who says the PWC was located 10 to 15 minutes after the search commenced.

¹⁰ See affidavit of Jake Murray Kingston, page 3 of 4.

¹¹ See affidavit of Sam Kingston, page 3 of 3.

18. Police records indicate that at 2.09am the Police Rescue helicopter arrived at the scene. In addition to police crew, an intensive care paramedic was on board the helicopter. The paramedic confirmed that Mr Lawrence was dead and CPR was discontinued.¹²
19. Attending police noted that the area was in total darkness and there was no ambient light or moonlight. In the centre of the Bay was a red lateral navigation beacon with an operating red flashing light on top. The light was seen to be operational by police.¹³

Investigation

20. The investigation into Mr Lawrence's death commenced at the scene. His body was formally identified and the scene was examined and photographed by a forensic services officer.¹⁴ The PWC was located, examined, photographed and seized.
21. Mr Lawrence's body was transported from the scene by the rescue helicopter and taken to the mortuary at the Royal Hobart Hospital.
22. The Police Vessel "Dauntless" attended the area to transport members of Marine Search and Rescue who carried out enquiries at the scene. Those enquiries determined that Mr Lawrence had collided with the red navigation beacon, mentioned above. The navigation beacon was photographed as well. Other officers took the details of all persons present at the party. Police indicated later that it was apparent that many or most were affected by alcohol and/or drugs and all or most were vague about the circumstances surrounding the timing associated with Mr Lawrence's death. I am quite satisfied that the general vagueness as to details was not in any way suspicious but rather due to a combination of intoxication and shock. Specifically, I am satisfied that no one deliberately endeavoured to hinder the investigation into Mr Lawrence's death.
23. An autopsy was carried out on Mr Lawrence's body by experienced forensic pathologist, Dr Donald Ritchey. Dr Ritchey found that Mr Lawrence had suffered severe traumatic injuries of the head, chest and legs. Specifically there was a 3cm laceration on the left side of the scalp that overlay an extensive fracture of the left side of the skull. The fracture extended into the basal skull bilaterally. Mr Lawrence had multiple posterior rib fractures, associated severe bruising of the left lung and internal bleeding in the left chest. He also had a gaping displaced fracture of the left femur. Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Lawrence's death was the multiple injuries

¹² See affidavit of Senior Constable Michael Preshaw, sworn 14 December 2017, page 2 of 2.

¹³ See affidavit of Senior Constable Timothy Keenan sworn 14 February 2018, page 2 of 4.

¹⁴ Affidavit of Constable Andrew Upton sworn 24 October 2017.

he sustained in the PWC crash. It is apparent that Mr Lawrence sustained a severe head injury which resulted in near instantaneous death.¹⁵

24. I note that the injuries to Mr Lawrence were predominantly on the left side of his body - something consistent with the damage identified on the left side of the PWC.
25. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. No illicit drugs were identified as being present in those samples. However, alcohol at a blood level at least 0.163 g per 100 mL of blood was found to be present in those samples.¹⁶ Alcohol is, as is well known, a central nervous system depressant. At high concentrations (such as the concentration found in Mr Lawrence's blood) there is a loss of critical judgement, lack of coordination, impaired balance, decrease in activity including sedation and sleep, reduced responsiveness and decreased intellectual performance. Indeed, as forensic scientist Neil MacLachlan-Troup observed in his report to me: "it has been estimated that the relative risk of a driver with a blood alcohol concentration of between 0.140 g of alcohol per 100 mL of blood and 0.180 g of alcohol per 100 mL of blood being involved in a crash is approximately 20 to 50 times that of a driver [of a motor vehicle] with nil blood alcohol." There is no reason to think that the situation is any different in relation to the operator of a PWC.
26. The PWC was inspected by Marine Surveyor, Mr Adam Brancher, on 23 October 2017. As a result of that inspection Mr Brancher expressed the opinion, which I accept he is well qualified to express, that Mr Lawrence hit a stationary and solidly fixed object at considerable speed slightly to the port (left) of the PWC's centreline.¹⁷ This finding is entirely consistent with the observations of investigating police as to the damage to the channel marker.
27. Mr Brancher found no evidence that there was any mechanical or other such issue with the PWC which could have caused or contributed to the happening of the accident.

Conclusion

28. The evidence obtained by Senior Constable Keenan as a result of his careful and thorough investigation satisfies me that Mr Lawrence died as a result of crashing his PWC, which he was riding at considerable speed, into an illuminated channel marker near Little Chinaman's Bay, Marion Narrows in Tasmania. The evidence also satisfies me

¹⁵ See affidavit of Dr Donald MacGillivray Ritchey MD, MSc, American Board Pathology (anatomic, Clinical and Forensic Pathology), FRCPA

¹⁶ Rule 19 affidavit of Neil MacLachlan-Troup, FSST, 2 January 2018

¹⁷ Affidavit of Adam Christopher Brancher sworn 8 November 2017, paragraph 16, page 7.

that, at the time of his death, which was almost instantaneous, Mr Lawrence had a high blood alcohol concentration. His blood alcohol concentration undoubtedly contributed to the happening of the crash. I note the evidence was that the night was dark and the lack of ambient light was also likely to have been a factor in the collision with the channel marker.

29. There is no evidence of the involvement of any other person in Mr Lawrence's death and no evidence to suggest that his death was anything other than a tragic accident.
30. It is quite obvious that the principal contributing factor to Mr Lawrence's poor decision-making and death was the fact that he was significantly affected by alcohol at a time when he operated his PWC.

Comments and Recommendations

31. I extend my appreciation to investigating officer Senior Constable Timothy Keenan for his investigation and report.
32. The circumstances of Mr Lawrence's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*.
33. I do however comment that the risks associated with operating a PWC after consuming alcohol are starkly illustrated by this tragic case. I urge all operators of PWC not to ride their watercraft whilst affected by alcohol. I note that it is an offence to do so¹⁸ - and for good reason as Mr Lawrence's death also illustrates.
34. I convey my sincere condolences to the family and loved ones of Mr Lawrence.

Dated 2 March 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

¹⁸ *Marine Safety (Misuse of Alcohol) Act 2006*, Part 2, Division 2.