



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 Leon Dennis Sheehan

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

- a) The identity of the deceased is Leon Dennis Sheehan;
- b) Mr Sheehan died as a result of injuries sustained by him as driver in a single motor vehicle crash;
- c) The cause of Mr Sheehan's death was positional asphyxia; and
- d) Mr Sheehan died on 10 December 2016 at Highlands Lake Road, Brandum, Great Lake Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Sheehan's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; the results of toxicological analysis of samples taken at autopsy; relevant police and witness affidavits; medical records and reports; forensic and photographic evidence; and a detailed report from an experienced Tasmania Police crash investigator.

After an afternoon and evening spent drinking alcohol with his wife and two friends at two hotels in Tasmania's Central Highlands, Mr Sheehan was driving a Mitsubishi Triton Utility north on the Highland Lakes Road at Brandum. He lost control of the vehicle and it rolled down an embankment before coming to rest on its roof. Mrs Sheehan, who was seated in the left hand rear passenger's seat was thrown out of the vehicle and suffered terrible injuries as a result. The other two friends in the vehicle also suffered injuries.

Mr Sheehan was trapped upside down in the vehicle hanging by his seat belt. It was at least 20 minutes before he was extracted from the position in which the crash left him and although initially conscious he died before he could be removed.

Police and emergency services removed his body from the vehicle. I am satisfied on the evidence obtained in the investigation that the response of emergency services personnel in light of the isolated area in which the crash occurred was as timely as could reasonably be expected.

Mr Sheehan's body was formally identified and transported by mortuary ambulance to the Royal Hobart Hospital where an autopsy was carried out by experienced forensic pathologist Dr Donald McGillivray Ritchey. Dr Ritchey expressed the opinion, which I accept, that the direct cause of Mr Sheehan's death was positional asphyxia. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. Alcohol was found in the samples of at least 0.287 g per 100 mL of blood, in other words nearly 6 times over the "legal limit" for driving in this state. The forensic scientist who conducted that analysis, and provided a report as part of the coronial investigation, expressed the opinion, which I accept, that a blood alcohol concentration of that level would significantly impair driving performance to the point of Mr Sheehan having been unable to properly control a motor vehicle. The scientist, Ms Connor, said that it has been estimated that the relative risk of a driver with a blood alcohol concentration of 0.18 g per 100mL of blood being involved in a crash is approximately 50 times that of a driver with no alcohol in their blood. She said it is to be therefore expected that a blood alcohol concentration higher than 0.18 g per 100 mL of blood would be associated with an even greater risk of involvement in a crash.

The circumstances of the crash were investigated comprehensively by officers from Tasmania Police Crash Investigation Services. That investigation showed Mr Sheehan was an experienced driver, appropriately licensed and very familiar with the road where the crash occurred. He suffered no medical conditions which could have caused or contributed to the happening of the crash.

Utilising data collected at the scene, crash investigators were able to calculate the speed of the vehicle immediately prior to it leaving the road as being 85 km/h. Senior Constable Cordwell expressed the opinion, which I accept, that that speed is not excessive for the section of roadway where the crash occurred it being relatively straight.

The vehicle that Mr Sheehan was driving (owned by one of his passengers, Mr Costello) was in a roadworthy condition at the time of the crash. I do note that the Transport Inspector who conducted the examination of the vehicle after the crash found that it was fitted with an LED single strip driving light mounted on the upper most rail of the bull bar

which amounted, in his view, to a dangerous protrusion and therefore was not compliant with the *Vehicle and Traffic (Vehicle Standards) Regulations 2014*. Be that as it may I am satisfied that the bull bar of the vehicle in no way caused or contributed to the happening of the crash.

Nothing about the road surface or weather conditions was identified as causing or contributing to the happening of the crash.

The evidence obtained as a result of the investigation positively excludes the involvement of any other vehicle or person in the happening of the crash.

The evidence as a whole satisfies me that at the time of the crash Mr Sheehan was significantly affected by alcohol and that this was the reason for the crash occurring in which he lost his life.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Kelly Cordwell for her investigation and report.

The circumstances of Mr Sheehan'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 convey my sincere condolences to the family and loved ones of Mr Sheehan.

Dated 18 October 2018 at Hobart, Tasmania.

Simon Cooper
Coroner