MAGISTRATES COURT TASMANIA

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 deaths of Nicholas George Williams and Shaun Lindsay William Ross

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, in respect of Nicholas George Williams that:

a) The identity of the deceased is Nicholas George Williams, date of birth 19 December 2001;

b) Mr Williams died from injuries sustained as the driver in a single motor vehicle crash, in the circumstances set out in this finding;

c) Mr Williams' cause of death was head and chest injuries; and

d) Mr Williams died on 11 March 2022 at Somerset in Tasmania.

And I find, pursuant to Section 28(1) of the *Coroners Act* 1995, in respect of Shaun Lindsay William Ross that:

a) The identity of the deceased is Shaun Lindsay William Ross, date of birth 28 June 1994;

b) Mr Ross died from injuries sustained as a front seat passenger in a single motor vehicle crash, in the circumstances set out in this finding;

c) Mr Ross' cause of death was neck and chest injuries; and

d) Mr Ross died on 11 March 2022 at Somerset in Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into both deaths. The evidence includes;

- The police reports of death for both deceased;
- Affidavits and reports confirming identification of both deceased;

- Opinion of the forensic pathologist regarding cause of death for each deceased;
- Toxicology reports of Forensic Science Service Tasmania for each deceased;
- Report of the Transport Inspector regarding the condition of the vehicle involved in the crash;
- Ambulance Tasmania patient reports for each deceased;
- Affidavit of Philip Williams, father of Mr Williams;
- Affidavit of Karly Donohue, partner of Mr Ross;
- Affidavit of Steve Gleeson, employer of Mr Williams and Mr Ross;
- Affidavits of ten witnesses to the circumstances prior to and surrounding the deaths;
- Affidavits of five attending and investigating police officers, including Forensic Services officers, together with body worn camera footage and scene photographs;
- Report and affidavit of Senior Constable Sven Mason, qualified crash investigator;
- Medical records for Mr Ross from Somerset Medical Centre; and
- CCTV footage from Somerset Hotel and central business district.

Mr Williams and Mr Ross

Mr Williams was 20 years of age and lived with his family in Wynyard. He was a qualified boilermaker welder and was employed at The Engineering Company in Somerset. He had a strong work ethic, enjoyed milling wood and was in good health. He was the holder of a current Novice P2 driver's licence.

Mr Ross was 27 years of age and lived with his partner and daughter, aged 18 months, in Somerset. He was also employed at The Engineering Company as a trades assistant. Before undergoing a shoulder reconstruction in 2019, he enjoyed motorcycle riding, boating and wake boarding. He was in good health and held a full driver's licence.

Circumstances surrounding the deaths

On Friday 11 March 2022, Mr Williams and Mr Ross finished work at the usual time of 1.00pm. They then went to the Somerset Hotel, where they stayed and consumed large quantities of alcohol, including spirits, until about 9.00pm. During the evening, they made a plan to go to the house of a friend in Yolla. Due to their state of intoxication, a friend at the hotel who had not consumed alcohol offered to drive them but they declined the offer. About one hour before they actually left, they called a taxi. However, due to their delay in entering the waiting taxi, the taxi driver left without them. The sober friend again offered to

drive them home (or possibly even to their intended destination) but they decided to travel to Yolla in Mr Williams' Toyota Landcruiser flat tray utility that was parked at the hotel. Mr Williams was driving, with Mr Ross a front seat passenger. Both Mr Williams and Mr Ross did not have their seat belts fastened at any time.

After travelling a distance of approximately 5.9 kilometres, they were driving in a westerly direction on Seabrook Road towards its intersection with Frenchs Road. At that point, Mr Williams lost control of the vehicle. The crash investigation evidence indicates that it travelled for some distance on the grass shoulder of the road, narrowly missing large trees and stumps before reaching a residential driveway, where it likely became airborne and tipped to the left. It then impacted with a gum tree and rotated, causing Mr Williams' head to impact with the windscreen before being ejected from the vehicle through the rear window and hitting a tree trunk. He suffered massive head injuries and died immediately. Mr Ross remained inside the cabin of the vehicle but suffered extensive neck and chest injuries and was deceased upon the arrival of emergency services. The investigation has not been able to determine the speed of the vehicle at the time it left the road.

Testing of post-mortem blood samples revealed that Mr Williams and Mr Ross both had blood alcohol levels in excess of 0.200g/100mL, over four times the legal driving limit. The degree of driving impairment at this blood alcohol level is extremely high and the risk of being involved in a crash is approximately 50 times that of a driver who has consumed no alcohol. The large quantity of alcohol consumed over a prolonged period was the predominant factor in the fatal decision of Mr Williams to drive his vehicle and of Mr Ross to travel as a passenger in the vehicle.

Comments and Recommendations

The deaths of Mr Williams and Mr Ross were tragic and entirely preventable. If they had planned the day to ensure that a vehicle was not accessible after consuming an excessive quantity of alcohol, they would not have died.

Unfortunately, despite prominent and repetitive public campaigns aimed at preventing drink-driving, similar deaths continue to occur. Tasmanian Coronial records show that in the last five years between 2018 and 2023, excessive consumption of alcohol has been the main contributory factor in the deaths of 16 people in motor vehicle crashes. This loss of life, as well as the lives of other lawful road users, has far-reaching consequences for the community as a whole.

I do not make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I extend my appreciation to Senior Constable Sven Mason for his helpful investigation and report.

I convey my sincere condolences to the family and loved ones of both deceased.

Dated: 15 May 2023 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner