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 Dion Ronald Hardy

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

a) The identity of the deceased is Dion Ronald Hardy;
b) Mr Hardy died as a result of injuries sustained by him in a collision between the motorcycle he was riding and a car;
c) The cause of Mr Hardy's death was a broken neck; and
d) Mr Hardy died on 14 October 2016 at Brooker Highway, Glenorchy, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Hardy'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; relevant police and witness affidavits; medical records and reports; and forensic and photographic evidence. I have also had regard to the complete prosecution brief of evidence in relation to charges laid against the driver of the vehicle who collided with Mr Hardy.

At about 11.00pm on 14 October 2016 Kristel Cee-Anne Cowen was driving a motor vehicle south on the Brooker Highway in the northern suburbs of Hobart. She was on the wrong side of the highway, that is, travelling in the 2 northbound lanes. I note the highway is separated by a physical barrier in that area. It is not a situation where a driver can "drift" inadvertently into the wrong lane. The evidence of witnesses makes it clear that Ms Cowen drove her car in the wrong lane for at least 2 ½ km before she collided with Mr Hardy.

On the evening she was driving Ms Cowen was extremely affected by alcohol. After the crash a blood sample taken from her revealed a blood alcohol concentration of 0.213 g of alcohol per 100 mL of blood, that is to say in excess of 4 times over the legal driving limit. In addition a number of prescription drugs were found in her blood. The

combination of alcohol and drugs undoubtedly significantly adversely affected her ability to properly control the car she was driving. I am also satisfied that Ms Cowen was speeding, travelling in the order of between 100 and 120 km/h in an area of road with a speed limit of 80 km/h when she hit Mr Hardy.

In contrast Mr Hardy was travelling in the correct lane for him, within the speed limit and with no alcohol or drugs in his blood. Eyewitnesses subsequently told investigators that he had been riding his motorcycle in the lead up to the crash in an appropriate and safe manner. It is quite clear that there was nothing about the manner in which he rode his motorcycle which caused or contributed to his death in any way.

Mr Hardy stopped for a red light at the junction of Brooker Highway and Elwick Road. When the light changed he moved forward heading north on the highway towards his family home at Bridgewater. The road surface in the area was in good condition. The area was, generally speaking, well lit. Nothing about the weather caused or contributed to the happening of the crash. Mr Hardy's motorcycle was in good order and the headlight operating. Just beyond the intersection the car driven by Ms Cowen collided with Mr Hardy's motorcycle. He was thrown from the motorcycle and came to rest 10.4 metres from the point of impact. The helmet he was wearing - appropriately fitted and which complied with necessary safety requirements - came free at the moment of impact. Mr Hardy suffered appalling injuries in the crash and died instantly.

Police and emergency services were quickly on the scene. Nothing could be done for Mr Hardy. After formal identification at the scene by his friend (and owner of the motorcycle he was riding) Mr Ian Williams, Mr Hardy's body was transported by mortuary ambulance to the Royal Hobart Hospital. At the Hospital an autopsy was carried out by highly experienced forensic pathologist Dr Donald McGillivray Ritchey. Dr Ritchey found that Mr Hardy had suffered numerous injuries including to his limbs, pelvis, neck and head. Dr Ritchey expressed the opinion, which I accept, that Mr Hardy died instantly from a broken neck sustained in the crash.

On 6 June 2018 Ms Cowen, having pleaded guilty to one count of manslaughter of Mr Hardy, was sentenced to 6 years imprisonment by His Honour Justice Brett.

When he died Mr Hardy was 48 years of age. He was a married man, a father and grandfather as well as a friend to many and a valued co-worker. The impact of his death upon his family and friends was understandably devastating.

Comments and Recommendations

I extend my appreciation to the investigating officer now retired Mr Rodney Carrick for his investigation and report.

The circumstances of Mr Hardy'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 Hardy.

Dated 3 June 2019 at Hobart in the State of Tasmania.

Simon Cooper
Coroner