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 death of Michael William McLean

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

a) The identity of the deceased is Michael William McLean;
b) Mr McLean died as a result of injuries sustained in a motorcycle crash;
c) The cause of death was chest injuries; and
d) Mr McLean died on 18 March 2017 on Henty Road, Zeehan, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr McLean's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; expert crash investigation evidence; police and witness affidavits; medical records and reports; and forensic evidence.

I make the following further findings;

Mr McLean was born in Western Australia on 10 December 1969 and was aged 47 years. He separated from his wife in 2016. There were no children of the marriage. He was employed as a train driver, an occupation he held through his adult life. He was a resident of Western Australia and lived with his sister Judy Reynolds ("Ms Reynolds"). Mr McLean did not drink alcohol and did not smoke. He undertook regular medical checks for his employment, and was in good mental and physical health.

Mr McLean had ridden motorcycles for many years and held a full and unrestricted motorcycle licence.

In 2016, he traded in his existing sports motorcycle for a new Harley Davidson motorcycle. The Harley Davidson arrived on Christmas Eve in 2016. Mr McLean rode the motorcycle at every opportunity over the following two months and purchased new, high-quality riding gear in preparation for a planned trip to Tasmania.

Mr McLean departed from Ms Reynolds' house on 19 February 2017, riding across to Melbourne where he boarded the Spirit of Tasmania ferry. He arrived in Devonport on 5 March 2017. Mr McLean then spent time travelling throughout Tasmania, and was in daily contact with Ms Reynolds, updating her as to his whereabouts with text messages, phone calls and Facebook posts.

Mr McLean telephoned Ms Reynolds on the morning of 18 March 2017, asking her to collect a helmet for him from a shop in Perth. Ms Reynolds did so later that day, and sent Mr McLean a message with a photo of the helmet. Mr McLean did not reply.

At about 1.00pm on the same day, 18 March 2017, Mr McLean was riding his motorcycle on Henty Road at Pyramid Creek, 4.6 kilometres south of Zeehan. He was on the west coast of Tasmania travelling in a northerly direction towards Zeehan.

Mr McLean was riding on a long, straight section of the road approaching a sweeping left-hand bend at Pyramid Creek. At this point Henty Road comprised one lane in each direction, with an applicable speed limit of 100 km/h. The roadway was constructed of bitumen and in good condition, with each lane 2.7 metres in width. The gradient of the bend was less than 1% and the corner had a positive camber of 3 degrees to assist vehicles to negotiate it.

At the same time as Mr McLean was riding his motorcycle on Henty Road, Mr Peter Duncan was driving his 2010 Nissan Navara dual cab on Henty Road in the opposite direction. Mr Duncan's wife, Mrs Helen Duncan, was a front seat passenger. Mr Duncan, who swore an affidavit in this investigation, stated that he was travelling between 90 and 100km/h approaching the bend. At that time both he and Mrs Duncan (who also provided an affidavit) stated that as they rounded the corner travelling within their correct lane, they saw a motorcycle coming toward them on the incorrect side of the road.

In his affidavit Mr Duncan stated *"I had no time to brake or swerve, I maintained my line. The bike collected the left front corner of my vehicle. The steering wheel started shaking quite badly, and I tried my best to steer the vehicle off the road. We came to a stop on the left gravel verge".*

After the crash the motorcycle came to rest directly opposite the point of impact. The rider, who was subsequently identified as Mr McLean, was thrown upwards and came to rest with the motorcycle at a point on the road verge opposite the point of collision.

Ambulance Tasmania personnel attended the scene and pronounced Mr McLean deceased at the scene.

State Forensic Pathologist, Dr Christopher Lawrence, conducted an autopsy and concluded that the cause of death was due to chest injuries suffered in the crash.

Toxicology reports indicate that no alcohol or drugs were present in the blood of Mr McLean or Mr Duncan.

Both vehicles were inspected by a transport inspector, who found them both to be roadworthy at the time of the collision.

I find that Mr McLean was travelling on the incorrect side of the road as he rounded the corner and encountered Mr Duncan's vehicle. I am satisfied that Mr Duncan was travelling at or below the speed limit and that Mr McLean, also, was not travelling above the speed limit. I am satisfied, based upon the evidence, that Mr Duncan could not have avoided the crash.

Evidence of Mr McLean's "Go-Pro" footage from his motorcycle from the day prior to his death was viewed by the crash investigator, First Class Constable Haydn Barnard, himself an experienced motorcyclist and police motorcycle instructor. He provided an affidavit that Mr McLean's cornering technique was not the ideal "low risk" technique. Further, he suggested that as wind gusts were recorded of up to 25km/h at the time of the crash, the path of the motorcycle may have been affected by crosswinds.

I am not able to determine the nature of any error in Mr McLean's riding, or the extent of any wind gusts, that caused him to travel onto the incorrect side of the road and into the path of Mr Duncan's vehicle. I am satisfied that Mr McLean made an inadvertent error in his riding and that his actions were not deliberate.

The tragic death of Mr McLean highlights the fact that motorcyclists, in the event of an error leading to a crash, are exposed to a significantly higher risk of death than other motorists.

Comments and Recommendations:

I extend my appreciation to investigating officer First Class Constable Haydn Barnard for his investigation and report.

The circumstances of Mr McLean'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 Michael William McLean.

Dated: 19 August 2019 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner