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 Gavin John Barber,

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

a) The identity of the deceased is Gavin John Barber;
b) Mr Barber died as a result of injuries sustained in a single motorcycle crash;
c) The cause of death was head injury; and
d) Mr Barber died on 2 September 2018 at Lower Barrington in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Barber's death. The evidence comprises an opinion of the forensic pathologist; toxicological evidence; expert crash investigation evidence; vehicle inspection evidence; family, police and witness affidavits; medical records and reports; and forensic and photographic evidence.

Mr Barber was born in Paddington, New South Wales, on 18 February 1963. At the time of his death Mr Barber was aged 55 years and widowed. He lived with his mother and shared a unit with her in East Devonport.

Mr Barber was adopted as a baby by a family who lived in New South Wales. As a youth, he was troubled and spent time living on the streets of Sydney and engaging in drug use and criminal activity. He served numerous periods of imprisonment. In about 2004, Mr Barber reconnected with his birth mother, Ms Shirley Maree Hugen.

In 2005 Mr Barber began treatment on the methadone program to control and overcome his opioid addiction. In about 2010, Mr Barber married Ms Nicole Gillam. They had no children together but he assisted in raising two of Ms Gillam's children. Ms Gillam died in 2014. Mr Barber then moved in with his mother, Ms Hugen, as her carer.

Mr Barber was, until his death, under the care of his general practitioner, Dr Emil Djakic. His medical records indicate that he was not in a good state of health. In addition to taking methadone, he suffered mental health illnesses (including bipolar disorder and obsessive

compulsive disorder), asthma and bronchiectasis. He was a long-term smoker and cannabis user. Dr Djakic's recent medical notes state that Mr Barber was stressed because his mother was sick and that Mr Barber had "very few skills to cope".

In 2014 Mr Barber obtained his motorcycle licence in Tasmania, although his mother stated in her affidavit that he had been riding motorcycles illegally for many years. Three months before his death, Mr Barber bought a Harley Davidson motorcycle.

In mid-August 2018, Mr Barber had a minor crash on his Harley Davidson motorcycle. It occurred on wet grass and, whilst the motorcycle and helmet were undamaged, Mr Barber sustained a fractured left clavicle and possible fractured ribs. He attended the Mersey Community Hospital after the crash and also saw Dr Djakic on 13 and 15 August 2018. He was scheduled to attend the orthopaedic clinic in Burnie on 4 September 2018 (two days after his death). Dr Djakic prescribed him pain medication for his injuries.

Circumstances of Death

On the morning of the crash, Mr Barber rode to see a friend, Mr Olaf Alsop, at his home in Acacia Hills. From there they both rode their motorcycles to the Baptist Church at Lower Barrington, arriving at around 10.00am. Mr Barber and Mr Alsop attended the service and later spoke with the minister, Mr Christopher Aulich. Mr Aulich described Mr Barber to be in good spirits and did not appear to be under the influence of substances or unwell. He said that Mr Barber was a "terrific fellow" who lit up the church with his presence.

Mr Barber and Mr Alsop then headed off to see another friend at Spreyton, travelling on Sheffield Road. Mr Alsop was in front of Mr Barber. Sometime later he noticed that Mr Barber was not riding behind him and became concerned. He rode back to the church but was unable to find Mr Barber or his motorcycle.

Mr Alsop continued back down the hill slowly. He located Mr Barber in the driveway of the property of 802 Sheffield Road. Mr Barber's motorcycle was several metres away from him, laying on its side. He was sitting on a garden wall hunched over with his helmet off. He was unresponsive and there was blood coming from his mouth. Mr Alsop yelled out for assistance. The residents of the property came and helped Mr Alsop to perform CPR until paramedics arrived. Upon arrival, paramedics determined that Mr Barber was deceased.

Police officers, including Forensic Services and Crash Investigation officers, subsequently arrived to examine the scene and investigate the crash.

Mr Barber was transported to the Launceston General Hospital where an autopsy was performed. The State Forensic Pathologist, Dr Christopher Lawrence, formed the opinion after autopsy that death was due to the effects of a head injury from the motorcycle crash. He noted recent bruising on Mr Barber's right shoulder and an acute subdural haemorrhage in the brain. There was old bruising present on his left chest and shoulder area consistent with his previous crash. Dr Lawrence noted the presence of bronchiectasis which would have further decreased his pulmonary function. Dr Lawrence also had regard to analysis of Mr Barber's blood, which showed that Mr Barber had methadone in his system as well as a range of respiratory-depressant prescription drugs, including oxycodone, diazepam and olanzapine. It does not appear that he had been prescribed all of the substances by a medical practitioner. There was also a high level of THC (cannabis) at 8.6ug/L in his blood.

Transport Inspector, Mr Alan Fitzpatrick, inspected the motorcycle after the crash and found no defects that would have contributed to Mr Barber losing control of his motorcycle.

Senior Constable Sven Mason, crash investigator, was able to calculate that the speed of the motorcycle was well under the 100km/h speed limit, likely in the vicinity of 45km/h, being an appropriate speed for the curve that Mr Barber was required to negotiate. The weather was dry, visibility excellent and there was no loose surface material or issues with the roadway at the time of the crash. Mr Barber was wearing an approved safety helmet that was in good condition and was wearing appropriate motorcycle protective gear.

Based upon the crash investigation evidence I find that Mr Barber was negotiating a right hand curve on Sheffield Road when he lost control of the motorcycle, diagonally crossing the driveway of 802 Sheffield Road to his left. In doing so, he travelled up an embankment onto a garden bed and a metal mailbox. Mr Barber was thrown off his motorcycle and was conscious when he came to land about 7 metres further on from the final resting place of the motorcycle. He made his way back towards the motorcycle for several metres to a raised garden bed. At this point he sat and removed his gloves and helmet. However, he quickly succumbed to his head injury and passed away.

Senior Constable Mason opined that a contributing factor in the crash was Mr Barber's existing fractures. He explained in his report that when riding a motorcycle around a right hand curve, the rider pushes forward with their left arm and shoulder. A fractured collarbone would have inhibited this action and caused Mr Barber considerable pain. Mr Barber had negotiated four other right-hand curves between the church and the crash site. However, the final curve was the tightest, requiring significantly more input from his left arm and shoulder.

The combination of illicit and prescription drugs in Mr Barber's system would also have affected his riding ability, including his reflexes and perception / reaction times. The speed of the motorcycle at the time of the crash was relatively low and most alert and diligent riders should have been able to negotiate the curve safely.

Comments and Recommendations

The death of Mr Barber represents yet another instance of a motorcyclist losing control of the motorcycle and suffering fatal injuries. In Mr Barber's case, the combination of multiple drugs, his ill-health and his existing injuries from a recent crash were major factors in the crash which caused his death.

The circumstances of Mr Barber's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Gavin John Barber.

Dated 18 May 2020 at Hobart Coroner's Court in the State of Tasmania.

Olivia McTaggart
CORONER