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 Christopher Mark Lane

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

a) The identity of the deceased is Christopher Mark Lane;

b) Mr Lane died as a result of injuries sustained in an off-road motorcycle crash;

c) The cause of Mr Lane's death was a ruptured spleen; and

d) Mr Lane died on 18 April 2021 near Trial Harbour, Tasmania.

**Introduction**

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Lane's death. The evidence includes:

- Police Report of Death for the Coroner;
- Opinion - Dr Christopher Lawrence, Forensic Pathologist;
- The results of toxicological analysis of samples taken at autopsy;
- Affidavits confirming identification and life extinct;
- Affidavit – Ms Bronwyn Gibson, sworn 8 June 2021;
- Affidavit – Mr Craig Elphinstone, sworn 18 August 2021;
- Affidavit – Mr Benjamin Wilson, sworn 17 August 2021;
- Affidavit – Transport Safety and Investigation Officer Philip Evans, sworn 24 May 2021;
- Affidavits of attending and investigating police officers;

- Records – Ambulance Tasmania;
- Medical Records – Patrick Street Clinic Ulverstone;
- Records of ST2ST; and
- Forensic, body worn camera and photographic evidence.

**Circumstances of Death**

Mr Lane died whilst participating the annual St Helens to Strahan off road motorcycle ride (ST2ST).

The event, in which he had previously participated, commenced on Thursday, 15 April 2021 at St Helens on Tasmania's East Coast. Riders made their way via dirt and off-road tracks across the northern part of Tasmania, with a view to finishing at Strahan on the West Coast.

On Sunday, 18 April 2021, the last day of the event, Mr Lane rode from Cradle Mountain towards Trial Harbour. Approximately 2 km north of Trial Harbour, whilst riding on the beach, Mr Lane struck a log in the sand. The impact appears to have driven the handlebars of his motorbike into his abdomen, rupturing his spleen.

Mr Lane was able to stop and get off his motorbike. Another rider – Mr Craig Elphinstone – found him leaning over his motorcycle in pain. Mr Lane was at this stage still conscious and told Mr Elphinstone that he had hit a log. Shortly after this discussion, Mr Lane's condition deteriorated and he stopped breathing. At 3.16 pm a call was made to emergency services for help. An ambulance was dispatched three minutes later. So were police. At the same time Mr Elphinstone and other participants in the ride commenced CPR upon Mr Lane.

CPR continued for a considerable period until well after the arrival of emergency service personnel. It is apparent from the body worn camera footage that that CPR was carried out in a competent and effective manner.

The first police officers arrived at the scene at about 4.30 pm. Ambulance paramedics arrived at 5.23 pm. Despite the best efforts of paramedics, police and participants, Mr Lane could not be revived and he was declared dead at the scene.

**Investigation**

Mr Lane's body was identified at the scene and then transported to the mortuary at the Royal Hobart Hospital. At the Royal Hobart Hospital, experienced Forensic Pathologist Dr

Christopher Lawrence performed an autopsy. Dr Lawrence found that Mr Lane had suffered significant abdominal injuries, the most serious of which was a lacerated (or ruptured) spleen. This injury caused his death. Dr Lawrence found approximately 2 litres of blood in Mr Lane's abdomen as a result of the ruptured spleen. I accept Dr Lawrence's opinion.

Toxicological analysis of samples taken at autopsy did not indicate the presence of alcohol or any illicit drugs in Mr Lane's body.

An inspection of the motorcycle he was riding at the time of the crash did not reveal any mechanical defects that could have either caused or contributed to the happening of the crash.

**Conclusion**

I am satisfied that there are no suspicious circumstances associated with Mr Lane's death. No other person caused or contributed to the happening of the crash.

I consider that the event in which Mr Lane was participating was appropriately organised with sufficient attention paid to safety. The response of paramedics and emergency services was as timely as possible, given the extremely remote location in which Mr Lane suffered his fatal accident. Finally, I do not consider a lack of attention to safety on Mr Lane's part contributed to his death. He was an experienced and apparently careful off-road motorcycle rider on a serviceable motorcycle wearing appropriate protective equipment at the time he suffered his fatal accident.

**Comments and Recommendations**

The circumstances of Mr Lane'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 Christopher Mark Lane.

**Dated**: 1 November 2021 at Hobart in the State of Tasmania.

**Simon Cooper**
**Coroner**