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, Andrew McKee, Coroner, having investigated the death of ST,

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

a) The identity of the deceased is ST;
b) ST died as a result of injuries sustained in a motorcycle crash;
c) ST's cause of death was complications of abdominal trauma following a motorcycle crash; and
d) ST died on 3 February 2019 in the Royal Children's Hospital in Melbourne, Victoria.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into ST's death. That evidence is comprised of the following:

a) An opinion of the Forensic Pathologist who conducted an external post-mortem examination;
b) Tasmania Police Report of Death;
c) Victoria Police Report of Death;
d) Relevant police and witness affidavits;
e) An affidavit of Mr D Quinn, a transport inspector employed by the Department of State Growth;
f) An affidavit of Senior Constable H Barnard, a crash scene investigator;
g) The medical records relating to ST's treatment at the Mersey Community Hospital, the Launceston General Hospital and the Royal Children's Hospital, Melbourne; and
h) Forensic evidence.

ST was born in Burnie in 2005 and was aged 13 years at his death. ST had a twin sister as well as an older sister.

ST and his twin sister were born about six weeks premature. Both he and his sister spent four weeks in the Royal Hobart Hospital. Other than a broken leg when he was nine months old, ST was a normally developed healthy young man.

ST commenced kindergarten in 2010 in Roseberry. His family moved to Ulverstone when he was in grade 2. The family moved to Devonport where ST attended school in grades 4 to 6. He was a student at a College at the date of his death.

ST was a proficient motorcycle rider. He learnt to ride his first motorcycle, a Yamaha Pee Wee 50, when he was just three years old.

At five years of age ST commenced riding a larger motorcycle, a Honda CRF 50 and at this time he began racing with the Tasmanian Endurance Riders Club. He was a successful competitor, winning a number of trophies. As well as competing in enduro races he also competed in short track motocross events.

At age 9 or 10 ST commenced riding a Yamaha TTR 110. He continued competitive riding and would practice during the week. The next bike that ST owned was a Yamaha TTR 125 which was the first bike ST rode that had a clutch. He quickly adapted to riding a motorcycle with a clutch.

In 2016 ST commenced riding a Husqvarna TC85. The engine on that motorcycle was a two-stroke. ST continued to compete in motocross and enduro events. These events were held state-wide. He was an avid competitor.

ST always wore protective gear when riding his motorcycle, including when he was not competing and simply riding for enjoyment. He would always wear his helmet, goggles, gloves, boots, kneepads, body armour and usually a neck brace. All of his equipment was well maintained.

Circumstances Surrounding ST's Death

Consideration of the sworn affidavits of the various witnesses obtained during the coronial investigation enables me to make the following findings of fact regarding ST's movements in the hours preceding the crash, and the manner of his driving shortly prior to the crash.

Arrangements had been made for ST to go motorcycle riding with KP on Saturday, 17 November 2018. A group of young persons aged between 12 to 19 intended riding on land owned by KP's grandfather.

KP collected ST from his home at around 10.30am on 17 November. ST and KP then returned to his home before heading to his grandfather's land.

While they were out riding, one of the other riders noticed that the kick starter on ST's motorcycle was loose. KP attempted to fix the kick starter but was unable to do so as he did not have any tools with him.

He indicated to ST that they should ride down to KP's grandfather's house to effect repairs. KP and ST left the group and road to his grandfather's home. KP effected repairs to ST's kick starter. On the return journey to the group, KP stopped to close a gate that he had left open. KP instructed ST to continue riding and not wait for him. ST continued to ride up a gravel track on a fairly steep hill which followed the fence line. Once ST reached the crest of the hill he was out of KP's line of sight. At the top of the hill, just over the crest, is a 90° left hand turn.

KP estimates that ST had ridden on the gravel track three or four times and would have been aware of the existence of the corner. After KP closed the gate he rode up the hill. The gate is roughly 100 m from the bottom of the hill. As he crested the hill he saw ST laying up against the wooden fence to the left of the gravel track. He noticed ST's bike was lying on its left side facing back down the hill. KP stopped to render assistance. He initially thought that ST was badly winded. At that time ST was talking to him. He removed ST's helmet. At this point ST lost consciousness. KP then left ST to travel to the group of riders. On the way he met HJ. HJ immediately drove to where ST was situated. She provided assistance to ST. When she arrived at the scene, she noted that ST was in significant pain. He indicated to her that his stomach was hurting. HJ made the decision that ST needed to be transported to hospital. With the assistance of the other riders he was placed in HJ's van and driven to hospital.

ST's mother, BR, was contacted by telephone and advised that ST had been in a crash. She was on her way to the property when she was directed to attend the hospital.

BR arrived at the hospital before HJ. She alerted staff to ST's arrival.

ST was assessed at the Mersey Community Hospital. He was transported to the Launceston General Hospital where he underwent surgery. He was then transported to the Royal Children's Hospital in Melbourne.

Unfortunately, despite multiple operations, ST's condition continued to deteriorate. After consultation with his family a decision was made to stop active treatment.

I am satisfied that ST received appropriate care and treatment at each and every hospital he attended.

Condition of ST's Motorcycle Prior to the Crash

ST's motorcycle was inspected after the crash by Mr D Quinn, a transport inspector employed with the Department of State Growth. I am satisfied that he is appropriately qualified to express the opinions contained in the affidavit he swore in the coronial investigation. He expressed the opinion that ST's motorcycle was in good mechanical condition prior to the crash. I am satisfied that the mechanical condition of ST's motorcycle did not cause or contribute to the crash.

Crash Scene Investigation

A thorough investigation of the crash scene was conducted by Senior Constable H Barnard, a crash scene investigator. He concluded that ST had failed to negotiate a 90° left hand corner at the top of the hill, and skidded into a wooden fence post. ST was travelling at 28 km/h when the motorcycle commenced to skid.

Post-Mortem Examination

An external post-mortem examination was undertaken by Forensic Pathologist, Dr Victoria Francis. Dr Francis opined that the cause of ST's death was complications of abdominal trauma following a motorbike collision. I accept Dr Francis' opinion as to ST's cause of death.

Supervision of ST

I note that the riding of motorcycles, the recreational driving of motorcycles, and the sport of motocross, carries the risk of serious injury or death. ST had taken appropriate precautions by riding a mechanically sound motorcycle and by the wearing of well-maintained and appropriate safety equipment.

When the collision with the fence post occurred, ST was riding alone and unsupervised. I am not in a position to indicate if the presence of KP would have prevented the incident. ST's death should serve as a reminder of the necessity for those supervising children in such sports to be vigilant.

Comments and Recommendations

I extend my appreciation to investigating officer, Senior Constable Barnard, for his investigation and report.

The circumstances of ST'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 ST.

Dated: 1 February 2021 at Hobart Coroners Court in the State of Tasmania.

Andrew McKee
Coroner