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 Garth McDonald Leighton

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

a) The identity of the deceased is Garth McDonald Leighton;
b) Mr Leighton died as a result of injuries he sustained when the motor cycle he was riding collided with a motor vehicle;
c) The cause of Mr Leighton's death was chest and abdominal injuries; and
d) Mr Leighton died, aged 58 years, on 4 January 2021 at Hollow Tree Road, between Hamilton and Bothwell, Tasmania.

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

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Forensic Science Service Tasmania;
- Report – Dr Christopher Lawrence, Forensic Pathologist;
- Ambulance Tasmania records;
- Affidavit – Mr Paul Wells, Transport Inspector, sworn 22 January 2021;
- Affidavit – Mr Brian Hawkins (witness), sworn 21 January 2021;
- Affidavit – Mr Russell Willcox (driver of other vehicle), sworn 15 January 2021;
- Affidavit – Ms Angela Shearn (passenger in other vehicle), sworn 15 January 2021;
- Affidavit – Dr Michael Lees, sworn 25 March 2021;
- Affidavit – Dr Henry Hancock, sworn 15 April 2021;
- Affidavit – Mr Anthony Johnston (Volunteer Ambulance Officer), sworn 10 April 2021;
- Affidavit – Mr Wayne Doran (Volunteer Ambulance Officer), sworn 11 April 2021;

- Affidavit – Constable Steven Fry, sworn 25 March 2021;
- Affidavit – Constable Jared Gowen, sworn 12 April 2021;
- Affidavit – Constable Dean Walker, sworn 19 March 2021(and photographs);
- Affidavit – Ms Louise McCarthy, sworn 29 January 2021;
- Medical Records – Tasmanian Health Service;
- Volunteer Ambulance inventory list Department of Health;
- Crash Investigation Services – Collision Analysis Report (including scene diagrams);
- Results – blood test- Russell Willcox;
- Licencing and registration details;
- CCTV footage – Bothwell General store;
- Bureau of Meteorology Weather Observations; and
- Road crash data.

Circumstances of death

Mr Leighton died from injuries sustained when he lost control of his 1999 Yamaha XJR 1300 motorcycle as he attempted to negotiate a left hand curve on Hollow Tree Road, in the early afternoon of Monday, 4 January 2021. He drifted into the incorrect lane, into the path of a white Nissan T32 X Trail hire car driven by Mr Russell Willcox.

Mr Willcox could do nothing to avoid hitting Mr Leighton, who was thrown from his motor cycle into a road side drain.

Passing motorists stopped to help. Local police, Volunteer Ambulance Officers and Volunteer Fire Fighters also attended. The rescue helicopter was deployed. Initially conscious and able to converse, Mr Leighton was treated at the scene and transferred into the helicopter when it arrived. However, before the helicopter could take off, Mr Leighton suffered a cardiac arrest. He could not be resuscitated and died at the scene.

Investigation

Mr Leighton's body was formally identified at the scene (he had been riding with a large group of friends and acquaintances). It was then taken by mortuary ambulance to the Royal Hobart Hospital, where an autopsy was performed by highly experienced Forensic Pathologist, Dr Christopher Lawrence. Dr Lawrence found that Mr Leighton had suffered numerous, massive injuries of his chest and abdomen.

Those injuries included a fracture dislocation T9/T10, retroperitoneal haemorrhage, multiple rib fractures, a lacerated spleen and liver, pelvic fractures and significant internal bleeding.

Toxicological analysis of samples found no alcohol or illicit drugs to have present in Mr Leighton's body.

Meanwhile, Mr Willcox was subject to the usual post-accident blood testing. No trace of alcohol or any illicit drugs were found to have been present in his body at the time of the crash either.

The Nissan and Yamaha were both impounded and examined by a transport inspector, Mr Wells. Mr Wells provided a report in which he said, and I accept, that both the car and motor cycle were in roadworthy conditions before the crash.

Bureau of Meteorology data and witness accounts indicate that weather was not a factor in the happening of the crash.

Mr Leighton was an experienced and appropriately licenced motor cycle rider.

The circumstances of the crash were extensively investigated by officers from Tasmania Police Crash Investigation Services. The comprehensive report from CIS has informed these findings.

Mr Brian Hawkins was riding behind Mr Leighton when the crash occurred. He told investigators that prior to the crash Mr Leighton was riding appropriately. Mr Hawkins described seeing Mr Leighton head up a hill before negotiating a sweeping left hand turn in the road, entering the curve too sharply, standing the motorcycle up to avoid running off the road and over correcting before losing control and veering into the path of the oncoming X Trail.

Mr Willcox and his passenger described a similar sequence of events. Physical evidence at the scene supports this having occurred.

I am satisfied that the collision between Mr Leighton's motor cycle and the Nissan X Trail occurred wholly within the northbound lane of Hollow Tree Road, which was the correct lane for the X Trail. Furthermore, I am satisfied that Mr Willcox steered his vehicle to the left in an attempt to avoid the collision, but was unable to avoid Mr Leighton.

There is no evidence that excessive speed on the part of Mr Leighton or Mr Willcox caused or contributed to the crash.

Road Conditions

Hollow Tree Road is a typical two lane, sealed rural road. It runs for approximately 29 km between Bothwell and the Lyell Highway south of Hamilton. It is windy in parts and has a number of hills and tight corners.

The two lanes where the crash occurred are approximately 3.15 metres wide, separated by a single solid white line.

The road has gravel verges and no fog line at either edge.

The evidence is that the bitumen surface at the scene of the crash was in reasonable condition. Certainly, I am satisfied that the road surface did not cause or contribute to the happening of the crash.

I note that on 4 January 2021, yellow and black diamond shaped 55 km/h advisory signs were in place either side of the curve in the road where Mr Leighton lost control of his motor cycle. Since the crash those signs have been replaced with 45 km/h advisory signs.

Mr Leighton's medical management

As I think should be clear already, Mr Leighton suffered terrible injuries in the crash. Immediately after the crash three doctors - a surgeon, a physician and a GP – were on the scene, providing assistance. Mr Leighton was initially conscious and able to communicate. He told those treating him he had no feeling below the waist. He was diagnosed, correctly as it turned out, as having suffered serious spinal injury, and requiring urgent fluid and resuscitation.

VAO Anthony Johnson was the next to arrive at the scene. He helped the doctors already there to stabilise Mr Leighton. Dr Hancock, a highly qualified doctor with relevant accident and emergency and surgical experience, asked VAO Johnson for IV fluids from the ambulance. However, there were no fluids on the ambulance, they having apparently been removed in accordance with a policy of Ambulance Tasmania[1].

In that regard, when asked, Ambulance Tasmania explained that:

> *' As Volunteer Ambulance Officers only hold a First aid level qualification they operate under a limited set of Clinical Field Protocols with a limited scope of practice and are not able to safely operate or administer all the equipment and drugs available to qualified Paramedics. Volunteers do not cannulate or administer intravenous fluids".*[2]

Dr Hancock said in his affidavit that:

> *"If the country ambulance had an IV access and IV fluid resuscitation package, and an airway resuscitation package (even if the drivers themselves are not qualified to use it) it would give considerable advantage should a qualified medical professional happened to be in attendance. It could have saved this man's life".*[3]

[1] See affidavit of Wayne Phillip Doran, sworn 11 April 2021.
[2] Letter Department of Health, Ambulance Tasmania to CIS, dated 5 May 2021.
[3] Affidavit Dr Henry Hancock, sworn 15 April 2021.

I think Dr Hancock makes a very good point. Lest it be thought the chances of a medical practitioner happening upon a crash are remote, I observe that not one but three were on the scene of Mr Leighton's crash before any ambulance officers or emergency services personnel arrived.

It also seems to me that further training for Volunteer Ambulance Officers in the administration of IV fluids is also worthy of consideration, if a lack of training is thought to be a genuine impediment to volunteer crewed ambulances being provided with life saving equipment.

Comments and Recommendations

I consider that the circumstances of Mr Leighton's death are such that it is appropriate for me to **recommend** pursuant to Section 28 (2) of the *Coroners Act* 1995 that Ambulance Tasmania consider providing all volunteer crewed ambulances with IV access and IV fluid resuscitation packages. I further **recommend** consideration be given to additional training for Volunteer Ambulance Officers, where appropriate, in the administration of IV fluids.

I convey my sincere condolences to the family and loved ones of Mr Leighton.

Dated 4 July 2022 at Hobart in the State of Tasmania.

Simon Cooper
Coroner