



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Robert Webster, Coroner, having investigated the death of Lyndsay Kenneth Salter

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

- a) The identity of the deceased is Lyndsay Kenneth Salter (Mr Salter);
- b) Mr Salter died as a result of injuries sustained in a motor vehicle crash;
- c) The cause of death was pulmonary fat embolism complicating interstitial lung disease; and
- d) Mr Salter died on 26 February 2019 at the Launceston General Hospital (LGH), Launceston, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into the death of Mr Salter. That evidence consists of the following:

- Police Report of Death for the Coroner;
- affidavits establishing identity and life extinct;
- affidavit of Dr Rosanne Devadas, forensic pathologist;
- Forensic Science Service Tasmania toxicological and analytical report;
- affidavit of Mr David Quinn, transport inspector;
- Ambulance Tasmania electronic patient care record;
- medical records obtained from the Tasmanian Health Service (THS);
- medical records obtained from Dr David Rutherford, renal and general medicine physician;
- medical records obtained from Dr Kugathasan Nadarasa, consultant cardiologist;
- affidavit of Mr Mason Salter;
- affidavit of Ms Kirsty Anderson;
- affidavit of Mr Tim Flack;
- affidavit of Senior Constable Benjamin Elliott;

- affidavit of Sergeant Nigel Sheahen;
- affidavit of Constable Sven Mason;
- affidavit of First-Class Constable Dean Wotherspoon;
- affidavit of Senior Sergeant Mark Forteach; and
- photographs and forensic evidence.

Background

Lyndsay Kenneth Salter was born in Scottsdale, Tasmania on 26 September 1935. He was aged 83 years, married and lived with his wife in Thurgoona, New South Wales at the date of his death. Mr and Mrs Salter had 5 children. Mr Salter was an avid motorcycle enthusiast and a member of the Ulysses Motorcycle Club. He had a long and varied occupational career. He was a sail rigger by trade however when he was about 25 years of age he left Tasmania for mainland Australia where he coached a number of football teams. Thereafter he worked in civil construction all over Australia on large projects such as the Snowy River Scheme, the Dartmouth Dam and a number of highways. He also worked on the Bass Link project and when he retired he was a pipeline inspector on the Dubbo to Tamworth pipeline.

Mr Salter suffered from a number of medical conditions which included atrial fibrillation, chronic type II diabetes controlled by insulin, ischaemic heart disease with angina on strenuous exertion and chronic renal impairment. He had also undergone two hip replacements. He had consulted a cardiologist in April and October 2018. Mr Salter had undergone, since about 2006, long-term testing, monitoring and treatment for his renal condition.

Mr Salter owned several motorcycles in his life time and he had held a valid driver licence in NSW since prior to 1975. In 1999/2000 he purchased a new 1999 Yamaha Vmax motorcycle. He later bought a custom fitted side car and a camper trailer to tow. He had owned numerous motor cycles fitted with sidecars over the years. He was a very experienced rider.

On 17 February 2019, Mr Salter and his grandson, Mason Salter (Mason), arrived in Tasmania on the Spirit of Tasmania to ride around Tasmania on a holiday for a two week period. Mr Salter travelled to Tasmania with the Vmax motorcycle, sidecar and camper trailer while Mason was riding a Harley Davidson motorcycle. They travelled from Devonport and stayed in Launceston for four nights and used Launceston as a base from where they went on a number of day rides. They then travelled to Triabunna for two nights where they did more day rides before travelling to Snug for two nights.

Mason says by this stage of the trip Mr Salter was getting tired and not doing a lot of riding and so therefore Mason did a few trips by himself. While at Snug Mr Salter experienced a hypoglycaemic event and he was taken to the Royal Hobart Hospital (RHH) by ambulance where he was treated and released. His blood sugar level had gone down to 1.8 before he was treated by ambulance personnel. In addition he indicated to staff at the RHH he suffered from angina which only occurs on exertion but was always relieved by rest. He had also been suffering from a shortness of breath on exertion over a period of several weeks but he had a follow-up appointment booked in New South Wales. He indicated to medical staff he becomes breathless when walking on the flat now and was only able to walk 10 to 20 m without stopping. Mr Salter was described by his grandson as short of breath and a bit sluggish the next day and somewhat slower than usual. They then headed off to Queenstown without any issues and stayed overnight in a hotel.

Circumstances surrounding Death

On the morning of 26 February 2019, they headed off to Devonport. Just outside Queenstown, Mr Salter had problems with his front brake, where the front calliper had broken away and was rubbing against the front wheel rim, causing the front brake not to work. The back brake still operated properly. Some rudimentary temporary repairs were undertaken just outside Tullah which resulted in Mr Salter having some braking in the front of his motorcycle. He still had full use of his back brake which was also linked into a braking system on the sidecar.

They resumed their journey with Mr Salter travelling well under the posted speed limits. Just after Cradle Mountain they stopped again at which time Mr Salter told his grandson the bike was feeling much better now that he had some front brakes. They were intending to stop in Sheffield but to Mason's surprise Mr Salter did not stop but instead started to travel towards Railton. They travelled through Railton without stopping and continued on towards Latrobe.

On approaching the junction of Railton Road and Mersey Main Road, which is just south-west of Latrobe, Mr Salter should have completed a left turn onto Mersey Main Road to travel towards Devonport via Spreyton. Instead, as he continued towards the T-junction, he failed to brake or slow, crossed over three lanes on Mersey Main Road and hit an Armco railing on the northern side of the junction. As a result of that collision Mr Salter was thrown over the railing and into a grassed area.

Another vehicle travelling on Mersey Main Road from South Spreyton towards Latrobe was close to the junction when Mr Salter rode straight out in front of that vehicle which had to take evasive action to avoid a collision. Mason says he was following his grandfather who, as they got closer to the junction, seemed to be getting further ahead. He did not see any brake lights come on and he could tell his grandfather was not changing down the gears. He presumed his grandfather thought it was just another sweeping bend in the road. Mason says he saw the signs on the approach to the junction and was aware he was coming up to the junction but he thinks his grandfather was tired and lost concentration for a few moments and once he realised he had gone through the junction it was too late to correct his error.

Mason parked his bike at the junction and ran across to his grandfather who was conscious but in a lot of pain. It was clear to Mason his grandfather had broken his right leg. Ambulance personnel arrived and treated Mr Salter at the scene before transporting him to the LGH. Mr Salter arrived at the emergency department of the LGH at 3.59pm. His grandson reports he spoke to Mr Salter while he was in emergency and he told him he couldn't get his legs to be where they needed to be and that he probably lost concentration which caused him to crash.

Investigations revealed Mr Salter had suffered a bruised right shoulder and a fractured scapula. He had also suffered a compound fracture of his right leg with neurovascular compromise. He was therefore taken to theatre for emergency surgery because of the lack of blood flow to his right foot. Mr Salter was stable until the anaesthesia was administered but then his blood pressure dropped and he started going into cardiac arrest. CPR was performed for around 40 minutes but Mr Salter was unable to be resuscitated and died.

Investigation

An examination of the scene conducted by police determined Mr Salter came to rest 10.3 m from where his motorcycle collided with the Armco barrier. The motorcycle itself stayed upright and travelled west along the barrier for 14.3 m before veering right, travelling across a grassed area and coming to a stop up against a wire straining fence. The distance between the holding line on Railton Road and the point of impact on the Armco railing on the northern side of Mersey Main Road is 15.6 m. At the impact point with the railing was a small gouge on a grassed shoulder which measured 800 mm long and appeared to have been caused by one of the wheels on the motorcycle.

The motorcycle came to rest 42 m north-west from the point of impact with the railing. The railing itself is 37 m and appears to have been placed at that location so motorists are

protected from colliding with power poles and signs situated behind it. The railing itself is 660 mm high. There were marks on the railing caused by this crash which were 3.22 m long and they were a combination of black scuff marks from the front tyre and a small amount of red paint. The railing had been pushed inwards by 15 mm at the point of impact.

The condition of the road surface at the junction was good and the weather at the time of the accident was fine and sunny and the road was dry. In the direction that Mr Salter was travelling there is a raised traffic island at the junction, which is known as "Frogmore Corner", and there is a keep left and a give way sign which were clearly visible to him on that traffic island. To the left of the junction there is a second give way sign which would have also been clearly visible to him. Across the junction are two faded holding lines and double continuous white lines separate the two lanes of Railton Road at the junction. There is an 80 km/h speed limit sign erected 300 m south of the junction. Between that sign and the junction are two advisory signs indicating give way signs are ahead. There is a slight uphill gradient for traffic travelling north on Railton Road up to the junction.

Mersey Main Road runs from Frogmore Corner through to Spreyton. It also has an 80 km/h speed limit. At the junction it is comprised of three lanes, one westbound, one right turn lane into Railton Road and an eastbound lane. All road markings are visible but slightly faded. As already mentioned the Armco barrier is situated on the northern side of Mersey Main Road.

The police crash investigator, Constable Mason, determined from his examination of the scene that Mr Salter had failed to observe the junction and had travelled straight ahead, possibly only realising his mistake when it was too late. The investigator's opinion is that immediately prior to impact with the railing, the front wheel was turned some degree to the left. At impact, Mr Salter was thrown over the right side of the motorcycle and onto the grass where he came to rest whereas the motorcycle has continued to travel westwards along the Armco railing before then veering right onto the grass and coming to a stop up against the fence. Constable Mason calculated the impact speed of the motorcycle and Armco railing at between 37 and 39 km/h. Mr Salter's motorcycle was registered and he was wearing full protective dress, boots and a helmet at the time of the crash.

Ambulance Tasmania received the call to attend the crash at 2.20pm and personnel arrived at the scene at 2.27pm. Mr Salter was treated for approximately half an hour before he was stabilised and driven to the LGH; arriving at 3.58pm.

The transport inspector, Mr Quinn, inspected the Vmax motorcycle, sidecar and trailer on 19 March 2019. As a result of his examination he determined that the motorcycle was not roadworthy because the left hand brake caliper was not mounted. The mounting bracket was missing and the caliper had a ring/open end spanner jammed between the brake pads which was hanging on the left fork leg attached by PVC insulation tape and nylon cable ties. In addition when tested the front brakes were ineffective and failed to lock the front wheel. The hand/park brake failed to lock the sidecar brakes which allowed the wheel to rotate freely. Finally when operating the throttle it failed to return to the idle position. Clearly the problems with the front brake occurred on the journey from Queenstown to the accident site and the problems with the throttle were, according to Mason, well known to his grandfather who was used to it and it didn't seem to bother him at all. Mr Quinn does not say whether these defects caused or contributed to the crash. In my view they did not.

The State Roads Division of State Growth considered this crash from a traffic engineering and environment perspective. There were eight reported crashes, including this one, at this intersection in the five year period to 26 February 2019. However there had been no other crashes, besides this one, involving vehicles on the Railton Road approach continuing through the intersection without giving way. There had been no fatal crashes at this intersection in the 10 years preceding this crash. As a result of the inspection of the accident site it was determined there was good forward sight distance to the junction and there were a series of signs to alert motorists to the presence of the junction. I accept and agree with this determination.

For motorists travelling north in the direction Mr Salter was travelling there was an 80 km/h speed limit sign some 300 m prior to the junction, there was a give way ahead warning sign approximately 230 m prior to the junction, there was an advance direction sign some 100 m prior to the junction indicating direction to Spreyton and Devonport to the left or west and Latrobe to the right or east, and there was a second give way ahead warning sign some 90 m prior to the junction. In addition there was a give way sign on the left-hand side of the junction and a give way sign and keep left sign on the traffic island in the mouth of the junction but on Railton Road. Despite this signage it was recommended a second 80 km/h speed limit sign on the right hand side of the road, opposite the existing one and a second give way ahead sign on the right hand side of the road, opposite the existing one be provided. Those recommendations were implemented and finalised in May 2019.

Post Mortem Examination

The forensic pathologist, Dr Devadas, conducted an autopsy on 28 February 2019 and noted Mr Salter's medical history and the fact that he had sustained a compound fracture to the right tibia in a motorcycle accident. As a result of her examination and her consideration of the medical records and histology she determined the cause of death was pulmonary fat embolism complicating interstitial lung disease. The embolic material appeared to Dr Devadas to be bone marrow from the traumatic fracture of the right tibia. Diffuse fibrotic interstitial lung disease was also present. Interstitial lung disease is progressive scarring (fibrosis) of the lungs which makes it difficult for a person to get oxygen into the bloodstream. This is because the lungs become stiff. A fat embolism or blood clot often follows an insult, for example a fracture to a bone such as the femur, pelvis or tibia. That clot forms in the leg and travels to an artery in the lungs and blocks blood flow which then, in this case, led to the cardiac arrest.

The toxicology report reveals Mr Salter had no alcohol or illicit drugs in his blood. He had a therapeutic level of one of his prescription medications in his blood and sub therapeutic levels of other drugs which were used by medical staff to treat Mr Salter. The level of prescription medication in his blood would have had no effect on his capacity to drive.

Conclusion, Comments and Recommendations

Having considered all of the evidence in this matter I am satisfied that as Mr Salter approached the Railton and Mersey Main Road junction he momentarily lost concentration and it was this that led to the crash. Factors that could have led to the loss of concentration either alone or in combination were the fact he had been unwell recently and he was tired due to the long journey he and his grandson had undertaken. In addition, on 26 February 2019 Mr Salter had driven a significant distance with a defective front brake which would have required his full concentration for a long period.

He appears, given the findings of Constable Mason, to have become aware of his predicament just seconds prior to the crash. Given the state of the evidence I am unable to definitively determine whether the defective front brake prevented Mr Salter from avoiding the collision with the Armco railing and the subsequent leg injury which he sustained. My suspicion is that by the time Mr Salter realised he had missed the turn and was travelling straight across the junction it would have been too late to avoid a collision with the Armco railing even with all the brakes on his motorcycle working effectively.

I am satisfied that the level of care provided by both Ambulance Tasmania and the THS was to the appropriate standard.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, and cause of death and the relevant circumstances concerning how his death occurred. I do not consider a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations pursuant to s28 of the *Coroners Act 1995*.

I convey my sincere condolences to Mr Salter's family and loved ones.

Dated: 9 March 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner