MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends, youths and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995

I, Simon Cooper, Coroner, having investigated the death of BP

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

a) The identity of the deceased is BP;

b) BP died as a result of injuries sustained by him as rider in a quad bike (ATV) accident;

c) The cause of BP's cause of death was transection of the liver and inferior vena cava laceration; and

d) BP died, aged 16 years, died on 5 November 2022 at the North West Regional Hospital, Burnie, Tasmania.

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

- Police Report of Death for the Coroner;
- Tasmanian Health Service – Death Report to Coroner;
- Affidavits confirming life extinct and identity;
- Report – Dr Christopher Lawrence, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Ambulance Tasmania records;
- Tasmanian Health Service – Medical Records;
- Affidavit – Philip Evans, Transport Safety and Investigation Officer, sworn 16 November 2022;
- Affidavit – RH, sworn 28 November 2022;
- Affidavit – OL, sworn 28 November 2022;

- Affidavit – NU, sworn 7 November 2022;
- Affidavit – QT, sworn 8 November 2022;
- Affidavit – VI, sworn 8 November 2022;
- Affidavit – Senior Constable Carmen Duthoit, sworn 27 January 2023 (and body worn camera footage);
- Affidavit – Senior Constable Stephen Barrow, sworn 10 November 2022;
- Affidavit – Constable Robert Oberrauter, Forensic Services, sworn 30 November 2023 (and photographs);
- Affidavit – First Class Constable Dean Wotherspoon, sworn 23 November 2022 (and photographs); and
- Affidavit – Senior Constable Hayden Barnard, sworn 28 January 2023.

Introduction

BP was born on 22 March 2006 and the son of RH and EY.

At the time of his death, he was an apprentice light vehicle mechanic. In the week prior to the crash which caused his death, he had been undertaking training in Launceston.

BP was the holder of a Car – Novice L licence at the time of his death.

He owned and was using a Polaris 300 ATV that had been bought for him as a 14-year-old.

The ATV was designed for a single rider only. It was fitted with warning stickers advising very clearly that it should not be operated or used with a passenger on board. It was a Type 1 ATV.

There is evidence that he had experience riding the ATV. It was kept at his grandparents' house in Wynyard.

Circumstances of death

On Saturday 5 November 2022 BP, his OL (also 16 years old) met up with friends, NU, his partner QT and QT's four children aged between 18 and 10 years at a location known as the skid pan, off or near Deep Creek Road, Olinda, near Wynyard.

The intention was for the group to have a barbeque and ride ATVs and motor bikes.

After having lunch, the group decided to leave the skidpan area and go exploring.

BP had OL as a pillion passenger. They were in front of the group. They travelled in a generally southerly direction on Tram Road, a public street on land managed by Sustainable Timber Tasmania. Tram Road runs off Deep Creek Road. It has a gravel surface.

A bridge on Tram Road crosses Big Creek. The bridge is approximately 2.2m above the level of the creek. It does not have a guard rail. It is oriented roughly east- west.

The approach to the bridge has a 75m straight section, followed by a left hand corner, as the road enters the bridge. The edges of the road, in common with many gravel roads in this state are not well defined. There is no sign warning of the left-hand turn at the approach to the western end of the bridge.

The ATV left Tram Road where it entered the bridge and crashed into the creek below.

NU was first upon the scene. The ATV was on its wheels in the creek. BP and OL were both on the bank. OL had little memory of what occurred.

QT arrived next. It was now 3.16pm. She tried to call an ambulance, but did not have mobile telephone coverage. BP was semi-conscious and unable to stand. NU and QT (with help from her eldest child) managed to get BP onto the tray of a ute and drove slowly away from the scene of the crash until QT got through to 000 at 3.25pm.

Treatment

An ambulance met the party at 3.39pm. BP was agitated, confused, pale and sweaty. He had obvious and serious blunt force traumatic injuries to his chest and abdomen. He was stabilised at the scene before being transported by ambulance to the North West Regional Hospital (NWRH), where he arrived at 4.40pm.

Upon arrival at the NWRH, BP was breathing spontaneously but remained confused. An ultrasound revealed he had fluid around his lung. Two intravenous cannulae were inserted and fluid resuscitation was commenced at 4.57pm using saline and blood. BP's blood pressure dropped and a decision was made to insert left and right side chest tubes under sedation. He was treated with drugs at 5.12pm to address his low blood pressure. Intubation continued and a second blood transfusion occurred.

Chest and pelvic x-rays identified the presence of intra-abdominal fluid, clear evidence of internal bleeding. Due to this bleeding and his continued low blood pressure a decision was made for BP to be transferred immediately to theatre. A third bag of packed red blood cells was administered, commencing at 5.59pm and more drugs were administered to help combat his low blood pressure. He was urgently transferred to theatre at 6.08pm.

In theatre, BP's abdomen was opened, all the blood was removed, and he was packaged around his internal organs in an attempt to stop the bleeding. However, the surgical team was unable to locate the source of the bleeding.

His blood pressure reached a level which was incompatible with life and a decision was made to reopen BP's abdomen. A tear was located along the length of his portal vein extending into his liver. Surgeons then wrapped the torn vein in a blood clotting inhibitor with the intention of stabilising him sufficiently to enable him to be transported to the Royal Hobart Hospital by air ambulance.

Following surgery, BP was moved to the hospital's ICU, but his blood pressure remained catastrophically low, his heart entered cardiac arrest rhythm and he died as a result.

Investigation

The fact of BP's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified at the NWRH before being taken to the mortuary at the Royal Hobart Hospital (RHH).

At the RHH, highly experienced forensic pathologist Dr Christopher Lawrence performed an autopsy. He provided a report following the autopsy in which he expressed the opinion, which I accept, that BP died as a result of the transection of his liver and a laceration of his inferior vena cava.

Toxicological analysis of samples taken at autopsy did not reveal the presence of any illicit drugs or alcohol. The only drugs detected were drugs administered as part of the emergency treatment he received in the aftermath of the crash.

A comprehensive investigation in relation to the scene and circumstances of the crash was carried out by Senior Constable Hayden Barnard, an experienced crash investigator. His report has also informed these findings. Specifically, Senior Constable Barnard did not find anything in particular about the road construction or surface which caused or contributed to the happening of the crash. The road was a gravel road of a type very common in much of rural Tasmania.

The ATV was examined by a Transport Inspector who did not find any mechanical defects which could have caused or can attributed to the happening of the crash in which BP sustained his fatal injuries.

Conclusion, Comments and Recommendations

I am quite satisfied that the treatment BP received in the aftermath of his crash was of an appropriate standard. He could not have been transferred to the RHH by air ambulance until his condition was stabilised sufficiently to enable that to occur. Sadly, given the catastrophic nature of the injuries he sustained he could not be stabilised.

I am satisfied that there are no suspicious circumstances associated with BP's death. I am also satisfied that mechanical defect, alcohol and drugs played no role in relation to the crash.

The evidence satisfies me that the crash occurred because BP entered a left-hand corner too fast, resulting in his ATV understeering towards the outside of the bend. This in turn led to the ATV launching off the edge of the bridge and crashing into a creek 2.2m below.

At the time of the crash, BP was carrying a pillion. The ATV was not designed for two people and the presence of the pillion passenger undoubtedly affected the handling of it and was, in my assessment, a major contributing factor to the crash.

A coroner investigating a death "must whenever appropriate, make recommendations with respect to ways of preventing further deaths".[1]

In 2017, I had occasion to make a number of recommendations following an inquest in relation to seven ATV related deaths. Amongst other things I **recommended** that:

> "Consideration given by the Law Reform Institute and the Attorney-General to the introduction of legislation requiring mandatory training and licensing of all persons using quad bikes; and
>
> Consideration be given by the Law Reform Institute and the Attorney-General to the introduction of legislation prohibiting the carrying of passengers on type I quad bikes (and any more than one passenger on type II quad bikes)."

The circumstances of BP's death require me to repeat the above **recommendations** pursuant to Section 28 of the *Coroners Act* 1995, noting that so far as I am aware no action has been taken in relation to either or both of the recommendations made four years ago and noting also that since I made those recommendations there have been several ATV related deaths.

I express my thanks to Senior Constable Barnard for his careful and comprehensive investigation in relation to this tragic matter.

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[1] section 28 (2) of the *Coroners Act* 1995.

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

Dated: 21 June 2024 at Hobart, in the State of Tasmania.

Simon Cooper

Coroner