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## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Brian Oakley Woods

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

- a) The identity of the deceased is Brian Oakley Woods;
- b) Mr Woods died as a result of injuries sustained in a single motorcycle crash;
- c) The cause of Mr Woods' death was head and chest injuries; and
- d) Mr Woods died on 25 September 2016 at Black Charlie's Opening, Tasman Highway, Orielton in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Brian Oakley Woods' death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; police and witness affidavits; an opinion of the crash investigator; medical records and reports; and forensic evidence.

Mr Woods was born in Snug, Tasmania on 2 April 1937 and was aged 79 years. He lived at 5 Osprey Road in Claremont. He shared this residence with his partner of three years, Jan Tapp. He had been married on four occasions, prior to establishing his relationship with Ms Tapp.

Mr Woods was a committed member of Riders of Tasmania, a group of recreational motorcycle riders who met for monthly rides. He had previously been a successful competitor in motorcycle races across Australia and was the last Tasmanian to win a race at Longford in the Moto GP. Mr Woods also owned a yacht, in which he had participated in 10 Sydney to Hobart races over the years. He was highly regarded in the fraternity and was considered probably the most experienced rider in the group, with around 65 years of riding experience.

On 25 September 2016 Mr Woods was a member of the Riders of Tasmania group, comprising approximately 30 riders, who met for an organised ride. The group met at Richmond between 9.30am and 10.00am and planned to travel from Richmond to the Bark Mill at Swansea. The group left Richmond and travelled onto the Tasman Highway via Fingerpost Road just after 10.00am.

Mr Woods was riding a black 2012 Kawasaki Ninja ZX14R motor cycle registered number A154T.

At Black Charlie's Opening, a winding section of road on the Tasman Highway at Runnymede, Mr Woods negotiated the hairpin corner at the southernmost end of the winding section of the road. He was then observed to overtake two riders in the group on a sweeping bend on a blind corner travelling at a speed well in excess of the 100km/h speed limit and across unbroken double white lines. The two riders who were overtaken by Mr Woods were Christopher John Tomlinson and Darren Leslie Beresford, both of whom provided affidavits in the investigation.

Mr Tomlinson and Mr Beresford then observed Mr Woods to cut back into the left lane across the double white lines and appear to apply the rear brake heavily, causing the bike to come to an upright position and wobble two to three times. Mr Woods' feet appeared to come off the pegs as he lost control of the bike. He crashed into the Armco railing at an angle and came off the motorcycle. He then travelled along the top of the Armco rail. He came to rest slumped with his middle over the rail, his head facing towards the bush and his feet on the edge of the road. These witness accounts are consistent with footage from a Go-Pro camera worn by another rider in the group, Anthony How, which captured vision of much of the crash in his rear view mirror. The Go-Pro footage provides an indication of the speed of Mr Woods in relation to Mr How's motorcycle, as Mr How's speed display is visible in the footage. That speed display showed that he was travelling at 120km/h just prior to the crash. Mr Woods' motorcycle was travelling well in excess of this speed and can clearly be seen to be making ground on Mr How's motorcycle before the crash.

Mr Tomlinson and Mr Beresford both stopped and provided immediate assistance to Mr Woods. They removed him from the Armco railing and lay his body on the western side of the Armco railing. Mr Tomlinson removed Mr Woods' helmet and commenced CPR and maintained this for about 8 minutes under instruction from Tasmania Ambulance via the phone of a member of the public who had stopped to see if there was anything she could do.

Mark William Dance, a member of the State Emergency Service, also arrived at the scene and completed a full check of Mr Woods. His wife, Naomi Dance, bandaged a large cut to Mr Woods' right leg. Mr Dance then took over CPR duties from Mr Tomlinson.

Tasmania Ambulance paramedics arrived and confirmed that Mr Woods was deceased. He was pronounced deceased at 10.42am.

Police officers, including crash investigators and forensics officers, also attended the scene.

Dr Christopher Lawrence, State Forensic Pathologist, performed an autopsy upon Mr Woods. Dr Lawrence noted massive substantial traumatic injuries to the base of the skull which he concluded would have rapidly caused death. He also noted multiple rib, pelvic and arm fractures and a deep laceration on the right leg. Dr Lawrence stated in his report that Mr Woods' previous abdominal aortic aneurysm had been repaired with a stent but this issue did not play any role in the cause of death. I accept the conclusions of Dr Lawrence.

Toxicological testing revealed no alcohol or substances in Mr Woods' blood that would have impaired his driving ability.

The attending crash investigator, Senior Constable Kelly Cordwell, concluded in her report that Mr Woods took a poor line through the corner and applied the rear brake which brought the motorcycle to the upright position. She concluded that these two events in combination

resulted in Mr Woods colliding with the Armco railing which resulted in fatal injuries. I would add that his excessive speed was also a significant contributing factor in this crash.

The evidence indicates that Mr Woods' motorcycle was in excellent, roadworthy condition before the crash. I am also satisfied that the road and weather conditions played no part in the crash.

I cannot determine why Mr Woods chose to overtake other motorcycles at excessive speed over unbroken, double white lines in an area comprising blind corners and where overtaking was not lawfully permitted. His partner, Jan Tapp, stated in her affidavit that Mr Woods preferred to ride at the head of the group. It may be that he was attempting to secure a lead position. Unfortunately, whatever his motivation, his poor decision led to a fatal loss of control.

#### **Comments and Recommendations:**

Road safety campaigns frequently warn of the risk of serious injury and death from driving at excessive speed and performing high-risk overtaking manoeuvres. Continuing coronial findings highlight the vulnerability of motorcyclists in these situations to the risk of serious injury and death arising from bodily impact with roadside barriers, including Armco railings.

I extend my appreciation to investigating officer, First Class Constable Brett Clews, for his investigation and report.

The circumstances of Mr Woods' 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 Brian Oakley Woods.

**Dated:** 8 December 2017 at Hobart in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**