



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION



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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 Gary Peter Halson

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

- a) The identity of the deceased is Gary Peter Halson;
- b) Mr Halson died as a result of injuries suffered in a motorcycle crash with another vehicle;
- c) The cause of death was multiple blunt traumatic injuries; and
- d) Mr Halson died on 17 September 2017 at West Ulverstone, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Halson's death. The evidence comprises the police report of death; opinion of the forensic pathologist who conducted the autopsy; toxicological results of blood analysis; expert evidence of a crash investigator and transport inspector; crash reconstruction evidence; relevant police and witness statements and affidavits; medical records and reports; and forensic evidence.

I make the following further findings.

Gary Peter Halson was born on 18 November 1950 and was 66 years of age at the time of his death. He was a retired builder who lived alone at Sulphur Creek, his wife having passed away. Mr Halson was the holder of a current driver licence for heavy rigid vehicles and motorcycles. His traffic record shows some minor traffic offences but does not indicate a disregard for the road rules. Mr Halson had ridden motorcycles for many years and in many parts of Australia. His daughter, Ms Sheena Halson-Grant, indicated to investigators that her father had always been a cautious rider.

At the time of his death, Mr Halson suffered lung cancer and would often travel from his home to Launceston for treatment. He also suffered depression and was prescribed medication. He consulted his general practitioner on a regular basis.

At about 5.50pm on Sunday, 17 September 2017, Mr Halson was travelling along Penguin Road in a westerly direction on his Yamaha XVS 650 V-Star motorcycle. He was following another motorist, Mr Michael Groom, who was driving a 2015 Nissan Navara four-wheel-drive flat tray fitted with two large toolboxes on the rear.

Penguin Road is a two-lane carriageway running in an east/west direction with beachfront on the northern side and residential housing on the southern side. A 60 km/h speed limit is applicable. In his affidavit for the investigation, Mr Groom stated that the motorcycle (ridden by Mr Halson) had been following him very closely before travelling on to Penguin Road. He stated that the rider of the motorcycle would veer between being out towards the centre of the road and then pulling back behind his vehicle. He believed on a number of occasions the motorcycle was intending to pull out and overtake him. He stated that when the motorcycle moved back in close behind his vehicle he was only able to see the rider but not the bike in his rear vision mirror. He believed the motorcycle was travelling very close to the rear of his vehicle.

As Mr Groom approached Westland Drive, a street intersecting with Penguin Road, he indicated to turn left into that street. At the same time, Mr Glenn Stephens was driving his Nissan Navara utility on Westland Drive and indicated to turn right onto Penguin Road at the intersection. Mr Stephens' daughter and son-in-law were passengers in his vehicle. Mr Stephens stopped at the intersection, facing a give way sign, upon seeing Mr Groom's vehicle to the right-hand side.

Once Mr Stephens saw that Mr Groom had indicated to turn left into Westland Drive and was actually commencing the left-hand turn, he proceeded to drive out onto Penguin Road to make his intended right-hand turn. He did not see the motorcycle driven by Mr Halson behind Mr Groom's vehicle. As Mr Stephens proceeded onto Penguin Road, Mr Halson overtook Mr Groom's vehicle to continue straight along Penguin Road. In doing so, Mr Halson crashed into Mr Stephens' vehicle, which was in the process of the right-hand turn. Mr Halson was thrown from his motorcycle and suffered severe traumatic injuries.

Persons at the scene provided first-aid to Mr Halson who was, at times, conscious. Ambulance paramedics arrived and attempted resuscitation, however due to the injuries sustained, this was without success and subsequently Mr Halson was declared deceased. The forensic pathologist who performed the autopsy, Dr Donald Ritchey, concluded that the cause of Mr Halson's death was multiple blunt traumatic injuries as a result of a motorcycle crash. I accept Dr Ritchey's opinion as to the cause of death.

The scene of the crash was secured by police with forensic services officers and crash investigation officers attending to commence an investigation. For the investigation, specialist

crash investigator, Constable Sven Mason, conducted a reconstruction of the crash involving Mr Groom's vehicle and positioning a Harley Davidson motorcycle at 4 metres behind it, then having the motorcycle drive out towards the centre of the lane. On both occasions of the reconstruction it was not possible for a driver at the Westland Drive intersection to see the motorcycle following the Nissan. Mr Stephens stated, in his statement for the investigation, that he did not see the motorcycle until it was about two seconds away and about to crash into the front of his vehicle.

I accept that, on the basis of the evidence of Mr Stephens and the crash reconstruction, Mr Stephens could not have seen the motorcycle before executing his turn. However, the reconstruction revealed that the motorcycle could easily have been seen if it had followed Mr Groom's vehicle at an appropriate distance of 20-25 metres.

In his investigation, Constable Mason determined that Mr Stephens' vehicle was travelling at about 25 km/h at the time of the crash and Mr Halson was likely to have been travelling at about 60 km/h.

Toxicological testing of Mr Halson's blood subsequent to his death revealed an alcohol reading of 0.024 g/100mL which [at this] concentration would not generally impair driving performance. Prescribed antidepressant medication was also present. Mr Stephens submitted to a blood test which returned a negative reading for both alcohol and illicit drugs.

A transport inspector who examined Mr Stephens' Nissan and the motorcycle found that both vehicles were mechanically sound and roadworthy with no faults that could have caused or contributed to the crash. The road and weather conditions also did not play any part in the crash.

The evidence in the investigation was considered by the Director of Public Prosecutions, who determined that no driving charges should be laid against Mr Stephens on the basis that he displayed adequate attention by stopping and only commencing to proceed onto Penguin Road when Mr Groom had indicated and was slowing to make the turn. In this case, it is not appropriate for me to comment upon whether Mr Stephens should have refrained from making a right-hand turn until Mr Groom's vehicle had fully entered Westland Drive and his vision to the right was completely clear. It may have been a cautious approach to do so, although the manoeuvre conducted by Mr Stephens was one that many drivers in his circumstances would have safely conducted.

I find that the primary cause of the collision was the fact that Mr Halson was travelling too closely behind Mr Groom's vehicle and was not able to be seen. Further, if he had been

travelling at a safe distance behind Mr Groom, he would have had clear vision of Mr Stephens' vehicle intending to turn right, and should have refrained from the overtaking manoeuvre. However, having overtaken Mr Groom's vehicle, Mr Halson did not have time to take action to avoid hitting Mr Stephens' vehicle.

I cannot determine the reason for Mr Halson's manner of riding, which had been observed by Mr Groom for a period of time as Mr Halson closely followed his vehicle before the crash. I can only emphasise that coroners too often encounter the fatal results of poor riding in the case of motorcyclists, who are offered little protection in the event of a crash.

### **Comments and Recommendations**

I extend my appreciation to investigating officer Senior Constable Sven Mason for his investigation and report.

The circumstances of Mr Halson's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.

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

**Dated:** 19 August 2019 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**

**Coroner**