FINDINGS and **RECOMMENDATIONS** of Coroner Robert Webster following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Kane Mathew Leary

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Robert Webster, Coroner, having investigated the death of Kane Mathew Leary (Kane), with an inquest held at Launceston and Hobart in Tasmania, make the following findings.

Hearing dates

1. 26 and 27 September 2022 in the Launceston Magistrates Court:
2. 27 and 28 February 2023 in the Launceston Magistrates Court; and
3. 21 August 2023 in the Hobart Magistrates Court.

Representation

Counsel Assisting the Coroner: Mrs Emily Brett[1]

Counsel for Ms Melissa Baillee: Ms Kim Baumeler

The course of the hearing

Notice of the commencement date for this inquest was given to Kane's mother and senior next of kin, Ms Melissa Baillee, and other interested parties namely the Department of Communities[2], the Launceston General Hospital (LGH) on behalf of the Tasmanian Health Service (THS) and Mr Lee Pearton by letter dated 26 July 2022. That letter also gave notice of a case management conference (CMC) which was to be held on 23 August 2022. The CMC proceeded on 23 August 2022 and Mr Ashman appeared for Ms Baillee whereas Ms Galanos of Child and Youth Services appeared for the Department of Communities and the THS was represented by Dr Mohan, Dr Croswell, Dr Reed, Ms McPherson, Ms Hutton and Ms Collins. I set out the purpose of the CMC and I confirmed the date the inquest would commence was 26 September 2022 in Launceston. I indicated the inquest would

[1] When this inquest commenced Counsel Assisting, Mrs Brett was not married and was known by her maiden name of Stone. I have referred to her as Mrs Brett in this decision.

[2] The Department of Communities Tasmania was established in July 2018, taking over the administration of Children and Youth Services from the Tasmanian Department of Health and Human Services. Through Children and Youth Services, the Department of Communities facilitated out of home care, child welfare, and custodial youth justice services in Tasmania amongst other services. The Department of Communities was abolished on 1 December 2022, with functions for Children, Youth and Families and Youth Justice Services transferred to the Department for Education, Children and Young People.

be dealt with in two parts; first all the non-medical witnesses would be called and then at a subsequent date all the medical evidence would be called. I also commented on an email my office had received from Ms Baillee dated 22 August 2022 suggesting there were two relevant witnesses the police had not spoken to and that she had not heard from the coronial liaison officer[3] (CLO) who had been appointed to this case. Given that Ms Baillee had sent a number of emails to my office and that she was now represented I indicated that all further contact from her was to come from her solicitor so that he would know about all contact with our office and vice versa. In addition I indicated the associates in my office had been for some time seeking the names of any witnesses Ms Baillee believed could assist so they could be interviewed and called. If there were any such witnesses then contact details and the names of those witnesses was required so that a statement could be taken from them. Without a statement I indicated they would not be permitted to give evidence. I therefore sought that information. I also indicated the CLO had just commenced her role, we only had one such person, and as Ms Baillee was represented the CLO had been allocated to assist in relation to an inquest being heard in Devonport at the same time as this one. Counsel Assisting summarised the proceedings and set out what the issues to be determined were. I then made orders disclosing inquest materials to Ms Baillee's lawyer and to the THS. Each of those attending were given an opportunity to raise any issues at that point but nobody did. The inquest was then adjourned for hearing to 26 September 2022. Ms Baumeler was the only counsel who appeared at the inquest; apart of course from Mrs Brett.

All witnesses with respect to the circumstances surrounding the accident and its aftermath, except for First Class Constable Housego who was unavailable due to personal reasons, gave evidence on 26 and 27 September 2022. Assistance was then sought from the THS to provide affidavits of the relevant medical witnesses. Both the medico-legal department of THS and the Office of the Solicitor General (OOSG) declined my office's request for assistance with the latter indicating *"neither the Agencies nor this office has sufficient resources to dedicate to the preparation of affidavits for all of the inquests in which the State is involved."* The OOSG did however offer to settle any draft affidavits prepared by the Coroners' office.

My associate then issued summonses to nine doctors for them to attend to give evidence or produce documents in the Hobart Magistrates Court on 15 November 2022 in order to take depositions in

[3] This is a position within the coronial office whereby the coronial liaison officer (CLO) assists family members, witnesses and those who have contact with the coronial jurisdiction to understand the coronial process and the role and legal powers of the coroner. The CLO provides general information about the inquest process. This can include court familiarisation and practical information about attending court and support during inquest proceedings. They CLO assists with the initial triaging and advising family and friends of other appropriate services as needed.

lieu of affidavits. Without notice to my office the Honourable the Attorney General filed an application in the Supreme Court for relief in the nature of a writ of certiorari or other relief pursuant to rule 623 of the *Supreme Court Rules* 2000. It was contended my associate had exceeded her power in issuing the summonses. On 9 November 2022 Chief Justice Blow made a general order to show cause why the summonses should not be set aside and the decision to issue them quashed. His Honour also made an order that the summonses be stayed and there was an order as to service of the general order and other documents. The order and other documents were served on both my associate and myself and I provided notice submitting to the jurisdiction of the Supreme Court. Legal representation was arranged for my associate.

The show cause hearing took place before Justice Wood on 14 December 2022. It was asserted by the Attorney General my associate had made a jurisdictional error, that the issuing of the summonses amounted to an abuse of process and the summonses were issued for an irrelevant reason. Her Honour handed down her decision on 2 March 2023.[4] In short she found the summonses did not fall outside a coroner's powers set out in section (s) 53 of the *Coroners Act* 1995 (the Act), it was not necessary to consider the arguments about jurisdictional error as there had been no error in the first place and the prosecutor's argument about an abuse of process fell away when there was an obvious remedy available to address any concerns that were held with respect to the issuing of the summonses. In this case the remedy was seeking that I set aside the summonses on the basis that they were an abuse of process in that they were oppressive or lacked a legitimate forensic purpose. As Her Honour pointed out this is the usual way that objections of this kind to the issue of summonses are dealt with. Accordingly Her Honour found the grounds for relief specified in the general order to show cause not made out, she refused to grant the relief and she discharged the general order. Prior to the handing down of that decision affidavits from Doctors Mohan, Coulson and Croswell were received.

On 27 and 28 February 2023 First Class Constable Housego and Drs Lawrence, Mohan, Croswell and Coulson gave evidence in the Launceston Magistrates Court. Mrs Brett and Ms Baumeler appeared however nobody appeared for the THS doctors[5].

Affidavits were received from Dr Assad and Dr Hayden Bell in early May 2023. They gave evidence along with Dr Anthony Bell and Dr Daniels on 21 August 2023 in the Hobart Magistrates Court. Mrs Brett and Ms Baumeler appeared but again nobody appeared for the THS doctors namely Dr Assad

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[4] *Attorney-General v Barnes* [2023] TASSC 2.
[5] That is Drs Mohan, Croswell and Coulson.

and Dr Hayden Bell. Written submissions were received from Mrs Brett in September 2023 and from Ms Baumeler in October 2023.

Preliminary matters

Introduction

1. Kane Mathew Leary (Kane) died on 30 May 2021, aged 17, at Launceston in Tasmania after a motorbike he was riding collided with a Holden Colorado utility.

2. His death is subject to the Act because it is a reportable death; that is a death which occurred in Tasmania being a death *"that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury"* [6] or alternatively it occurred during or after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.[7] A coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death.[8] Although an inquest in this case was not mandatory[9] an inquest into this death may be held if the coroner considers it desirable to do so.[10]

3. On the basis of the evidence tendered at the inquest I make the following formal findings pursuant to s28(1) of the Act:

    (a) The identity of the deceased is Kane Mathew Leary;

    (b) Kane died in the circumstances set out further in this finding;

    (c) The cause of Kane's death was a stroke following a motor bike collision; and

    (d) Kane died on 30 May 2021 at the Launceston General Hospital (LGH), Launceston in Tasmania.

Coroner's jurisdiction and functions

4. In Tasmania, a coroner's functions are set out in s28(1) of the Act. By this section, a coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By s28(2), a coroner may make comment on any matter connected with the death; and by s28(3), a coroner must, whenever appropriate, make recommendations

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[6] See s3 of the Act and the definition of *reportable death* at paragraph (a)(ii) and (iv).
[7] See s3 of the Act and the definition of *reportable death* at paragraph (a)(v).
[8] See s21(1) of the Act.
[9] Because it did not fall within s24(1) of the Act.
[10] See s24(2) of the Act.

with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

5. Coroners complete their written findings pursuant to s28(1) into a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in his or her investigative function and subsequently, in the making of findings. Many of the public inquests held by coroners in Tasmania are made mandatory by the Act.[11] The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular circumstances of the investigation.[12] I considered it desirable to hold an inquest in this instance because of the issues to be ventilated in the investigation (as listed below) and further there is a real question as to the quality of medical care provided to Kane prior to his death.

6. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial; whereas in criminal or civil proceedings the proceedings are adversarial; that is one party against another. In these proceedings I am required to thoroughly investigate the death and answer the questions (if possible) that s28 of the Act asks. Those questions in s28(1) include who the deceased was, how he died (that is the circumstances surrounding Kane's death), what was the cause of his death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions.
7. A coroner does not have the power to charge anyone with a crime or an offence. In this case I have no power to charge anyone with any breach of the criminal law arising out of the death the subject of the investigation. Nor is it my role to review what the Director of Public Prosecutions did or did not do. A coroner also does not have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates.

8. As noted, one matter that the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular

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[11] S24(1) of the Act.
[12] S24(2).

circumstances surrounding the particular death so as to discharge the obligation imposed by s28(1)(b) upon the coroner.

9. A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment *"arises as a consequence of the [coroner's] obligation to make findings ... It is not free ranging. It must be comment "on any matter connected with the death" ... It arises as a consequence of the exercise of the coroner's prime function, that is, to make "findings".*[13]

10. The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[14]

Issues at the inquest

11. Given s28 of the Act, the scope of this inquest was as follows:
    1. The cause and circumstances of death.
    2. The collision including:
        a) The sequence of events leading to the collision;
        b) The cause of the collision;
        c) Whether there was adequate lighting on the motorcycle ; and
        d) Whether the deceased was wearing a helmet at the time of the collision.
    3. The medical treatment received by the deceased including:
        a) The effect of the failure to identify the occlusion of the terminal left internal carotid artery on 27 May 2021; and
        b) Any changes in the management of patients with severe multi trauma in the Emergency Department of the LGH since 21 May 2021.

Evidence in the investigation

12. The documentary evidence at the inquest comprised exhibits C1 to C49. The exhibit list is annexed to this finding.

13. The following witnesses gave oral testimony during the course of the inquest:

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[13] See *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[14] (1938) 60 CLR 336 per Latham CJ at 347 and Dixon J at 362 and 368-9.

a. Melissa Baillie;

b. Lee Pearton;

c. Daniel Rivette;

d. Scott Rivette;

e. Michael Hoskinson;

f. Nathan Schenk;

g. Anita Swan;

h. Malcolm Swan;

i. Justin Hoare;

j. Senior Constable Michael Grenda;

k. Inspector Darren Hopkins;

l. First Class Constable Nigel Housego;

m. Dr Christopher Lawrence;

n. Dr Sangeeth Mohan;

o. Dr Ashely Crosswell;

p. Dr Lori Coulson;

q. Dr Sheikh Asad;

r. Dr Hayden Bell;

s. Dr Anthony Bell; and

t. Dr Katherine (Katie) Daniels.

Background

14. Kane was born on 12 March 2004 at the Queen Victoria Hospital in Launceston, Tasmania. Kane lived with his mother, Melissa Baillee, at her home in Mayfield at the time of his death. Kane's father, Matthew Leary, was in and out of prison during his life and he died in a motorbike collision on 6 February 2009. Kane had a brother, sister and a half brother. In addition his mother had three older children.[15]

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[15] Exhibit C1-Police Report of Death to the Coroner and exhibit C9- Child Safety Services Records.

15. Kane spent the first six months of his life living in Campbell Town before the family moved to Launceston. He went to primary school in Ravenswood and Hagley and he spent a couple of years in Queensland. On his return he went to Brooks High School for a while until he was suspended after which he went to RADAR.[16] When Kane was 15 years of age he went to work at a pizza shop in Mowbray where he worked until the onset of the Covid 19 pandemic in 2020.[17]

16. In 2008 when Kane was four years of age, he suffered full thickness burns to 45% of his body. Consequently, Kane had large areas of scarring to his body namely his chin, torso, the right side of his back, the right upper arm, left arm, and both thighs.[18]

17. At the time of his death, Kane was subject to a Care and Protection Order pursuant to s42 of the *Children Young Persons and Their Families Act* 1997. The order was made on 20 December 2013, and was to operate until Kane was 18 years of age. The order granted guardianship of Kane to the Secretary of the Department.[19]

The cause and circumstances leading to death

Overview

18. On 27 May 2021, Kane owned a blue Yamaha motorbike (the motorbike). The motorbike was not registered, and Kane was not licensed to drive the motorbike. The motorbike was built and designed for off-road use, it was not fitted with road compliant tyres, it did not have front or rear lights, nor did it have reflectors, rear view mirrors, a chain guard or a speedometer. The motorbike was designed for a single rider as it only had one foot peg on each side. It was therefore not designed to carry a passenger.[20]

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[16] RADAR was a re-engagement program run through Learning Services North (Department of Education). Most of the students at RADAR were either unwilling or unable to function successfully in mainstream education. RADAR aimed to support students so they were able to live happy and balanced lives and engage through education. RADAR did this by providing a calm, safe, predictable environment where students could develop connection and belonging, experience trust and respect, and have some control over their learning-source: Education Thinkbank Working Together to Skill Tasmania November – December 2013.

[17] Exhibit C30-affidavit of Melissa Baillee.

[18] Exhibit C9- Child Safety Services Records and exhibit C5 –affidavit of Dr Christopher Lawrence forensic pathologist.

[19] Exhibit C9- Child Safety Services Records. In fact the records show Kane was subject to numerous orders under this legislation from 17 June 2005.

[20] Exhibit C10-affidavit of Barry Spencer; transport safety and investigation officer.

19. At approximately 5:30pm on 27 May 2021, Kane and his friend, Daniel Rivette (Daniel), left Melissa Baillie's home and went to the Dover Street Reserve in Launceston[21] to take turns riding the motorbike.[22] The Dover Street Reserve was approximately 5 minutes away from Kane's home.

20. Sometime prior to 6:00pm, Kane and Daniel decided to return home as it was starting to get dark. Kane rode the motorbike and Daniel was his pillion passenger. They did not take the most direct route back to Kane's home. Daniel says they left the Dover Street reserve and went through the Mowbray golf course car park onto George Town Road, past Avery's shop and then onto Alanvale Road. He says they were meant to go up the street that had the car wash, which I infer was Parklands Parade as that is on the same side of George Town Road as Kane's home, but instead they turned left onto Alanvale Road which is on the opposite side of George Town Road. They then turned right onto Tompson's Lane and travelled in an easterly direction.[23]

21. At the same time, Lee Pearton was driving his employer's white Holden Colorado flat tray utility registration number C48UI (the Holden Colorado) west along Tompsons Lane. He slowed down to commence a right hand turn into Franmaree Road.[24] As he turned into Franmaree Road he turned into the path of the motorcycle driven by Kane, causing both Kane and Daniel to be thrown off the motorcycle with Kane being propelled to his left landing on Franmaree Road and Daniel landing on the footpath.[25]

22. Kane was stabilised by paramedics at the scene before being transported via ambulance to the LGH.[26] Scans of his neck and brain on 27 May 2021, were reported at the time to be normal; that is showing no sign of trauma or injury.[27] Kane was put into an induced coma and required emergency surgery to stabilise the significant injuries to his right foot and femur.[28]

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[21] Exhibit C30-affidavit of Melissa Baillie.
[22] Exhibit C12A-affidavit of Daniel Rivette.
[23] Exhibit C12A-affidavit of Daniel Rivette.
[24] Exhibit C11-transcript of police interview with Lee Pearton at pages 5 and 11.
[25] Exhibit C13-affidavit of Michael Hoskinson.
[26] Exhibit C8-report of Ambulance Tasmania.
[27] Exhibit C41-affidavit of Dr Sangeeth Mohan at [77].
[28] Exhibit C17-report of Dr Anthony Bell.

23. During the evening of 28 May 2021 Kane's left pupil was observed to be fixed and dilated, and his Glasgow Coma Scale[29] (GCS) was 3, being the lowest possible[30]. Further examination of the scans revealed a left middle cerebral artery infarction. That is Kane had suffered a large stroke to the left side of his brain, leading to brain swelling. It was determined by treating medical practitioners that he was not a candidate for surgical intervention[31] and he was subsequently declared brain dead at 11.42 am on 30 May 2021.[32] Kane's breathing tube was removed at 11.10 pm on 30 May 2021[33], and he was formally pronounced dead on 31 May 2021.[34]

A note of caution with respect to the evidence of Daniel Rivette

24. Before considering the evidence in detail in relation to the collision, some observations should be made in respect of Daniel's evidence. I have analysed Daniel's evidence he gave in this case in relation to the collision and I have treated his evidence with caution. Daniel was best friends with Kane at the time of Kane's death and, quite understandably, was very distressed by his death and the events surrounding it. Daniel refused to provide an account to police about the collision when he was spoken to on the 16 June 2021[35] at a time when the events would have been fresh in his memory. He later gave an account to police on 11 March 2022[36], which was consistent with his oral testimony at the inquest. He agreed that his memory would have been better in June 2021 than it was when he was giving evidence in September 2022. His evidence was largely inconsistent with a number of independent eye witnesses. His evidence at the inquest appeared to me to be influenced by a desire to deflect any responsibility over the collision which lead to Kane's death away from Kane. Because of these matters I have determined that unless Daniel's evidence is corroborated I have not accepted it.

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[29] The GCS is a clinical scale used to measure a person's level of consciousness after a brain or other injury. It assesses a person based on their ability to perform eye movements, speak, and move their body. These three behaviours make up the three elements of the scale: eye, verbal, and motor. A person's GCS score can range from 3 (completely unresponsive) to 15 (responsive). This score is used to guide immediate medical care after an injury and it is also used to monitor hospitalised patients and track their level of consciousness.
[30] See for example exhibit C6-records of the Launceston General Hospital at page 240.
[31] Exhibit C17-report of Dr Anthony Bell and exhibit C42-affidavit of Dr Lori Coulson at [8]-[9].
[32] Exhibit C6-records of the Launceston General Hospital at page 263.
[33] Exhibit C6-records of the Launceston General Hospital at pages 270-271.
[34] Exhibit C3-declaration of life extinct.
[35] Exhibit C12-affidavit of Daniel Rivette.
[36] Exhibit C12A- affidavit of Daniel Rivette.

Events leading to the collision

25. Having decided to travel back to Kane's house because it was getting dark, Kane and Daniel did not travel by the most direct route. Instead, as explained in paragraph 20, they travelled from the Mowbray Golf Course car park, along George Town Road for a short distance, left along Alanvale Road and then right along Tompsons Lane. Daniel agreed that when he was with Kane they would often avoid going on main roads because the motorbike was unregistered and they did not want to be seen.[37] I note prior to his death Kane had two infringements for drive while not the holder of a licence and use an unregistered motor vehicle and one for being the rider of a motor cycle when not wearing a helmet.[38] This would no doubt provide him with the motivation to avoid main roads.

26. I note there is no dispute Kane was driving the motorbike along Tompsons Lane at around 6:00pm on 27 May 2021, and that Daniel was his pillion passenger. It is also uncontroversial that Mr Pearton struck the motorbike driven by Kane with his employer's Holden Colorado when he commenced a right hand turn from Tompsons Lane into Franmaree Road.

27. Mr Pearton had travelled from his work place, via a takeaway shop, and was on his way home when the collision occurred. He said he was travelling around 50 km/h along Tompsons Lane, but then slowed to approximately 25 km/h and put his indicator on to turn into Franmaree Road.[39] His evidence was he saw nothing was coming that he needed to stop for[40] (noting that there was an oncoming car further down Tompsons Lane but that he still had plenty of time to turn[41]), so he commenced the right hand turn into Franmaree Road. As he turned into Franmaree Road he hit the motorbike, and saw the driver and pillion passenger *"go in the air."*[42] He said he only noticed the motorbike just before he hit it[43], once he had commenced turning. He got out of his car after the collision and saw Daniel and Kane on the ground screaming in pain.[44] Kane was not known to him, and he had not had any altercations with riders of motorbikes or collisions with motorbikes prior to this collision[45].

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[37] Transcipt (T) page 99 lines [12]-[17].
[38] See Exhibit C26.
[39] Exhibit C11-transcript of police interview with Lee Pearton at page 11 and T73 [29]-[41].
[40] T73 [36]-[37].
[41] Exhibit C11-transcript of police interview with Lee Pearton at page 10.
[42] Exhibit C11-transcript of police interview with Lee Pearton at page 16.
[43] T74 [1]-[6].
[44] T74 [11]-[12].
[45] T75 [25]-[41].

28. An analysis of the blood sample provided by Mr Pearton did not detect any illicit drugs or alcohol.[46]

29. The Holden Colorado driven by Mr Pearton did not have any defects that could have caused or contributed to the collision[47].

30. Mr Pearton's account in relation to the collision was consistent between the 000 call he made at the scene shortly after the collision[48], his interview with police on 10 June 2021[49] and his oral evidence at the inquest. He did not see the motorbike prior to commencing the right hand turn into Franmaree Road.

31. Michael Hoskinson, Anita Swan and Malcolm Swan were all independent eye witnesses to the collision, although I note Mr Hoskinson knew Kane as he was a family acquaintance. At the time of the collision it was dark, and both Michael Hoskinson and Anita Swan had their respective vehicle's lights on[50] (Malcolm Swan was a passenger in the vehicle driven by Mrs Swan).

32. Mr Hoskinson was travelling east along Tompsons Lane prior to the collision. He was travelling around 50 km/h when he heard the sound of a motorbike approaching his vehicle. He could not see the motorbike behind him, but he could hear it getting closer. It was not until he was overtaken by the motorbike along Tompsons Lane that he saw the bike. He said it overtook him and he estimated it accelerated to around 65 km/h. It shocked him because as it went past he saw it had no lights on it at all. After he was overtaken by the motorbike he then observed the Holden Colorado approaching him travelling west, with the indicator on to turn into Franmaree Road. He described that the vehicle slowly turned right into Franmaree Road. He saw the bull bar of the Holden Colorado collide with the motorbike, and both the rider and passenger fly into the air.[51]

33. Mr and Mrs Swan were travelling west along Tompsons Lane, behind Mr Pearton's Holden Colorado. Mrs Swan was driving and Mr Swan was the front seat passenger. Mrs Swan observed the Holden Colorado indicate to make a right hand turn, then slowly commence the

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[46] Exhibit C18-Forensic Science Service Tasmania report, and certificate, of blood sample of Lee Pearton.
[47] Exhibit C10-affidavit of Barry Spencer; transport safety and investigation officer.
[48] Exhibit 8C.
[49] Exhibits 11 and 11A.
[50] Exhibit C13 affidavit of Michael Hoskinson and his evidence at T131 [20]-[22] and the evidence of Mrs Swan at T163 [23]-[24].
[51] Exhibit C13 affidavit of Michael Hoskinson.

right hand turn into Franmaree Road. Similarly to Mr Pearton, she noticed an oncoming car further down Tompsons Lane, but did not observe any other approaching vehicle. She said that as the Holden Colorado commenced turning, she saw the vehicle jerk and heard a massive bang. She parked her vehicle and immediately ran across the roadway to see what Mr Pearton's vehicle had hit. Mrs Swan provided support and assistance to Daniel who she found on the nature strip on *"the top corner"* of Franmaree Road.[52] Similarly, Mr Swan saw the Holden Colorado put on its right indicator and commence turning into Franmaree Road. He then heard a large crunching noise and saw a motorbike fly through the air. He did not see the motorbike prior to the collision. He immediately went over to Kane who was laying on the road about a metre off the kerb on the eastern side of Franmaree Road and provided support and assistance to him.[53]

Lighting on the motorbike

34. It is uncontroversial the motorbike had no front or rear lights, or reflectors.[54] It is also not in dispute that there was a torch found at the scene in the area of the collision, and that it must have been in the possession of Kane or Daniel prior to the collision. There was however conflicting evidence in relation to whether the torch was being used by Daniel to shine on the road as Kane was driving along Tompsons Lane.

35. In Daniel's oral evidence at the inquest[55], consistent with his affidavit to police in March 2022,[56] he described that when they were driving along Tompsons Lane, he was holding a big red Energiser torch in his right hand, and holding Kane with his left arm. He said he was shining the torch on the road so Kane could see where he was going. He stated that the torch was definitely on immediately prior to the collision, however he accepted that immediately prior to the collision he was trying to work out where to turn, as Kane had missed a right hand turn further down Tompsons Lane. It therefore appears Daniel was focused on looking for the next turn prior to the collision, and not specifically on whether the torch was on or off.[57]

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[52] Exhibit C14-affidavit of Anita Swan.
[53] Exhibit C15-affidavit of Malcolm Swan.
[54] See Exhibit C10-affidavit of Barry Spencer; transport safety and investigation officer.
[55] T99 [19]-[43]-T100 [1]-[7] and T107-108.
[56] Exhibit C12A.
[57] T100 [1]-[2].

36. In any event, Neither Mr Pearton[58], nor Mr and Mrs Swan[59] observed any lights on the motorbike (including any light from a torch). In fact Mr Pearton says he did not see the motorbike until immediately prior to the collision whereas Mr and Mrs Swan did not see it until it collided with the Holden Colorado. A number of witnesses, including attending police, described seeing a torch on the ground on the roadway around where the collision occurred.[60] The torch was captured in photographs of the scene.[61] Mr Hoskinson[62] and Mr Pearton[63] described that the torch was off, and it was off in the relevant photographs.

37. There were inconsistencies in Mr Hoskinson's evidence in relation to seeing a torch light between his affidavit[64] dated 3 June 2021 and his oral testimony. In his affidavit he says he observed no lights at all as the motorbike was approaching his vehicle and when the motorbike passed his vehicle. He described seeing a torch on the road after the crash which was off, and he stated that he "*didn't see any torch on when they passed me that's for sure*". In his evidence at the inquest he said he vaguely remembered seeing a little flash of light on the motorbike as the motorbike went past him, which he believed was a torch they were using.[65] He described that it was a flash, that he didn't see it for long, that he did not see it prior to being overtaken by the motorbike, and that the passenger on the bike had both arms around the driver, so he thought that the torch must have been sitting or hooked onto the front of the motorbike[66]. He accepted that he assumed the flash of light he saw must have been a torch light after seeing the torch on the ground following the collision[67].

38. Whether or not Daniel was holding a torch and it was on at the time of the collision does not need to be determined. This is because regardless of whether or not a torch was being held the lighting it produced, as a matter of fact, was insufficient for road users to see the motorbike. Mr Pearton did not see the motorbike until immediately prior to the collision and Mr and Mrs Swan, who were following Mr Pearton, did not see it until after the collision occurred. Mr Hoskinson did not see the motorbike until it overtook him.[68]

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[58] Exhibit C11 at page 15.
[59] Exhibits C14 and C15.
[60] Exhibit C19-affidavit of Constable Grenda and exhibit C20-affidavit of Senior Constable Rodney Walker.
[61] Exhibit C20 photographs at photographs numbered 50 and 51.
[62] T137 [1].
[63] T75 [23].
[64] Exhibit C13.
[65] T132 [35]-[37].
[66] T132 [39]-T133 [5], [32] and T134 [1]-[7].
[67] T144 [1]-[2] and [10]-[18].
[68] T132 [27]-T133 [2].

Whether a helmet was being worn

39. There was inconsistent evidence in relation to whether Kane was wearing a helmet at the time of the collision.

40. According to Ms Baillie, Kane never usually wore a helmet when riding his motorbike, but it was something he had started doing around eight to ten days prior to the collision.[69] Daniel said Kane never rode the motorbike without a helmet, and that he had the motorbike for about a month or two prior to the collision.[70]

41. Daniel says, in his second affidavit to police in March 2022[71], that Kane was wearing a helmet at the time of the collision, but that he was not wearing one himself. He maintained this account during oral testimony at the inquest. He said he saw Kane's helmet on the road immediately after the collision, and that it was only two metres away from where Kane was.[72] This evidence was contradicted by other evidence.

42. Ms Baillie in her affidavit and a number of other written documents[73] says Kane was wearing his helmet when he left her house prior to going to the Dover Street Reserve, and that he was definitely wearing a helmet at the time of the collision. I note she did not witness the collision and therefore her evidence does not assist me in determining whether Kane was wearing a helmet at that time.

43. When Mr Hoskinson observed the motorbike as it overtook his vehicle, he noticed that neither the driver nor the pillion passenger were wearing helmets.[74] Immediately following the collision, neither Mr Pearton, nor Mr and Mrs Swan saw either Kane or Daniel wearing a helmet. They also did not see any helmets on the roadway in the area of the collision.[75] Mrs Swan gave evidence at the inquest that she was specifically looking for helmets at the scene after realising that the boys had come off a motorbike, and this included looking under the Holden Colorado, and up and down the roadway.[76] Mr Swan was the first person to approach Kane after the collision and provide him with support but did not observe a helmet, yet Daniel

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[69] Exhibit C30-affidavit of Melissa Bailee at page 3. Also see T25 [28]-[30].
[70] T100 [12]-[23].
[71] Exhibit C12A.
[72] T102 [9]-[13].
[73] See exhibits C30, C30A, C30B, C30C and C30D.
[74] Exhibit C13-affidavit of Michael Hoskinson. See also T136 [28]-[31].
[75] Exhibit C11-transcript of interview with Lee Pearton at page 17 and exhibits C14 and C15-affidavits of Anita and Malcolm Swan.
[76] T 165 [30]-T166 [9].

said the helmet was only two metres from Kane. Mr Swan recalled someone at the scene producing an undamaged full face silver helmet to police sometime after the collision, and he heard them tell police that was what was worn at the time of the collision. Mr Swan said that was not correct as there were no helmets anywhere near either of the two boys when he and his wife stopped immediately after the collision. Mr Swan said the person who produced the helmet to police was not at the scene immediately following the collision, and that this occurred at least 20 minutes after the collision.[77] Nathan Schenk lived opposite Franmaree Road on Tompsons Lane and observed the aftermath of the collision from his residence. He did not see either Daniel or Kane wearing a helmet, and did not see any helmets on the ground or anywhere near the collision.[78]

44. Senior Constable Michael Grenda was the first police officer to arrive at the scene. He did not observe Kane to be wearing a helmet and he did not *"see one anywhere"*. Further, there is no helmet present in photographs taken by him which depict the scene of the collision, and the areas where Kane and Daniel were receiving treatment.[79]

45. Numerous police officers who attended the scene were wearing body-worn cameras (BWC) which were recording while they were at the scene[80]. No helmet is depicted in the BWC footage at the scene of any police officer upon their initial arrival at the scene. A helmet is captured on the BWC footage of Constable Moir a few metres away from Kane, and at the feet of a bystander. The helmet appears on this footage over 14 minutes after the commencement of Constable Moir's BWC footage. The helmet was not in that location previously, nor is it in initial BWC footage captured at the scene. The helmet appears to have been placed in the location near Kane some time after the collision. By this time there were numerous bystanders in the area. In addition the traffic crash investigator First Class Constable Housego did not observe any helmets at the scene. It is his normal practice, especially when attending fatalities, to seize any helmet found at an accident scene and check it against the Australian Standards and photograph it. No helmet was seized in this case.[81]

46. In addition Kane had an abrasion and bruise to his left forehead and a separate bruise on his right temple following the collision[82]. A full face helmet of the type that Kane was purportedly

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[77] See T178 and exhibit C15-affidavit of Malcolm Swan.
[78] Exhibit C16-affidavit of Nathan Schenk and T 155 [29]-[33].
[79] Exhibit C19-affidavit of Constable Grenda together with the 11 photographs taken by him.
[80] See exhibits C37A, C37B, C37C and C37D.
[81] T204 [31]-T241 [8].
[82] Exhibit C5-affidavit of Dr Christopher Lawrence at page 7.

wearing, and which was provided to police[83] would likely have protected both Kane's forehead and right temple from injury. Further there are no significant impact marks in the corresponding areas of the helmet which might be expected given the speed at which the collision occurred and the force at which Kane was ejected from the motorbike. I note Dr Lawrence says it would have been hard for Kane to sustain the abrasion if he was wearing the helmet it has been alleged he was wearing; that is exhibit C40.[84]

47. The evidence of the independent witnesses, that is those other than Daniel and Melissa Bailee, that Kane was not wearing a helmet, the absence of any helmet(s) being located at the scene immediately after the collision, the absence of any helmet(s) in the scene photos and police BWC footage (at least in the footage captured when police initially arrived), the abrasion and bruise to Kane's forehead and bruise to his right temple that would likely have been protected if he was wearing the helmet it was alleged he was wearing, coupled with the absence of any significant damage to that helmet, all leads to an inference that a helmet was not being worn by Kane at the time of the collision. Accordingly I make that finding.

48. In coming to this conclusion I have not ignored the evidence of Daniel's father Scott Rivette. He says in his affidavit, sworn in excess of 12 months after the accident, he went to the scene with his partner after the accident had occurred and arrived after police. He says sometime after the ambulance arrived he saw one helmet 10 m down Franmaree Road close to its centre. He later saw someone else holding a helmet in a group who were standing near Daniel.[85] In his evidence he says the helmet was closer to Kane than Daniel[86] but he did not know whether the helmet he saw on the road was the same helmet he later saw someone holding.[87] Mr Rivette's evidence does not establish Kane was wearing a helmet at the time of the collision and only corroborates an inference which I draw from the other evidence summarised in paragraph 47 that a helmet was introduced to the scene by a person or persons unknown after the collision had occurred.

49. The finding that Kane was not wearing a helmet is not a significant finding in the context of the medical evidence particularly that of Dr Lawrence which is discussed in detail below. This is because, in short, Dr Lawrence says Kane sustained an injury to his carotid artery in his neck

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[83] Exhibit C40.
[84] T272 [17]-[30].
[85] Exhibit C34-affidavit of Scott Rivette.
[86] T118 [16]-[17].
[87] T124 [26]-[35].

and a helmet being worn would not have necessarily prevented that injury.[88] Ultimately it was the failure to identify and treat that injury which lead to Kane's death.

Cause of the collision

50. The collision was investigated by First Class Constable Housego. He is a very experienced crash investigator, having personally investigated 110 fatal crash scenes, and many more serious crashes.[89]

51. First Class Constable Housego attended the scene on the night of the collision, and returned to the scene following the crash to conduct further examinations.[90] He analysed road markings and debris in the area of the collision which are depicted in the photographs.[91]

52. Based on the evidence at the scene and his subsequent calculations, he was of the opinion that the motorbike was travelling in the range of the speed limit leading up to the collision (50 km/h), and it was unlikely to be speeding. There was also clear evidence (in the form of a rear tyre skid mark) that Kane had commenced braking prior to the collision, which indicates he was paying attention and saw the approaching Holden Colorado prior to the collision.

53. First Class Constable Housego says the cause of the collision could only be attributed to the actions of Kane because:

    a. Kane did not have a motorbike licence and therefore should not have been using a motorbike;

    b. Kane was riding a motorbike that was not registered;

    c. The motorbike was not designed to be ridden on the road and did not have reflectors or lights, which posed a significant risk to those who used the motorbike that they would not be seen; and

    d. Mr Pearton did not see, nor could he be expected to see, the approaching motorbike.

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[88] T278 [9]-[22].
[89] T231 [38]-[41].
[90] Exhibits C21 and C21A-affidavits of First Class Constable Housego.
[91] Exhibit C20.

54. I accept First Class Constable Housego's opinion although riding an unregistered motorbike while being unlicensed to drive it per se is not causative of the collision. The point I think First Class Constable Housego is simply attempting to make is that Kane should never have been using this motorbike on the date of his death.

55. There have been some assertions made by Ms Baillie, in written documents tendered at the inquest, that prior to his death Kane was threatened by a man in a white ute who tried to run him off the road.[92] There have also been some questions raised by her as to whether Mr Pearton deliberately hit/ran Kane off the road. There was no evidence at the inquest to support an inference that Mr Pearton was the man in a white ute who had previously threatened Kane. The evidence on the inquest was not capable of leading to any inference or conclusion that Mr Pearton deliberately hit Kane on his motorbike on 27 May 2021. In fact, prior to this collision, Mr Pearton says he had never met and did not know Kane, he had not had any altercations with riders of motorbikes and he had not been in a collision with a motorbike.[93] Further the clear evidence of Mr Pearton is he did not see the motorbike until immediately prior to the collision.

Medical Treatment

56. The inquest also considered the medical treatment received by Kane and specifically the following:

    a) *The effect of the failure to identify the dissection of the left carotid artery on the 27 May 2021; and*
    b) *Any changes in the management of patients with severe multi trauma in the Emergency Department of the LGH since 27 May 2021.*

Summary of the medical treatment Kane received

57. Kane's medical treatment began at the scene of the collision, where he was seen by paramedics employed by Ambulance Tasmania (AT). One of the paramedics who treated Kane was Justin Hoare. He prepared an affidavit[94] and gave oral testimony at the inquest. Upon his arrival at the scene he described Kane as being "*quite agitated*".[95] He explained during his evidence that

[92] See for example exhibits C30 and C30A.
[93] T75 [28]-[41].
[94] Exhibit C33.
[95] Exhibit C33.

Kane was restless, irritable and clearly in a lot of pain, but it was difficult to ascertain whether he was fully alert or was slightly confused.[96]

58. In terms of Kane's injuries, Mr Hoare said Kane had a partially amputated right foot, a fractured right femur, a possible fractured pelvis, a laceration to his right armpit and a haematoma to the centre of his forehead. He described the injuries as very serious, requiring urgent management through pain relief and stabilising of the fractures.[97] The bruise to Kane's head raised questions in relation to a potential head strike.[98] He did not recall that Kane was wearing any protective equipment and he did not remove a helmet from Kane.[99]

59. In order to move and transport Kane to the LGH, he was given morphine and ketamine due to the nature and extent of his injuries. Mr Hoare said Kane was in an altered conscious state upon hand over at the LGH, however this was not unexpected given the amount of analgesia he required to be humanely transported.[100]

60. In the AT report prepared by Mr Hoare[101], next to "Presenting History", Mr Hoare wrote "helmet worn". He explained during the course of his evidence that he asked bystanders at the scene if Kane was wearing a helmet and someone said that he was.[102] Despite this, he had no memory of seeing a helmet at the scene[103], and gave evidence that it was his usual practice (as well as standard ambulance practice) to take the helmet with the patient to the hospital if there is one at the scene, which is done to help the treating medical team with patient care. He outlined that if there was a helmet at the scene, he would have taken it with him.[104] He explained that when he handed Kane over into the care of the Emergency Department at the LGH he advised those staff he was unsure if any protective equipment had been worn because he remained unsure about this despite being told by someone that Kane was wearing a helmet.[105] For this reason, staff at the LGH assumed that Kane was not wearing a helmet, which is what is done for the patient's safety.[106]

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[96] T193 [5]-[9].
[97] Exhibit C33.
[98] T192 [21]-[27].
[99] See exhibit C33 and T192 [16]-[18] and T188 [9]-[13].
[100] T193 [11]-[29].
[101] Exhibit 8A.
[102] T190 [37]-[41].
[103] T190 [33]-[34].
[104] T192 [5]-[18].
[105] T190 [41]-T191 [5].
[106] T308 [39]-T309 [1].

61. Dr Sangeeth Mohan was the emergency medicine consultant who was involved in the care and treatment of Kane at the LGH on 27 May 2021. He prepared an affidavit[107] and gave oral evidence at the inquest. He advised there was a trauma call process initiated prior to Kane's arrival, which involved staff from a large number of specialties being notified to attend the Emergency Department, with each being designated specific roles. As he was the emergency consultant he assumed the role of team leader.[108] Dr Mohan indicated the trauma call process in relation to Kane operated as it should.[109] In addition to the staff who would normally attend a standard trauma call, Dr Mohan arranged for an anaesthetist and an orthopaedics registrar to be present given Kane's specific circumstances, namely the scarring from his childhood burns and his reported injuries from the collision.[110]

62. Dr Mohan outlined that the information the trauma team were provided about the collision at the point of handover was that it was a motorbike crash with a stationary vehicle. Whilst it is clear this information is not factually accurate, Dr Mohan confirmed that the treatment provided to Kane would not have been any different had they been told that it was a motorbike crash with a moving vehicle.[111]

63. Kane's GCS[112] was reported as being 14-15 at the scene[113], and it was then reassessed as 6 in the Emergency Department.[114] During the course of the inquest there was significant focus on the rapid drop in GCS and whether specialists, namely the neurosurgical team in Hobart, should have been consulted.[115]

64. Whilst in the Emergency Department, Kane was intubated and his sedation was maintained. This continued throughout his treatment at the LGH. His sedation occurred initially due to trauma, pain and the administration of medication, then it continued in order to facilitate a number of surgical procedures. This meant however that medical staff who were treating Kane were unable to assess his neurological status via the GCS score.[116] Dr Mohan says at paragraph 92 of his affidavit:

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[107] Exhibit C41.
[108] Exhibit C41 [18].
[109] T307 [27]-[29].
[110] Exhibit C41-affidavit of Dr Sangeeth Mohan [15] and [23] and T309 [34]-T310 [2].
[111] T309 [4]-[20].
[112] See Dr Mohan's evidence at T310 [9]-[29].
[113] Exhibit 8A-AT report and T310 [5]-[7].
[114] T310 [31]-[32]. Also see exhibit C41-affidavit of Dr Mohan at [51].
[115] This issue is considered at [111] onwards.
[116] Exhibit C41-affidavit of Dr Sangeeth Mohan at [52].

"During the emergency management phase there were no available specific findings to confirm an intracranial pathology. Master Leary had received many sedative drugs pre-hospital and he arrived in a comatose state. He was also subsequently placed in an induced coma to facilitate his breathing by a ventilator. These things made it impossible to reliably assess his head and neck condition by physical examination".

65. The oral testimony of Dr Mohan and Dr Coulson at the inquest highlighted that when a patient is in an induced coma treating doctors are reliant on scans and other clinical changes to assess if a patient has suffered brain trauma. Other clinical changes can include dilated pupils and the patient's heart rate dropping too low and blood pressure going up at the same time (Cushings Response).[117] None of these signs were present during the initial phase of Kane's treatment in the Emergency Department.[118]

66. CT scans were performed and after some delay by the radiologist and follow up by Dr Mohan, the following key findings were reported by the radiologist[119] (I note there were 8679 images taken in the CT series of the whole of the body[120]):

    a. There was no intracranial haemorrhage and no acute intracranial trauma;

    b. There was no cervical or lumbar spine fracture;

    c. There was a right sided subcutaneous emphysema along the anterior right chest wall;

    d. There was no vascular injury from the penetrating trauma;

    e. There was no traumatic aortic injury and no mediastinal haematoma;

    f. There was a non-displaced fracture of the right scapula; and

    g. There was a severe pelvic fracture in additional to serious femoral and lower limb injuries.

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[117] T311 [24]-T312 [23], T341 39]-[41]..
[118] T312 [25]-[29].
[119] The radiologist's report list many other findings; see exhibit C6 pages 145-153.
[120] T345 [38]-[40].

67. The images were also reviewed by the treating team including Dr Mohan, the surgical registrar and the orthopaedics registrar. They did not identify anything that was inconsistent with the radiologist's report, however I note they are not specialists in CT interpretation[121].

68. Given the significant injuries to his right lower limb (which included a right lisfranc fracture with vascular compromise of the foot), which may have been lost if surgery was not performed, Kane was transferred to the operating theatre where he underwent corrective surgery.

69. He was then transferred to the Intensive Care Unit (ICU) where he was stable, intubated and sedated.

70. During routine monitoring of Kane at approximately 10:00pm on 28 May 2021, a nurse reported Kane had a fixed dilated pupil. The ICU Registrar, Dr Coulson, arranged for an urgent CT scan to be conducted. The scans demonstrated significant swelling in half the brain.[122] Dr Croswell explained during his evidence that a pupil blowing is caused by compression of the third cranial nerve which in turn is caused by brain swelling[123] and that it's a very late sign of a stroke[124].

71. Dr Coulson contacted the neurosurgical registrar in Hobart, Dr Asad, who indicated he would look at the scans and call her back. Dr Asad reviewed the images and discussed the case with the on call neurosurgical consultant, Dr Peters-Wilkie. The consultant's decision was not to offer surgery because any neurosurgical intervention would not improve Kane's chance of recovery as the neurological injury was irreversible. Dr Coulson says it was requested she discuss the case with the stroke consultant based in Hobart, Dr Dean Jones, who advised after reviewing the CT scans there was a large infarct affecting the middle cerebral artery and likely the anterior cerebral artery and there was no flow in the left internal carotid artery. Dr Jones confirmed the neurological injury was irreversible and even if Kane survived his advice was Kane would be severely disabled and unable to communicate.[125] Dr Asad explained during his testimony at the inquest that a craniectomy, whilst possible, would have not altered his position; that is Kane would still have been left in a permanent vegetative state[126], which I infer is why surgery was not offered. A craniectomy is performed when pressure inside the skull

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[121] Exhibit C41 [75]-affidavit of Dr Sangeeth Mohan and T321 [36]-T322 [6].
[122] Exhibit C42 [3],[4] and [6]-affidavit of Dr Lori Coulson.
[123] T349 [10]-[20].
[124] T 352 [1]-[3].
[125] Exhibit C42-affidavit of Lori Coulson [7]-[9]. See also the LGH records at exhibit C6 page 241.
[126] T424 [32]-[42].

increases in order to avoid the brain herniating and leading to a patient's death. The procedure involves removing part of the patient's skull so the brain can swell instead of causing brain death which occurs when the brain herniates and crushes the brainstem. Dr Asad went on to say that without the brainstem there is no life.[127]

72. Dr Asad gave evidence that the ICU observation charts would have been of assistance to determine if there were any earlier signs of Kane's decline, such as a decrease in his heart rate and/or blood pressure increasing. I therefore adjourned so that Dr Asad could consider the hospital records and advise if these signs were present in the records. On resumption he advised the observation charts were not included in the records provided by the LGH but he did locate a nursing note from 8.20pm on 28 May 2021[128] which indicated an episode of bradycardia; that is a slow heart rate[129], which he said is evidence of Kane's declining state.

73. Ms Baillie was informed about Kane's condition by Dr Coulson in the early hours of 29 May 2021. Dr Coulson advised her Kane had suffered a large stroke and was not expected to survive.[130]

74. By 7.25am on 29 May 2021, both of Kane's pupils were observed to be fixed and dilated, and at 11.42am on 30 May 2021 he was declared brain dead. At 11.10pm on 30 May 2021, Kane's breathing tube was removed and he died shortly afterwards.[131] He was formally pronounced dead on 31 May 2021.[132]

75. An autopsy was conducted by the forensic pathologist Dr Lawrence on 1 June 2021.[133] The autopsy revealed a swollen brain with infarction in the left cerebral artery. In summary Dr Lawrence says Kane died from a stroke following a motorbike collision. He explained that there were four potential causes of the infarction which were as follows:

    a. Damage to the intraosseous portion of the left carotid artery with thrombus formation and embolization;

    b. A limited intraosseous carotid dissection;

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[127] T425 [1]-[34].
[128] Exhibit C6 at page 238. This note also confirms the existence of the ICU charts.
[129] T454.
[130] Exhibit C42-affidavit of Dr Lori Coulson at [12].
[131] Exhibit C42-affidavit of Dr Lori Coulson at [12], [13] and [15].
[132] Exhibit C3-declaration of life extinct completed by Dr Lori Coulson.
[133] His affidavit is exhibit C5.

c. Spasm of the left carotid artery associated with subarachnoid haemorrhage; or

d. Thrombosis in the sagittal sinus.

76. Dr Lawrence explained that while he did not observe a dissection to the carotid artery, he could have dissected the portion of the bone at autopsy which the intraosseous portion of the carotid artery travels through to confirm whether or not there had been a dissection. However this requires extensive dissecting and can be quite disfiguring, so he chose not to do it.[134]

77. The staff specialist interventional neuroradiologist, Dr Hayden Bell, gave evidence at the inquest and provided an affidavit[135]. He was not involved in the treatment or care of Kane. He was asked by Dr Lawrence to review Kane's scans after his death and provide an opinion as to whether the cause of the stroke was visible on the CT scans. He gave oral testimony that he identified a dissection to the left internal carotid artery[136] on the scans from 27 May. He explained that a dissection can narrow the blood vessel movement into the brain, or in some cases it can become a site for blood clots to form. He said it was clear from the scans Kane either had a significant narrowing of the internal carotid artery, or he had a blood clot into the middle cerebral artery of his head. Either way, in his opinion there was clear vessel irregularity to the left internal carotid artery into the head.[137] In this case he says the cause of the dissection would likely have been blunt trauma to the neck, head, chest or torso, but most likely to the area of the neck, associated with some de-acceleration which caused a tear in the blood vessel lining.[138] The injury to Kane's carotid artery does not assist in any determination as to whether or not he was wearing a helmet at the time of the collision, given that the injury was likely caused by blunt trauma to the neck, which could have occurred whether Kane was wearing a helmet or not. This is why I have said my finding that Kane was not wearing a helmet is not a significant finding in this case.[139]

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[134] T273 [15]-T274 [6].
[135] Exhibit C49.
[136] This he said means there has been trauma to the inner lining of the blood vessel wall which has resulted in a tear in the vessel at T462 [20]-[22].
[137] T462 [18]-[31].
[138] T464 [29]-T465 [5].
[139] See paragraph 49.

78. Dr Anthony Bell explained that injuries to the internal carotid artery in general are rare but potentially devastating events.[140] In his extensive career[141] he has never seen the type of injury that Kane sustained in this collision.[142]

79. Following Kane's death, there was a review of the initial CT scans of the head and neck. During the inquest there was a significant focus on the initial scans that were ordered and whether they were sufficient. Additionally, there was a focus on the radiologist's interpretation of the initial scans, and whether there were signs of the injury that led to Kane's death on the initial scans that were not identified by the radiologist.

80. The radiologist who reported on Kane's CT scan on 27 May 2021, did not participate in the inquest. The level of experience and training of that radiologist is unknown.

81. Dr Mohan gave evidence that the LGH uses an after-hours external radiology service called i-telerad who generally report on radiology outside the hours of 8:00am and 4:30pm.[143] The radiologists are based off site, in some cases in other parts of Australia or even abroad.[144] Dr Mohan explained that there is often a delay in obtaining the radiologist's report, as there was in this case, which can impact the treating doctor's ability to care for the patient as it holds up other steps while the treating doctor is waiting for the report.[145] The delay in Kane's case was approximately an hour and a half between the scan and receipt of the report, during which time Dr Mohan made two calls to enquire about the report.[146] It is noted that the delay in the provision of the report in this case could not have adversely affected Kane's outcome as the injury which lead to death was not identified by the reporting radiologist.

The scans

82. During Kane's treatment at the Emergency Department, under the care of Dr Mohan, he was sent for CT scans. The scans were ordered by the Emergency Department registrar number 2 prior to Kane's transport to the LGH, and comprised a CT trauma series scan and CT angiogram

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[140] Exhibit C17-report of Dr Anthony Bell.
[141] Dr Anthony Bell obtained his medical degree in 1975 and a fellowship of the Royal Australian College of Physicians in 1985. He also has a doctorate in medicine and is a fellow of the College of Intensive Care Medicine.
[142] T483 [31]-[33].
[143] Exhibit C41-affidavit of Dr Sangeeth Mohan and T317 [25]-[38].
[144] T319 [14]-[15].
[145] T318 [26]-[31].
[146] Exhibit C41-affidavit of Dr Sangeeth Mohan [74]. In addition it is a receptionist who picks up the phone, Dr Mohan has to leave a message and then the receptionist will call back and connect the radiologist to the call-T379 [22]-[25].

of the lower limbs. The CT trauma series scan is the traditional scan performed for all patients with major trauma. The CT angiogram of the lower limbs was ordered as a result of the significant injuries to Kane's lower limbs and was ordered to assess the state of the arterial blood supply to those limbs.[147]

83. Dr Mohan determined that the scans ordered were insufficient, and when Kane was taken to the CT scan room Dr Mohan requested arterial phase (angiogram) scans of the head, neck and abdomen, in addition to those already requested. Dr Mohan requested the additional scans to specifically rule out a blood vessel injury to the head or neck.[148] Dr Mohan gave evidence that he was concerned that there may be fractures to the neck and underlying injuries to the neck vessels as a result.[149] He employed the Denver criteria which is a guideline used by Emergency Department physicians *"used to determine um steps of further scanning and other management of anyone who has blunt injuries to the neck and head blood vessels specifically. According to that if someone has a GCS of 6 um and you suspect head or neck trauma you have to ask for a[n] angiogram of the head and neck. Um so hence I asked for adding those."* [150]

84. There was some conflicting evidence about whether the most appropriate scans were ordered by Dr Mohan. The Root Cause Analysis (RCA) Team who conducted a review of the care provided to Kane, found that there had been *"incomplete imaging"*[151], however that conclusion appears to be based on a misunderstanding that there were no additional scans requested of the brain and neck over and above the standard trauma series which given the evidence in paragraph 83 is incorrect.

85. The RCA conclusion appears to be based on a misapprehension of the scans that were ordered. According to Dr Mohan, he raised this with the RCA Team following the finalisation of their report, however it does not appear to have been amended.

86. An experienced radiologist, Dr Katie Daniels, gave evidence on the inquest. Dr Daniels was not involved in the treatment or care of Kane. She was engaged during the course of the inquest to review the images from 27 May 2021, and provide a report. She was told Kane died after being involved in a motor vehicle collision when he was the rider of a motorbike.[152] Dr Daniels

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[147] Exhibit C41- affidavit of Dr Sangeeth Mohan [64].
[148] Exhibit C41- affidavit of Dr Sangeeth Mohan [65] and [93].
[149] T315 [10]-[11].
[150] T315 [13]-[19].
[151] Exhibit C31-RCA report at page 10.
[152] Exhibit C46-report of Dr Katie Daniels.

was not informed of the specific cause of death and she also did not review the initial radiologist's report, nor any prior or subsequent imaging.[153]

87. Dr Daniels explained that the field of the CT angiogram that was performed of the neck was unusual, because it did not include the whole brain and stopped just above the Circle of Willis.[154] However, she explained that the CT angiogram scans obtained were the most appropriate to identify the injury to Kane's internal carotid artery, and there were no additional or more appropriate scans that would have identified the injury to that vessel.[155]

88. Therefore instead of there being insufficient or incomplete scans ordered, it seems that the failure to identify the injury to Kane's carotid artery arose from the interpretation and reporting of the images by the i-telerad radiologist.

89. The RCA Team also expressed the view there was a lack of timely and direct communication between the radiologist and Dr Mohan during CT scanning which contributed to incomplete imaging.[156] This conclusion also appears to be based on a misapprehension, as Dr Mohan did directly consult with the radiologist, despite the radiologist being offsite. Dr Mohan gave evidence that he also raised this with the RCA Team, however it did not appear to be amended in the RCA report.[157] Further, as outlined above, whilst the imaging/radiological investigation did not include a CT angiogram of the whole brain, there was a CT angiogram of the neck that captured the area of injury namely the left internal carotid artery.

90. Counsel Assisting submitted that on the totality of the evidence, the scans ordered by Dr Mohan were appropriate in the circumstances, and his decision to verbally request a CT angiogram of the head and neck was based on a well-founded concern about the potential for injuries to Kane's blood vessels in his neck. I agree with that submission.

Interpretation of the scans

91. The radiologist who interpreted Kane's scans on 27 May 2021, reported no abnormalities in the head and neck. As outlined by Dr Anthony Bell, this gave a false sense of security to the

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[153] T495 [7]-[23].
[154] The Circle of Willis is a group of blood vessels in the brain which connect with each other and form a continuous structure that resembles a circle. These arteries supply blood to a large portion of the brain.
[155] T501 [12]-[28].
[156] Exhibit C31-RCA report at page 6.
[157] T384 [15]-[40].

treating clinicians.[158] The report shifted any focus of concern away from Kane's head and neck towards the significant trauma sustained to his right lower limb.

92. For reasons which are not known the radiology report from 27 May 2021, made no mention of the CT angiogram of the neck, despite specifically referring to the other parts of the scan that were done, including for example the CT head and cervical spine without contrast, and the CT of the chest, abdomen and pelvis arterial phase. Dr Daniels gave evidence that radiologists tend to have different styles and while she includes pertinent negatives as well as positive findings in her reports, not all radiologists do. That is she refers to each part of the scan which was done to acknowledge that each part was reviewed and considered.[159] In saying that, both Dr Daniels and Dr Hayden Bell gave evidence that they would expect there to be some reference in the radiologist's report to the CT angiogram of the neck having been performed, as well as a comment on the vessels.[160] It is not known why there was no reference by the radiologist to the CT angiogram of the neck in the report and whether this was because those images were not reviewed, because it was the specific radiologist's style, or for some other unknown reason.

93. Given the significance of Kane's injuries and his need for further surgery, once intubated and sedated, the treating doctors were limited in their ability to conduct neurological examinations and therefore the scans and the interpretation of them assumed paramount importance.

94. A number of medical professionals gave evidence in relation to the initial scans, and whether the injury to Kane's internal carotid injury was visible in those initial scans.

95. Dr Daniel's evidence at the inquest, consistent with her report[161], was that there was an occlusion of the left internal carotid artery[162] which was present on the initial images. This was present in less than 10 of the more than 6,500 images that were obtained from the scans on 27 May 2021.[163] In relation to the images, Dr Daniels explained that the CT angiogram consisted of an enormous block of images with the carotid artery injuries at the start and the eye catching, or obvious, abnormalities to the foot and thigh were at the end of the block of

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[158] Exhibit C17-report of Dr Anthony Bell at page 3.
[159] T502 [24]-[39].
[160] T461 [4]-[28], T502 [32]-[39].
[161] Exhibit C46.
[162] T503 [17]-[19].
[163] T504 [1]-[9].

images.[164] It may be that this lead to some distraction and oversight on the part of the radiologist from i-telerad.

96. In relation to the occlusion of the carotid artery, Dr Daniels gave evidence that this was subtle and was in the terminal segment, over a very short length of around 5mm.[165] She explained in her evidence that the identification of the occlusion was complicated by the fact that the occlusion was at the end of the vessel and there was collateral flow from the other side of the brain. Dr Daniels explained that typically everything distal to the blockage is blocked, however in this case, there was blood getting to the left side of the brain at the time of the scan, and the flow to the brain looked normal.[166] She further explained that had the occlusion been lower down the carotid artery in the neck (which is more commonly seen), or had there not been collateral flow, the injury would have been more obvious.[167]

97. Dr Daniels gave evidence that she would expect a general radiologist of reasonable competence to have identified the injury to the carotid artery from the initial scans[168], particularly given that this type of injury is the main injury that is looked for in CT angiograms of the neck in circumstances where the patient has been involved in a motor vehicle accident. However, she did outline that a carotid artery dissection is an injury that is commonly missed. She explained that in a CT angiogram, radiologists are looking firstly to see if the blood vessels are injured or bleeding, and secondly to see whether the blood vessels are blocked. She explained that where there are injuries or bleeding, there will generally be associated soft tissue injuries, however when there is a blockage, only the blockage will be visible and therefore, not as obvious as injured or bleeding blood vessels.[169]

98. Whilst Dr Daniels identified the blockage, she gave evidence that she could not see the dissection to the carotid artery, but she inferred there was a dissection from the tapered occlusion of the left internal carotid artery.[170]

99. Dr Hayden Bell identified the occlusion and dissection to the left internal carotid artery. It was his view that the injury to Kane's internal carotid artery was present, and indeed obvious on the initial scans, and had been missed by the radiologist. He expressed sympathy for the

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[164] T505 [18]-[22].
[165] T507 [35]-[42].
[166] T513.
[167] T507 [7]-[11], T514 [4]-[9].
[168] As did Dr Hayden Bell; T464 [15]-[17].
[169] T508 [9]-[22], T510 [17]-T511 [10].
[170] T503 [16]-[39].

radiologist reporting on the images noting that there were *"thousands and thousands and thousands"* of images to go through.[171]

100. Dr Mohan and Dr Coulson both gave oral evidence that they could not see the injury to the left carotid artery on the initial scans, however neither are radiologists.[172] Dr Mohan could only identify the injury on the initial scans once he viewed the subsequent scans to identify the general area of the abnormality, which enabled him to then find the injury on the initial scans.[173] Dr Mohan explained the Emergency Department have had educational sessions in relation to Kane's case and no one has been able to identify the injury on the initial scans. He roughly estimated that 25-30 people had reviewed the scans in those sessions and were not able to identify the injury. He explained that this included a sample of senior consultants, registrars and junior doctors.[174]

101. Dr Asad said in evidence he did not identify an occlusion or a dissection to the left internal carotid artery, however he suspected a base of skull fracture. He said he suspected the fracture was at the base of the skull where the blood vessels traverse and he thought this had led to the evolution of an ischaemic stroke which led to *"whole brain infarction on the left side."* [175] It is noted that no other medical professional that gave evidence on the inquest identified a skull fracture including the interventional neuroradiologist, Dr Hayden Bell who said he was not convinced there was a skull fracture but he did not think it mattered because you do not need a skull fracture to have a dissection.[176] A skull fracture was also not identified by Dr Lawrence during the autopsy.[177] Importantly, Dr Asad gave evidence that he would expect 5 out of 10 people to miss the injury to Kane's carotid artery.[178]

102. Dr Anthony Bell opined in his report[179] that the radiological interpretation of the initial CT scan of the brain was difficult. He explained in oral testimony at the inquest that he thought the interpretation of the images would have been difficult for a non-specialist radiologist and he

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[171] T462 [40]-T463 [8].
[172] Dr Mohan at T321 [36]-T322 [6], and Dr Coulson at T365 [29]-[39].
[173] T389 [36]-[41].
[174] T389 [42]-T390 [21].
[175] T420[20]-[42].
[176] T464 [19]-[27].
[177] Exhibit C5-affidavit of Dr Christopher Lawrence. The closest one gets is a fracture to the left orbital plate; see page 8. The orbital plate is a triangular-shaped bony plate that makes up the roof of the orbital eye socket. The two orbital plates, one on each side, are separated from each other by an ethmoidal notch in the middle.
[178] T421[25]-[28].
[179] Exhibit C17.

thought it would be hard for a general radiologist but he did not know the standard of the radiologist who reported in this case.[180]

Effect of the failure to identify the injury and options available had the injury been initially identified

103. If the injury to Kane's carotid artery had been identified by the radiologist in the report provided with respect to the scans on 27 May 2021, it appears likely that treatment would have been offered, as Kane had not at that stage suffered an irreversible neurological injury.[181]

104. As outlined by Dr Hayden Bell in his evidence, had he been consulted after the initial scans on 27 May 2021, he would have requested a CT perfusion scan. This would provide an estimate of the portion of established stroke versus the salvageable brain.[182] He said there did not appear to be any established stroke on the CT scans from 27 May 2021, so he would expect the CT perfusion, if performed, to have been favourable, and if this was the case he would have offered treatment. He described that it was almost impossible to estimate the window of time between the initial scans and when he would still offer treatment, although he said Kane had good collateral supply, and some patients can last hours and hours before there is an established stroke to the extent that would mean the CT perfusion scan was not favourable, and treatment would not be offered. He said people based in Launceston are therefore not precluded from being transported to Hobart so that an endovascular clot retrieval can be performed. There may therefore be a number of hours between the initial scanning taking place and the suffering of an irreversible neurological injury caused by a stroke.[183]

105. Dr Asad gave evidence that it takes a number of hours before the brain injury becomes irreversible. He estimated there is approximately a six to eight hour window from the incident for the brain to still be salvageable.[184] He said this window is approximately eight to ten hours in a young patient, such as Kane. He explained that young patients have more blood flowing through the brain and the vessels are not narrow because of ageing, hence the additional time. He explained he would expect that within these timeframes, treatment would have been offered, and he hoped the treatment would be successful, however he could not guarantee the treatment would be successful.[185]

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[180] T486 [1]-[23].
[181] Dr Hayden Bell at T465 [11].
[182] T465 [21]-[25].
[183] T465 [40]-T466 [34].
[184] T428 [34]-[36].
[185] T429.

106. Dr Hayden Bell explained that the treatment offered would have been an endovascular clot retrieval, which involves guiding catheters through the femoral artery in the leg, through the aorta, chest, and into the internal carotid arteries into the neck until the site of the occlusion is reached. He explained that the procedure then involves deploying a stent retriever to catch the clot, and then you use a microcatheter, which provides suction, to pull the clot out and restore perfusion to that side of the brain. If there was still narrowing of the carotid artery after the endovascular clot retrieval, Dr Bell explained that he probably would have put a stent in to keep the vessel open. Open surgery would not have been an option for this type of injury.[186]

107. Dr Hayden Bell gave evidence that the risk of death from this procedure is very rare and he had seen it in probably less than 1% of cases. He described that another risk is the procedure can cause a distal stroke, which occurs in less than 5% of patients, and is reduced in cases involving young patients.[187]

108. In relation to the treatment that may have been offered, this could not have occurred at the LGH because there are no neurosurgical services there.[188] Consequently, Kane would have required transportation to Hobart for neurosurgical intervention.[189] A number of doctors gave evidence at the inquest about how long transport from Launceston to Hobart would ordinarily take. It appears that the transport time would take between 40 minutes and two hours, depending on the circumstances.[190]

109. I note Kane had significant injuries to his right lower limb which required surgery which commenced on 27 May 2021, and concluded on 28 May 2021.[191] Despite this, Dr Hayden Bell and Dr Asad both stressed that the brain is the first priority, and that had the injury to the carotid artery been identified, the treatment of the orthopaedic injuries could wait.[192] Dr Lawrence also said he would only expect the orthopaedic injuries to cause death if they were left untreated for a long period of time.[193]

110. Ultimately Kane's chances of survival with a return to full function, had the injury to his internal carotid artery been identified in the initial scans on 27 May 2021, is speculative. That

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[186] T466 [40]-T467 [23].
[187] T467 [26]-T468 [8].
[188] T416 [34]-T417 [10].
[189] Or, according to Dr Lawrence at T280 [32]-[34], occasionally to Melbourne.
[190] T426 [38]-T427 [4].
[191] See the hospital records at C6.
[192] Dr Hayden Bell at T468 [10]-[20] and Dr Asad at T441 [1]-[9].
[193] T278 [39]-T279 [2].

said had the injury to his internal carotid artery been identified I find it is probable treatment would have been offered, and the risk of death and/or stroke associated with the proposed treatment is low.

Rapid drop in GCS and consultation with the neurosurgical team

111. As indicated above, Kane's GCS was reported as being 14-15 at the scene of the collision, and it was then reassessed as 6 by the time he arrived at the Emergency Department. Treating paramedic, Justin Hoare, gave evidence that Kane was in an altered conscious state, but that this was not unexpected given the amount of analgesia he required to be transported. This included morphine and ketamine.[194]

112. Dr Mohan explained that a score of 6 is very concerning, and it can be consistent with trauma to the brain, but it can equally be explained by the multiple medications that were administered to Kane by paramedics for pain management.[195] Similarly, Dr Croswell gave evidence that the drop in GCS was the expected outcome of the medications that Kane was given.[196]

113. Despite this, Dr Anthony Bell gave evidence that he did not think the rapid drop in GCS could be explained by the administration of analgesia by paramedics because although you could induce such a fall by administering analgesia if you gave Kane enough Dr Bell did not think it was within the protocols of AT to administer that much. I do not accept Dr Bell's evidence on this point as the evidence of Drs. Mohan, Croswell and Lawrence is to the contrary.

114. There was conflicting evidence at the inquest as to whether the neurosurgical team in Hobart should have been consulted upon Kane's presentation at the LGH given his rapid drop in GCS.

115. Dr Mohan gave evidence that he would have contacted the neurosurgical team if the injury to Kane's internal carotid had been identified by the radiologist from the scans, but that in his opinion, there was nothing on first presentation that indicated to him that he should contact the neurosurgical team.[197]

116. The RCA contains a recommendation that there be a request to the Statewide Trauma Service to update the trauma protocol and include direction on when a clinician is required to contact

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[194] See paragraph 59.
[195] T310 [34]-T311 [15]. Dr Lawrence agreed at T285 [26]-[30].
[196] T352 [27]-[41].
[197] T378 [29]-T378 [8].

a tertiary referral centre.[198] The reasoning behind this recommendation was the lack of communication between the Emergency Department and the neurosurgical team in Hobart, which was described in the RCA as a missed opportunity for specialist advice. Dr Croswell gave evidence that the recommendation was made envisioning that anyone with a head injury and decreased GCS should be discussed with the Neurosurgical Registrar. Despite this, Dr Croswell said that he did not think the recommendation would have changed the outcome in Kane's case because the use of sedatives made the assessment of his GCS difficult and the drop in GCS was the expected outcome from the medications.[199] This was compounded because of the other *"distracting injuries"* Kane had suffered.[200]

117. Dr Hayden Bell, Dr Anthony Bell and Dr Asad[201] all shared the view that there should have been consultation with the neurosurgical team. This was contrary to the evidence of Dr Mohan and Dr Croswell.[202] Dr Asad expressed his disappointment to Dr Coulson on 28 May 2021 that the neurosurgical team were not consulted earlier[203], and he reiterated this disappointment while giving evidence at the inquest.[204]

118. Whilst Dr Asad accepted that the medication administered by paramedics might have explained the rapid drop in GCS, he said that given the concern of the treating clinicians about possible head trauma, combined with the scalp haematoma and the low GCS, this should have rung alarm bells and resulted in a call to the neurosurgical team. He expressed the view that consultation should have occurred at the time of the CT scan, which would have enabled review of the CT imaging that was ultimately performed by he and the neurosurgeon Mr Peters-Wilke when it was too late. He believed the treating clinicians were distracted by Kane's limb injuries.[205]

119. Dr Asad reiterated during his evidence at the inquest that this would have just meant a simple call. He explained that the LGH rang very frequently for advice but sometimes they did not ring because there was a lack of understanding or criticality which can be caused due to lack of exposure to conditions of the nature suffered by Kane.[206]

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[198] Exhibit C31-RCA page 14.
[199] T341 [34]-T342 [2].
[200] T340 [11]-[25].
[201] Dr Hayden Bell T468 [22]-[29], Dr Anthony Bell at T485 [1]-[7], and Dr Asad at T422 [5]-[16] and T434 [31]-[42].
[202] Dr Mohan at T378 [29]-T379 [8] and Dr Croswell at T354.
[203] Exhibit C6-the records of the RHH, at page 240.
[204] T421 [40]-T422 [3] and T426 [1]-[4].
[205] T437 [4]-[5] and T434 [22]-T435 [13].
[206] T433 [8]-[28].

120. Dr Croswell gave evidence that the LGH has direct access to the neurosurgical registrar at the Royal Hobart Hospital and they are usually very contactable, however he said as it was a very busy speciality they tend to only ring for things that *"definitely"* need neurosurgical input.[207]

121. Despite being a busy specialty, the neurosurgical team in Hobart is available and accessible to the LGH. Given the evidence of Dr Hayden Bell, Dr Anthony Bell and Dr Asad it is my view that the service should be utilised in cases such as Kane's, where a patient presents with multi-system trauma from a motorbike or motor vehicle collision and there is a rapid drop in GCS, even if the drop is GCS could be explained by the administration of analgesia. In addition in this case the clinicians had an additional fact that it was unclear whether or not Kane was wearing a helmet. While I accept this could ultimately result in a higher workload for the neurosurgical team, it could also lead to the early identification of life threatening injuries that could be treated if the injury is identified at an early stage. Consultation with the neurosurgical team should not be limited to situations that definitely require neurosurgical input. This view is only reinforced by the fact that Dr Asad said in his experience he has received calls from the LGH when a patient only presents with a headache. Consultation should occur even in situations where there is uncertainty about whether neurosurgical input is required, out of an abundance of caution.

122. It is clear that there was initial concern regarding the vessels in Kane's neck by Dr Mohan.[208] This is highlighted by the fact Dr Mohan requested arterial phase (angiogram) scans of the head, neck and abdomen, in addition to the traditional CT trauma series that had already been requested. Early consultation and advice from the neurosurgical team in Hobart in this case would have almost certainly resulted in the injury to Kane's carotid artery being identified on the initial scans by neurosurgical specialists, even if the injury was not identified by the general radiologist reviewing the images and providing the report.

123. As a result of the conclusion in paragraph 122 I **recommend** that the LGH update the trauma protocol and implement guidelines that provide direction on when a clinician at the LGH is required to consult the neurosurgical team in Hobart. These guidelines should stress that consultation even when there is only minor suspicion of head trauma is desirable.

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[207] T353 [1]-[8].
[208] T315 [10]-[19].

Changes in the management of patients with severe multi trauma

124. As a result of this case the authors of the RCA made a number of recommendations for the management of patients with severe multi trauma in the Emergency Department.[209] . When this case was heard limited change had been actually implemented however it appears a number of the recommended changes were still in the consultation phase.[210] As explained by Dr Croswell the purpose of an RCA investigation is to identify systems issues that contributed to a safety event; for example a death, that could be altered in order to prevent similar events happening again and to identify other systems issues not related to the safety event but which nonetheless could be improved which would, once implemented, lead to improvements in the delivery of medical care and services.[211] Having considered the recommendations made in the RCA and Dr Croswell's evidence about those recommendations I **recommend** they all be implemented if they have not been implemented to date.

125. One of the recommendations made in the RCA was a diagnostic imaging flowchart for patients with severe trauma. As at 28 February 2023, the flowchart was in draft form, and was being considered by the Statewide Trauma Service. A draft of the flowchart was tendered on the inquest[212]. The rationale for the provision of the flowchart was to prompt treating clinicians to consider ordering a CT angiogram of the neck in cases of significant trauma. Because of Dr Mohan's sound practice, in this case, I note that is one of the additional scans which he ordered. It follows then that in this case the implementation of this flowchart would not have changed the imaging decisions that were made.

126. Another recommendation that was made by the authors of the RCA, as outlined above, was a request to the Statewide Trauma Service to update the trauma protocol and include direction on when contacting a tertiary referral centre is required. The reasoning behind this recommendation was the lack of communication between the Emergency Department and the neurosurgical team in Hobart, which, as I have noted, was described in the RCA as a missed opportunity for specialist advice. It is not known by me whether this recommendation has been implemented, however as outlined above, I have made that recommendation in paragraph 123.

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[209] See Exhibit C31.
[210] T343 [22]-[42].
[211] Exhibit C43-affidavit of Dr Ashley Croswell at [11] on page 5.
[212] Exhibit C41A.

127. In relation to changes that had been implemented, Dr Mohan gave evidence that the knowledge and awareness of blunt cerebral vascular injuries has increased significantly amongst staff within the Emergency Department at the LGH.[213] He explained that given the heightened awareness, there are more instances where angiograms of the brain and neck are being ordered, despite the fact that they are not routine scans in trauma. He did however highlight that there is some resistance to these scans by radiographers and radiologists, given that it increases their workload and can lead to longer delays. While this is not a formal change in policy or procedure[214], the increased awareness of the injury suffered by Kane is a positive development.

128. Dr Mohan also explained that as a result of this case, there is increased caution being taken in relation to trusting the contents of the radiology reports. He advised this is a topic they have discussed as a Department at meetings, the result of which has been the development of an attitude that a radiology report is not to be trusted straight away; more questions should be asked about its contents.[215]

After hours radiological services at the LGH

129. The use of radiologists who are not on site at the LGH between the hours of 4:30pm and 8:00am and the difficulties that creates are described in paragraph 81. If the radiologist on site has to report on scans and perform interventional radiology procedures during the day then they will determine how many scans they can report on and how many will be interpreted and reported on offsite. I-telerad may therefore be used prior to 4:30pm if the onsite radiologist is too busy.[216] At the time he gave evidence Dr Mohan said he had worked at the LGH for four years and the use of an after hours radiology service has been in place for as long as he has been working there.[217]

130. Dr Mohan indicated he would prefer to have someone onsite after hours[218] because he would receive reports faster particularly in cases involving an emergency like this one.[219] He also said:

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[213] T377 [41]-T378 [12].
[214] T391 [12]-[34].
[215] T392 [4]-[5].
[216] T317 [22]- [38].
[217] T318 [40]-[41].
[218] T319 [1]-[4].
[219] T320 [15]-[22].

"Ah instead of calling them we can actually just walk around, because radiology's just round the back and talk to them in person and they would often, if if we go there just open the computer and have a look at it right then. They won't let us wait."[220]

131. So not only would the delay be reduced the subsequent systems issues described in paragraph 81 may well be reduced. This would have been very important in a case such as this one.

132. Dr Mohan explained during normal hours there was one radiologist and one registrar in radiology rostered on. He acknowledged the problems he outlined might be corrected if more were employed but he said radiologists were hard to get. Not only will the problems identified by Dr Mohan be solved or at least improved, perhaps more importantly, the THS would have some control over the quality of the radiological reports being produced. As things presently stand there appears to be no quality control because nothing is known about the experience and/or qualifications of the radiologists interpreting scans at the LGH after hours. This is particularly important, as this case proves, because the evidence is that a radiologist of reasonable competence should have detected the injury which ultimately led to Kane's death.

133. While I acknowledge recruiting medical specialists is difficult due to the numbers of doctors qualifying and practising in a specific field such as radiology the difficulties identified by Dr Mohan could be overcome if the THS was prepared to pay attractive and competitive salaries for such staff. It stands to reason if a radiologist has the choice of accepting a number of positions she or he may well choose to accept a position at the LGH if the terms and conditions of employment are commensurate with or better than those being offered by other hospitals.

134. I therefore **recommend** the THS consider and explore whether the delivery of medical services could be improved by the employment of more radiologists during normal hours and in-house radiologists after hours. It seems to me that this case demonstrates the delivery of medical services could be improved if more radiologists were employed.

Additional matters

135. In a number of written documents tendered on the inquest, Ms Baillie raised concerns about her treatment by staff at the LGH and members of Tasmania Police. These are not matters a

[220] T320 [30]-[35].

Coroner has any statutory power over and are not relevant to what I must consider under s 28 of the Act. Accordingly, the appropriate pathway for Ms Baillie to raise these concerns is by way of formal complaints to the relevant Departments. As I understand it she has already made formal complaints. How they are dealt with is matter for the THS and Tasmania Police.

Conclusions

136. Kane's conduct in driving a motorbike at night without appropriate lighting led to the collision with Mr Pearton's utility. The responsibility for the collision lies with Kane. Mr Pearton cannot be expected to avoid a collision with an object he cannot see.

137. The nature and extent of Kane's injuries made his treatment and care at the LGH particularly difficult.

138. Unfortunately, the injury to his left internal carotid injury was not detected by the reporting radiologist from the scans conducted on 27 May 2021. This was not as a consequence of insufficient scans being ordered. Instead it was as a result of the injury not being identified by the radiologist on the CT angiogram images of Kane's neck. Whether this was due to inexperience, time pressures, oversight or some other reason is not known.

139. Regrettably, there was no consultation between the LGH and the neurosurgical team at the RHH in Hobart until Kane had already suffered an irreversible neurological injury. As I have indicated above my view is, in the circumstances of this case, the neurosurgical unit at the RHH should have been consulted when the results of the scans were first known.

140. Had the injury been detected, it is likely that treatment in the form of endovascular clot retrieval would have been recommended. The treatment, if performed, would have given Kane at least a chance of survival. Given what transpired Kane was never afforded that chance.

Comments and Recommendations

141. My formal findings in this matter appear in paragraph 3.

142. For the reasons outlined above I repeat the **recommendations** made in paragraphs 123, 124 and 134.

143. I acknowledge and thank First Class Constable Nigel Housego for his thorough investigation.

144. I thank both counsel, Mrs Brett, and Ms Baumeler, for their assistance and their submissions in this matter.

145. The finalisation of this matter was delayed by the intervention of the Honourable the Attorney General as explained on page 5. Given that intervention I note with some surprise that prior to Wood J's judgment being delivered I received affidavits from three doctors from the THS who, in addition to two others, gave evidence at the inquest. None of those doctors were represented by counsel from the OOSG which is again surprising given lawyers in that office had attempted to prevent me from summonsing the doctors in the first place. I place on the record that each of those doctors was very helpful in the evidence they provided both by way of affidavit and in their oral evidence at the inquest. I therefore sincerely thank each of them for their valuable assistance. Without their evidence I would not have been able to perform my statutory duties which are set out in s28 of the Act.

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

Dated: 27 March 2024 at Hobart in the State of Tasmania.

Robert Webster
Coroner