



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Jordan Jackson Kiley

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

- a) The identity of the deceased is Jordan Jackson Kiley (“Jordan”);
- b) Jordan died as a result of injuries from a single vehicle motorcycle crash;
- c) The cause of death was blunt injuries of head, neck and chest; and
- d) Jordan died on 27 March 2019 at Rosetta, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Jordan Jackson Kiley’s death. The evidence comprises the Police Report of Death; a report prepared by Crash Investigation Services; an opinion of the forensic pathologist who conducted the autopsy; opinion of a transport inspector regarding the condition of the motorcycle; toxicological evidence; police and witness affidavits; medical records and reports; and forensic evidence.

Jordan was born on 19 May 2001 and was aged 17 years at the time of his death. He was the only child of Karleen Jackson and Jason Kiley. He was undertaking his year 12 studies at Claremont College. He was healthy and had no history of medical conditions.

Jordan was the holder of a learner’s permit for motorcycles and a provisional licence for vehicles. He was the owner of a Honda 125cc motorcycle (registration number A651U).

On Wednesday 27 March 2019 Jordan attended Claremont College. He rode his motorcycle to school, as was his usual practice. He left the school premises at an unknown time during a free period, an event that was not unusual for the college students. He was travelling in the direction of his home in Glenorchy. It is unclear whether Jordan was intending to go home or was travelling to another unknown destination.

At approximately 10.30am, Rachell Robinson was driving from Claremont College to Glenorchy Bunnings with Christopher Weeding as her passenger, both having also left school on a free period.

Ms Robinson was travelling south on Main Road, Claremont towards Glenorchy. In her affidavit for the investigation she stated that she noticed a motorcycle behind her. She recognised it from school but was unfamiliar with who it belonged to. Mr Weeding, in his affidavit, said that he knew Jordan from school and that he was able to observe Jordan's face in a helmet due to his proximity to their vehicle and that he recognised him from school.

Ms Robinson stated that the motorcycle was travelling at a close distance, being approximately 2 metres behind her vehicle. At the time, Ms Robinson expressed concern to Mr Weeding about this close distance. She said in her affidavit that she was afraid to use her brake, fearing that the rider would crash into the back of her vehicle.

Ms Robinson continued under the highway overpass to remain on Main Road, stopping to give way to traffic. The motorcycle continued around a slight left hand bend towards the highway and Strathaven Drive.

Ms Robinson noted that the motorcycle appeared to be accelerating and estimated it to be travelling at approximately 90km/h. She stated that the rider was close to the gutter on the inside of the kerb and that the rear tyre appeared to be sliding out from underneath him.

Mr Weeding said that he observed the motorcycle swerving slightly from side to side as it started to manoeuvre around the left hand bend. Mr Weeding, also a motorcycle rider, stated that it appeared to him that the rider was manoeuvring the motorcycle in this way in order to warm up its tyres.

Ms Robinson completed her turn and emerged from the underpass. However, she was no longer able to see the motorcycle.

At 10.45am Police were notified of a single vehicle crash on Strathaven Drive in Rosetta.

Police officers immediately attended the scene and observed a male person (who they ascertained through records as being Jordan) laying on the footpath behind the Armco railing. CPR was being performed on Jordan by three males at that time. Constable Luke Bratt took over chest compressions to relieve one of the males. Whilst performing chest compressions blood began to flow from Jordan's mouth and nose. Paramedics arrived and took over treatment. However, Jordan was unable to be saved and was pronounced deceased at the scene. He was conveyed by mortuary ambulance to the mortuary at the Royal Hobart Hospital.

An autopsy was performed upon Jordan's body by forensic pathologist, Dr Donald Ritchey. At autopsy Dr Ritchey noted multiple traumatic injuries of the head and chest. He noted that these injuries would have resulted in near instantaneous death. Toxicological testing of samples of Jordan's blood taken at autopsy did not reveal the presence of any illicit substances, medications or alcohol which may have impaired Jordan's driving. In Dr Ritchey's opinion the cause of death was blunt injuries of the head, neck and chest. I accept his opinion.

As part of the coronial investigation, a report was prepared by Transport Inspector, Mr Jason Hardy. During the inspection, Mr Hardy noted that the rear brake assembly had been over-adjusted at some point prior to impact resulting in the rear brake 'dragging' and thereby resulting in a significant loss of power and the vehicle requiring additional throttle application at low RPM operation to avoid the vehicle stalling when any gear was selected. However, Mr Hardy was unable to conclude whether the brake adjustment contributed to the incident. The motorcycle was otherwise in a well maintained and roadworthy condition.

An analysis of the crash was completed by Sergeant Luke Walker of Southern District Crash Investigation Services. Sergeant Walker, who analysed the evidence from the scene, concluded that the road surface at the time of the crash was dry and in good condition and did not contribute to the crash. The debris located indicated that there was no involvement of any other person or vehicle. He concluded that, whilst negotiating a sweeping right hand bend in a southerly direction on Strathaven Drive, Jordan lost control of his motorcycle and crashed into the Armco railing. His body struck the railing, was ejected over it and landed on the concrete footpath. There was no evidence to suggest Jordan took any form of evasive action or was at any stage under maximum braking.

There was no clear evidence available to Sergeant Walker to calculate the speed of travel before the crash, although the scene evidence tended to indicate that Jordan was not travelling at high speed. I note that while Ms Robinson and Mr Weeding provided evidence that they observed Jordan to be travelling at a greater speed than the limit of 60 km/h, they themselves are inexperienced drivers and are therefore likely to have little, if any, experience in estimating speed.

Jordan obtained his learner's permit in January 2019. He was involved in three crashes since that time. In each instance the crashes only involved Jordan and were the result of driver error; they do not appear to have been caused by the involvement of any other persons or external factors. In each instance Jordan told his mother that he had lost control of his motorcycle.

Ms Jackson stated that Jordan told her that he learnt from his crashes. She also stated that he was focused on becoming a more experienced rider and would go for rides on different types of roads and terrains to gain experience, and also watch YouTube videos on how to be a safer rider. Despite these efforts, Jordan remained an inexperienced rider who struggled to safely control his motorcycle.

Although it is quite possible that Jordan was travelling at a higher speed than the speed limit before his crash, the clear evidence from the witnesses observing him indicates that the main contributing factor in the crash was Jordan's inability to safely control the motorcycle. It is unlikely that the over-adjusted rear brake assembly played any part in the crash.

I am satisfied on the evidence that, most tragically, Jordan died as a result of loss of control of his motorcycle whilst negotiating a sweeping turn.

Comments and Recommendations

I extend my appreciation to investigating officer Constable Toby Skeels for his investigation and report, and also to Sergeant Luke Walker for his crash investigation report.

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

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

Dated: 2 March 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner