Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Brett Jason Greaves

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

a) The identity of the deceased is Brett Jason Greaves;
b) Mr Greaves died as a result of injuries received in a motor cycle crash;
c) The cause of Mr Greaves’ death was blunt force trauma; and
d) Mr Greaves died on 13 January 2017 on Lake Leake Road, approximately 24 kilometres east of Campbell Town, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Greaves’ death. The evidence comprises an opinion of the pathologist who conducted the autopsy; relevant police and witness affidavits; results of toxicological analysis of samples taken at autopsy; and forensic and photographic evidence. Although Mr Greaves died as the result of injuries received in a motor cycle crash no evidence was available to me from a specialist road traffic crash investigator.

I am satisfied that Mr Greaves died as a result of injuries sustained by him in a motorcycle crash which likely occurred at approximately 7.00pm on 13 January 2017. No witness or witnesses to the crash have been identified. Mr Greaves, who had been riding his Harley Davidson motor cycle on a tour of Tasmania with a group of interstate riders, was noticed by members of his party to be missing when he did not arrive at Swansea on the east coast of Tasmania (the group having left Campbell Town and travelled east along the Lake Leake Road).

Concerned for his wellbeing, members of his party contacted police and retraced their route, looking for Mr Greaves. His body and motorcycle were located by a member of
his group at approximately 8.20pm, roughly 24 kilometres east of Campbell Town by the side of the Lake Leake Road. Police attended the scene, including uniform officers from Swansea and Campbell Town, the Northern duty Inspector and an officer from Forensics Services. However, no officer from Tasmania Police Crash Investigation Services (CIS) was tasked to attend.

Mr Greaves' body and the site of the crash were photographed. After preliminary inquiries at the crash scene his body was removed from the side of the road and transported by mortuary ambulance to the Launceston General Hospital. At the hospital, after formal identification, an autopsy was carried out on his body. Mr Greaves was found to have suffered multiple injuries and the pathologist who conducted the autopsy expressed the opinion, which I accept, that the cause of his death was blunt force trauma. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. The results of that analysis revealed the presence of an inactive metabolite of cannabis but not at a level such as to cause any riding impairment. No other drugs, licit or illicit, nor alcohol were identified as being present in those samples.

Mr Greaves’ motorcycle was inspected by a Transport Inspector. The inspector expressed the opinion, which I accept, that the motorcycle did not have any defects prior to the crash which could have caused or contributed to the happening of the crash.

The area of road where the crash occurred was sealed and reportedly in good repair. Specifically, there were no potholes or road defects or any other hazards prior to the crash site on the western side. The crash occurred on a sweeping downhill right hand curve. Just prior to the crash site is an advisory road sign advising motorists that they are approaching a right hand bend.

The weather conditions at the time of the crash were clear and fine. The road surface appears to have been dry.

I am satisfied that road conditions, weather and mechanical defects did not cause or contribute to the crash.
In the absence of any evidence from an officer of CIS or similarly qualified expert, I can make no assessment as to the likely speed Mr Greaves was riding his motorcycle in the immediate lead up to the crash.

In the absence of any evidence from an officer of CIS or other similarly qualified expert, I can reach no conclusion as to the likely involvement of any other vehicle in the crash which caused Mr Greaves’ death.

Comments and Recommendations

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

A coroner is authorised by the Coroners Act 1995 to make recommendations or comment in appropriate circumstances (see section 28 (2) and (3)).

I have already noted earlier in this finding the fact that no officer from Tasmania Police CIS attended the crash scene, or carried out any enquiries in respect of Mr Greaves’ death. The attendance of officers from that Service is governed by the Tasmania Police Manual. The manual relevantly provides:

“1.37.11 CRASH INVESTIGATION SERVICES

(1) Unless otherwise stated, Crash Investigation Services (CIS) will attend and investigate:

(a) all fatal traffic crashes on roads and road related areas, except where the crash involves a single crash with a sole occupant who was the driver, unless determined otherwise by a divisional inspector or duty inspector; and

(b) all ‘serious traffic crashes’ where there appears to be serious negligence, dangerous driving, grievous bodily harm, or a serious breach of the traffic or criminal law as determined by an inspector”.

I note that the non-attendance of an officer from CIS on this occasion was not inconsistent with the manual. I also observe that Tasmania Police take the view that
the part of the manual dealing with the attendance of CIS officers is flexible and allows for attending officers to request specialist support if required. However, in my respectful view, in the absence of specialist CIS investigation it is impossible to determine whether a fatal vehicle crash is, in fact, a ‘single crash with a sole occupant who is the driver’ (or in this case, rider). Clearly the involvement of another vehicle cannot be excluded until a complete investigation is carried out. In my view, despite the obvious level of competence displayed by Constable Nolan and the other officers who attended, an officer from CIS ought to have attended this crash and should attend every fatal crash.

Accordingly, I recommend an officer of Tasmania Police Crash Investigation Services attend all fatal motor vehicle or motorcycle crashes.

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

**Dated:** 26 July 2018 at Hobart in Tasmania.

**Simon Cooper**  
**Coroner**