Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Christopher Mark Best

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

a) The identity of the deceased is Christopher Mark Best;
b) Mr Best died in the circumstances set out in the below finding;
c) The cause of death was traumatic pulmonary artery rupture as a result of a motorcycle crash; and
d) Mr Best died on 21 December 2017 at Deloraine, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Best’s death. The evidence comprises an opinion of the pathologist who conducted the autopsy; police and witness affidavits; WorkSafe investigation documents and correspondence; medical records and reports; opinion of the crash investigator; and forensic evidence.

Mr Best was born in Launceston on 5 January 1959 and was aged 58 years at his death. He was married to Mrs Tania Best. There are three adult children to the marriage. Mr Best lived and worked on a farm in Deloraine. Initially belonging to his father, Mr Best took over the farm about 10 years before his death when his father could no longer run it. The property comprises approximately 500 acres and is run as an Angus beef stud. Mr Best also maintained a building business while running the farm. In his affidavit for the investigation, Mr Best’s son, Cody Best (“Cody”), stated that his father worked 12 hours per day.

Medical records provided for the investigation by the Deloraine Medical Centre indicate that Mr Best had been regularly treated for several long-term conditions including heart palpitations, presyncope (light headedness and fainting), profound insomnia, back injuries and arthritis. He was prescribed a number of medications.

On 21 December 2017, Mr Best had awoken at 6.30am and spent time with his first grandchild. He then left the house at about 8.30am and rode his 2007 Honda CRF 150 motorcycle onto the farm to move cattle. Mrs Best had left and returned to the house several times during the day and did not see or hear from her husband during this time. She asked Cody whether he had seen his father each time she returned to the house and he had told her that he had not. After 3.00pm, Mrs Best returned home following
her last outing and became concerned when she saw the motorcycle was not at the house. Cody then went to look for his father. At 3.50pm, Cody found his father lying deceased near a gate on the farm. Both the motorcycle and gate had been damaged.

On 22 December 2017 an autopsy was performed upon Mr Best by pathologist, Dr Rosanne Devadas. In her report, Dr Devadas states:

‘It is my opinion that this 58 year old man…died as a consequence of cardiac tamponade due to a massive haemopericardium. The cause of this appears to be rupture of the pulmonary trunk, most likely as a result of blunt trauma to the chest area sustained in a motorcycle accident in which he collided into a closed farm gate. Other injuries include lung contusions, minor skin abrasions and some evidence of traumatic brain injury. From the crash investigator’s report, it appears the decedent made no attempt to avoid the gate or stop the motorcycle prior to impact. This suggests the decedent may not have been conscious prior to the accident.’

‘The decedent had a past history of recurrent presyncopal and syncopal episodes associated with palpitations. Investigations by a cardiologist revealed evidence of neurocardiogenic or vasovagal syncope. Neurogenic syncope is a disorder of the autonomic regulation of postural tone, which results in low blood pressure, a slow heart rate and loss of consciousness. A wide variety of stimuli can trigger this reflex.’

I accept Dr Devadas’ opinion as to the cause of death.

In his comprehensive report for the investigation, based upon his analysis of the scene and all documentary evidence, crash investigator First Class Constable Nigel Housego concluded the following:

1. The motorcycle ridden by Mr Best at the time of the crash was not constructed to be used on public streets.

2. The motorcycle had no brakes and the throttle would remain in any position to which it was moved and not return to idle without rider input. For these reasons, it was not roadworthy or safe.

3. Mr Best was not wearing any form of helmet or gloves. However, he suffered internal chest injuries and the wearing of a helmet would not have prevented these fatal injuries.

4. Mr Best did not have alcohol or illicit drugs in his body at the time of the crash.

5. Mr Best was not using his mobile phone at the time and likely had both hands on the handle grips.

6. The weather and road conditions did not contribute to the crash.
7. The crash occurred at a low speed of around 30km/h.

I accept these conclusions.

Based upon the scene analysis conducted by Constable Housego, I find that Mr Best took no action to stop the motorcycle prior to reaching the gate. The motorcycle had no working brakes and a sticking throttle. Had Mr Best been distracted or suffering some form of medical event, the lack of brakes and sticking throttle would have caused the motorcycle to continue, without deceleration, into the gate. Mr Best was required to deliberately turn the throttle back and brake by changing down through the gears or placing his feet onto the ground to cause the motorcycle to come to a stop. This did not occur.

The most likely reason for the crash is that Mr Best suffered a neurocardiogenic syncope, (a temporary loss of consciousness due to a heart condition), while riding toward the gate, preventing him from taking the required action to stop the motorcycle. The impact with the gate was sufficiently forceful to cause Mr Best to suffer the fatal injuries. The evidence suggests that Mr Best attempted to dial his home number after the crash before he lost consciousness.

I consider the possibility of a distraction less likely due to Mr Best’s awareness of the motorcycle defects and knowledge of the location of the gate he was approaching.

Comments and Recommendations

In the investigation, I received a publication from WorkSafe Tasmania entitled Use of Motorbikes on Private Property. This publication provides assistance to the public in relation to the dangers of riding unsafe motorcycles on private properties. Relevantly, the publication includes the following recommendations:

- ‘Follow the regular maintenance programme from the operator’s manual, especially for brakes, footrests and controls;’
- ‘Conduct a pre-ride inspection every time you get on the motorbike. Check tyres, light-bulbs, chain-drive, mirrors, brakes, clutch, throttle, fuel and oil;’
- ‘After use remove any foreign material from in and around engine parts; and
- ‘Check for damage and, if found, take action to fix the damage or report it to the owner.’

Had Mr Best followed the above advice, he may not have had the crash that, very sadly, resulted in his death. In particular, I note that after Mr Best’s death the transport inspector removed debris from the throttle mechanism and then found it to operate correctly.
I extend my appreciation to investigating officer First Class Constable Nigel Housego for his investigation and report.

The circumstances of Mr Best’s death are not such as to require me to make any recommendations pursuant to Section 28 of the Coroners Act 1995.

I note that Mr Best died at his workplace of unnatural causes. As such, his death would ordinarily be the subject of a public inquest pursuant to section 24 of the Coroners Act 1995. However, I have received a representation from the senior next of kin, Mrs Best, under section 26A(2) of the Act that she does not seek that an inquest takes place. Further, I am satisfied under section 26A(3) of the Act that it is not contrary to the public interest not to hold an inquest. I therefore decided not to do so.

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

Dated: 29 March 2019 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner