



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 Aidan Denis Saltmarsh

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

- a) The identity of the deceased is Aidan Denis Saltmarsh;
- b) Mr Saltmarsh died as a result of injuries following a motorcycle crash;
- c) The cause of death was multiple injuries; and
- d) Mr Saltmarsh died on 9 December 2017 at Margate, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Saltmarsh's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; police and witness affidavits; medical records and reports; crash investigation report; Professional Standards review; and forensic evidence.

Aidan Denis Saltmarsh was born on 12 March 1981 and was aged 36 at the time of his death. Mr Saltmarsh was married to Gemma Saltmarsh and they have two daughters.

Mr Saltmarsh worked in a variety of occupations during his life. In 2011 Mr Saltmarsh sustained a serious back injury at work which led to him being bed-ridden for a period of time. The injury affected him significantly until his death. He developed depression and used cannabis heavily. Nevertheless, in 2016, he embarked upon a plumbing apprenticeship. His employer and family described his very strong work ethic.

Mr Saltmarsh purchased a Harley Davidson motorcycle in October 2017. According to his wife, he was extremely enthusiastic about the motorcycle and she believed it would give him a great deal of happiness.

In the weeks following the purchase of his motorcycle, Mr Saltmarsh rode it regularly. His best friend, Mr John Thomas, in his affidavit for the investigation, said that Mr Saltmarsh was not a natural rider. Mr Thomas was a very experienced rider and also owned a Harley Davidson. Mr Thomas stated that Mr Saltmarsh would forget “the basics” and he worried about Mr Saltmarsh riding motorcycles. He specifically stated that Mr Saltmarsh would exit corners too widely.

On the morning of 9 December 2017, Mr Saltmarsh took his motorcycle to Richardson Harley Davidson to have a part fitted. He then rode to Sorell and on to New Norfolk. He made contact with a friend, Mr Jamie Lang, and they met later that afternoon at a hotel in Kingston along with Mr Lang’s wife and young son. Mr Lang, in his affidavit for the investigation, said that Mr Saltmarsh only consumed one beer and one scotch whiskey whilst at the hotel.

Mr Saltmarsh left the hotel at about 7.30pm, not returning to his parent’s home until about 8.30pm. His father, in his affidavit for the investigation, observed that his son looked tired when he arrived. A short time later, Mr Saltmarsh received a message from Mr Thomas, who was distressed. Mr Saltmarsh decided to visit Mr Thomas in Snug and left the house on his motorcycle at about 9.30pm.

At approximately 10.00pm two police officers were on mobile patrol travelling north on the Channel Highway at Margate in the vicinity of Meredith’s Orchard. The officers were Constable Steven Fry (driver) and Senior Constable Chloe Carr (passenger).

The officers had their mobile radar device activated at the time and saw a motorcycle (being Mr Saltmarsh) approaching. The radar device indicated that the motorcycle was travelling at a speed of 93km/h in a 60km/h zone. The officers observed the motorcycle pass them travelling south.

Constable Fry executed a U-turn at the junction with Crescent Drive, Margate and travelled south to see if they could locate the motorcycle. They did not see the motorcycle when they turned around.

The officers proceeded to travel south to determine whether they could catch up with the motorcycle. They did not activate lights or sirens. They travelled through the 60km/h zone and accelerated once they reached the 80km/h zone near the junction with Gemalla Road.

Around the area of the Derwent Avenue junction, the officers observed a cloud of dust on a slight to moderate right-hand bend. They then noticed a flashing orange light on an

embankment on the left-hand side of the highway. The officers realised that the flashing lights were the indicators of a motorcycle resting on the grassy verge.

The officers then observed the rider lying on his back in a culvert on the side of the highway, a few metres north of the motorcycle. The rider still had his helmet on, however, it appeared that he had sustained significant injuries. There was severe damage to his chin strap and helmet generally, along with injuries to the left hand side of his body and head. The officers removed the rider's helmet in an attempt to render first aid assistance.

The rider initially made some slight movements but became unresponsive. CPR was commenced at the scene by the officers with the assistance of two people who had come from houses nearby and a nurse who happened to be travelling past.

Tasmania Fire Service officers attended the scene and a defibrillator was used upon Mr Saltmarsh, unfortunately to no avail. Ambulance officers arrived at the scene and declared the rider deceased at 10.42pm.

Checks revealed that the motorcycle was registered to Mr Saltmarsh and his licence was found on his person. His mother subsequently identified him formally.

Forensic and Crash Investigation Services (CIS) officers attended the scene and conducted a full scene examination and survey. In his thorough investigation into the happenings of the crash, Sergeant Rod Carrick of CIS calculated that the motorcycle was travelling at a speed of 97km/h prior to the crash. The permissible maximum speed limit on this section of the road is 80km/h. He observed that it was a dark night with no street or moon lighting and the weather was clear at the time of the crash.

At the scene, Sergeant Carrick noted that skid marks along the roadway surface and damage to the motorcycle were consistent with the rear tyre of the motorcycle entering a sideslip or "yaw". Sergeant Carrick stated in his affidavit in the investigation:

"The motor cycle involved in this incident has been travelling southbound on the Channel Highway. The motor cycle commenced to negotiate an open but sweeping right hand curve. The curve commences approximately 50 metres south of the junction of Derwent Avenue. It continues for a linear distance of approximately 100 metres and has a radius (measured from the eastern fog line) of 256 metres.

“The apex of the curve is south of the driveway entrance to 1892 and approximately 66 metres south of the commencement of the curve (when approaching from the north). The motor cycle travelled a distance of approximately 46 metres into the curve when the rear tyre has commenced to sideslip and rotate. The bike has veered off the bitumen road surface verge eastern side.

“The motor cycle continued travelling northbound (sic) on the gravel verge for a distance of approximately 25 metres. During this period, the line of travel has been slightly clockwise, and virtually parallel with the road edge. There has been no braking action or involvement. The rear tyre has been rotating and sideslipping. As it continued southbound the motor cycle commenced to rotate clockwise.

“The motor cycle continued southbound entering into the eastern table drain. It has struck a metal post causing the post to break at ground height it has continued up onto an embankment where it has struck a number of trees, breaking the tree trunks. At this point the deceased has separated from the motor cycle. The deceased bounced and slid along the grass area coming to rest in the table drain some 66 metres from where the motor cycle entered the gravel verge and 19 metres south of where he separated from the motor cycle.

“The motor cycle has continued bouncing and sliding along the grass embankment until it struck a tree causing it to come to rest on the embankment facing uphill. The motor cycle came to rest 73 metres (rounded) south of where it entered the gravel and 26 metres (rounded) from where it and the deceased separated.

“The scene evidence is consistent with the deceased initially attempting to drive/steer the motor cycle out of the gravel and back onto the road surface but in so doing he has lost vehicle control.

“The motor cycle was negotiating a sweeping right hand curve. Had the deceased looked behind towards following traffic he would have looked over his right shoulder. This action would have a tendency to cause the motor cycle to drift towards the centre of the road as opposed to the eastern verge.

“On the evening of the incident mention was made of an animal being in the immediate area when a resident heard the crash. It is a possibility the deceased was returning to the correct side of the road after having taken evasive action in order to avoid an animal strike. If this was the case he was undertaking the final stage of the avoidance manoeuvre when he has entered onto the gravel verge.

“Alternatively the cause of the crash may have been pure inattention (distraction) in the act of driving/riding by the deceased.

“There was no scene evidence to suggest or infer another vehicle was involved in this incident.”

I accept Sergeant Carrick’s analysis of how the crash occurred.

On 11 December 2017 an autopsy was performed upon Mr Saltmarsh by forensic pathologist, Dr Donald Ritchey. Dr Ritchey has concluded that the cause of Mr Saltmarsh’s death was multiple injuries sustained in a motorcycle crash.

Toxicological analysis of Mr Saltmarsh’s blood was conducted by Ms Miriam Connor of Forensic Science Service Tasmania. The results identified that Mr Saltmarsh had a blood alcohol level of 0.062 g/100ml and revealed the presence of cannabis (THC), codeine and anti-depressant medication. In her affidavit to the coroner, Ms Connor has stated:

“Studies have demonstrated that the combination of alcohol and THC may severely impede driving performance. The combined use of alcohol and THC increases reaction time, impairs visual search frequency, and leads to a reduced ability to perceive and/or respond to changes in relative speeds of other vehicles and therefore adjust vehicle speed as appropriate. Individuals under the influence of THC may potentially have a reduced capacity to avoid collisions if confronted with the sudden need for evasive action. It has been demonstrated that whilst effects of low doses of THC or alcohol (if less than 0.050 g/100 mL) may be minimal when either is present in isolation, when taken in combination the effects can be potentially dangerous for driving.”

I accept the conclusions of Dr Ritchey and Ms Connor.

Police Professional Standards conducted a comprehensive review for the purposes of scrutinising the actions and driving of the two police officers, and in particular, to determine whether they complied with their duties and if their actions amounted to an intercept or attempted intercept. In his review, Inspector Matthew Richman analysed the data obtained from the Automatic Vehicle Location (AVL) technology fitted to the police vehicle at the relevant time. He concluded that the officers were not engaged in a pursuit, interception or attempted interception. He concluded that their actions in executing a U-turn were actions preliminary to initiating an interception. He noted from the AVL data that they did not activate lights or sirens and that their vehicle was 550 metres (20.4 seconds) from the motorcycle when it crashed. Inspector Richman also concluded that the crash was not visible to the officers due to the curve of the road. He concluded that, in all respects, Senior Constables Fry and Carr

were acting appropriately and within the provisions of the *Tasmania Police Manual and Road Rules 2009* when attempting to catch up to Mr Saltmarsh to initiate an attempted intercept. I accept the conclusions of Inspector Richman in the review.

It is not possible on the evidence in this case to determine if Mr Saltmarsh saw the police vehicle or, if he did, that he altered his driving behaviour as a consequence. I do note, however, that he was travelling in excess of the speed limit when first sighted by the officers.

I find that Mr Saltmarsh died as a result of the traumatic injuries sustained by him when he lost control of his motorcycle and crashed. Road and weather conditions played no part in the crash. It is possible that Mr Saltmarsh may have altered his line to avoid an animal, although this cannot be known. Ultimately, the main causal factors in his death were his excessive speed and poor driving performance, both of which were exacerbated by his prior consumption of alcohol and cannabis.

Comments and Recommendations

Coronial findings, such as this relating to the death of Mr Saltmarsh, highlight the vulnerability of motorcyclists to serious injury and death when a riding error or excessive speed occurs. Coronial findings also continue to demonstrate the even higher risk of death where the rider's performance is impaired because of the consumption of alcohol and/or drugs.

I extend my appreciation to investigating officer Sergeant Nigel Ransley for his thorough investigation and detailed report.

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

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

Olivia McTaggart
Coroner