



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family and friends by direction of the Coroner pursuant to s. 57(1)(c) of the Coroners Act 1995.)

I, Simon Cooper, Coroner, having investigated the death of Mr F

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

- a) The identity of the deceased is Mr F;
- b) Mr F died as a result of injuries sustained when he was injured in a fall from a scooter at a skate park;
- c) Mr F's death was haemopericardium due to laceration of the heart;
- d) Mr F died in May 2015 at a skate park in northern Tasmania;
- e) Mr F was born in Launceston and was aged 17 years at the time of his death; he was single and a student.

In making the above findings I have had regard to the comprehensive material obtained as a result of the investigation into Mr F's death. That information includes a report from Dr Donald McGillivray Ritchey, pathologist, the results of an analysis of samples taken from Mr F's body at autopsy, a medical report from his treating general practitioner, a report from a Transport Inspector who examined the scooter he was riding, police reports and photographs, plans and details of the skate park, and affidavits from various witnesses.

All that material satisfies me that Mr F suffered terrible injuries as a result of a tragic accident when he crashed the scooter he was using at the skate park and hit his chin on the unprotected end of the handlebars and his chest on the scooter, which in turn caused a laceration of his heart.

There are no suspicious circumstances surrounding Mr F's death. The scooter he was riding was mechanically sound. Although he was not wearing a helmet that factor did not cause or contribute to his death.

Similarly, although THC (the active constituent of cannabis) was detected in a sample taken from Mr F's body at autopsy, I am satisfied that the presence of that drug did not cause or contribute to his death.

The efforts of the paramedics and police who attended the scene are to be commended, as are the efforts of Mr F's friend at the scene in performing CPR on his friend.

The accident which caused Mr F's death was in my view not in any way foreseeable, and nothing more could have been done by attending ambulance personnel to save his life.

Comments and Recommendations:

In the circumstances there is no need for me to make any further comment or recommendations pursuant to section 28 of the Coroners Act 1995.

I convey my sincere condolences to the family on Mr F on his tragic loss.

Dated: 13 May 2016 at Hobart in the State of Tasmania.

Simon Cooper
CORONER