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 Trent Liam Walliker

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

(a) The identity of the deceased is Trent Liam Walliker;

(b) Trent died as a result of injuries sustained following a single vehicle motorcycle crash on 28 April 2016 at Nook Road, Nook in Tasmania;

(c) The cause of death was blunt force trauma; and

(d) Trent died on 28 April 2016 at Nook in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Trent Walliker's death. The evidence comprises a detailed report by crash investigators; an opinion of the forensic pathologist as to cause of death; relevant police and witness affidavits; medical records and reports; and forensic evidence.

Trent Liam Walliker was born in Wantirna, Victoria on 12 March 1999. He lived at 987 Claude Road, Sheffield in Tasmania. He was aged 17 years at the time of his death. His parents are Kelly and Simone Walliker. He was single and employed at Harbro Engineering in Spreyton as an apprentice fitter and machinist.

Trent obtained his motorcycle licence on 6 August 2015 to enable him to easily get himself to and from work. He was the holder of a Novice L motorcycle licence. Kelly Walliker ("Mr Walliker") indicated that his son had no motorcycle riding experience prior to obtaining that licence. Mr Walliker described him as an "over confident" rider. Trent had a number of crashes since he was granted his motorcycle licence. The first was not long after he obtained it. The most recent was a few weeks before the crash resulting in his death, when he lost control in wet conditions around a corner.

On 24 October 2015 Trent purchased a green 2005 Kawasaki KLX250H motorcycle, registration number UY140. The motorcycle was approved for learners under the Learner Approved Motorcycle Scheme (LAMS). As a result, Trent was duly authorised and licenced to be riding the motorcycle. At the time of his death Trent had ridden about 10,000 kilometres on the motorcycle.

At around 7.00am on 28 April 2016, Trent left his home to travel to work as was his usual practice. The journey to work would usually take about 40 minutes.

At around 7.30am Trent approached Nook Road from West Nook Road. He proceeded onto Nook Road. A witness, Ms Hanna Dargie, also entered Nook Road from Morgan Road behind Trent. In her affidavit in the investigation, Ms Dargie stated that there was nothing unusual about the riding of the motorcycle but that as she and the motorcycle both turned onto Nook Road the motorcycle slowly pulled further away from her. As her vehicle reached around 70kmh she lost sight of the motorcycle at a left hand bend in the road.

Ms Dargie continued around the left hand bend and proceeded along Nook Road until she came to a right hand bend. At this time she saw a person (Trent) on the roadway with the motorcycle also lying on the roadway a short distance from him. She had to brake heavily, causing her to lose control and slide into the bank on the eastern side of the road.

Another witness, Mr Darren Long, was travelling south on Nook Road and approached the crash scene. Mr Long checked Trent for a pulse and signs of breathing. He could find neither and commenced CPR. Mr Long continued CPR until the arrival of paramedics, who determined that Trent was deceased.

Police attended the crash scene and commenced an investigation. The marks and disturbances on the roadway indicated that Trent had been travelling north in the correct lane. Upon the loss of control, Trent and his motorcycle parted, both separately impacting the vertical support posts on the Armco barrier on the left side of the roadway.

The crash scene was at the end of a gentle right hand curve in the road and within a 100kmh speed zone. There is good vision into and through the corner. The road is generally level in terms of cross fall and gradient. There are no edge lines and the centre line is a double continuous white line. The road would best be described as a typical country road, with a number of grooves and depressions in the road surface causing unevenness.

Crash reconstruction and analysis indicates that Trent was travelling between 62kmh and 80kmh at the time he lost control of his motorcycle. It was not raining at the time of the crash, although rain had fallen during the night and the road was wet.

The motorcycle was inspected by Transport Inspector, Philip Evans, who concluded that prior to, and at the time of impact, the Kawasaki KLX250H motorcycle would have been classed as un-roadworthy due to a non-compliant front tyre. The tyre did not comply with vehicle standards regulations for tyre tread depth requirements. The motorcycle was fitted with Dunlop D606 tyres. These are a legal off-road tyre and have a ‘knobby’ tread pattern. The centre of the front tyre was found to have a tread depth of 0.6mm, less than half the required depth of 1.5mm.

Further, the front tyre pressure was found to be 17.6% under the recommended pressure as described in the user manual for the motorcycle. The manual carries a clear warning that

failure to perform pressure checks every day before riding may result in serious damage or a severe accident. Underinflated tyres are known to cause stability issues.

Mr Walliker indicated that new tyres had been fitted to the motorcycle on 21 February 2016 and that in the two months that the tyres had been fitted to the motorcycle Trent had worn them out. The wear pattern, the expected kilometres travelled, and the nature of the tyre indicate that Trent rode with harsh braking and acceleration inputs, with the majority of the riding done on sealed roads. Mr Walliker indicated that Trent was aware that the tyres had become worn and had been talking about replacing them.

I am satisfied on the evidence that under-inflation, insufficient tread and uneven wear of the front tyre was a contributing factor in Trent's loss of control and crash.

I note that Trent was wearing full protective clothing including motorcycle boots, gloves and a full face helmet at the time of the crash.

An autopsy was conducted on 29 April 2016 by pathologist, Dr Rosanne Devadas. Dr Devadas concluded that Trent died as a result of blunt force trauma to his lower chest with massive injuries to his heart, liver and spleen. I accept Dr Devadas' opinion as to cause of death. Toxicological testing of Trent's blood showed no alcohol or drugs present in his body.

Although the evidence indicates that Trent was riding at, or below, the 80kph speed limit that applied to his licence, and below the 100kph limit that applies to Nook Road, it is apparent that he was riding an un-roadworthy motorcycle and riding too fast for the conditions and his experience.

The actual reason for Trent losing control of his motorcycle is unknown. I am satisfied that no other vehicle was involved. It would seem that inexperience, over-confidence, the wet road, an under-inflated and un-roadworthy front tyre, and the nature of the road surface all may have contributed to Trent losing control of his motorcycle. Upon losing control he slid along the road surface before impacting the vertical support posts of the Armco railing, causing his fatal injuries.

Comments and Recommendations:

Enquiries were made with the Department of State Growth in relation to crash data for the scene. This crash is the only fatal or serious crash to have occurred in the location in question within the preceding ten years. Further, there are no recorded minor crashes at that location.

The Kentish Council has responsibility for the maintenance of Nook Road. In the investigation, I sought information from the General Manager of the Kentish Council and the Department of State Growth regarding the safety of Nook Road in the area of the crash. As a result of the information, I am satisfied that the curvature of the section of road in question does not possess the degree of curvature that would require an advisory speed or curve warning sign.

At the time of the crash there was a “slippery when wet” sign before the corner in question. That sign remains permanent.

The Kentish Council has identified a section of Nook Road in the vicinity of the crash for reconstruction, including resurfacing in the 2018/19 financial year. This work will result in reduction of the effects of road defects and increasing friction. As part of this remedial work, the Kentish Council will assess the feasibility of installing under-run protection to the Armco crash barrier, to prevent injuries occurring through persons striking the support posts.

Apart from noting these positive developments I make no further comments or recommendations.

I commend Mr Darren Long for his efforts at the scene in attempting to revive Trent. I extend my appreciation to investigating officer, Constable Dean Wotherspoon, for his comprehensive investigation and report.

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

Dated: October 2017 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner