



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 and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of AL

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

- a) The identity of the deceased is AL;
- b) AL died as a result of injuries sustained by him as a rider in a quad bike crash;
- c) The cause of AL's death was multiple (chest, abdominal and pelvic) injuries; and
- d) AL died, aged 16 years, on 18 October 2023 at Minnies Road, near Wynyard, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into AL's death which includes:

- Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Report – Dr Andrew Reid, State Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Medical Records – Saunders Street Clinic;
- Records – Ambulance Tasmania;
- Medical Records – Tasmanian Health Service – North West Regional Hospital;
- Affidavit –HY, sworn 20 October 2023;
- Record of Interview – HY;
- Affidavit – Dean Johns, North West Motorcycles, sworn 24 October 2023;
- Affidavit – PO, sworn 20 October 2023;

- Affidavit – Georgia Manning, sworn 20 October 2023;
- Affidavit – DN, sworn 21 October 2023;
- Affidavit – Anna Welch, sworn 21 October 2023;
- Affidavit – Constable Martin Wilson, Search and Rescue Controller, sworn 10 December 2023;
- Affidavit – Brodie Debattista, Police Officer (rank not stated), sworn 1 November 2023;
- Affidavit – Constable Fraser Payne, sworn 1 November 2023;
- Affidavit – Senior Constable Sven Mason, sworn 19 February 2024 (and body worn camera footage);
- Affidavit – First Class Constable Dean Wotherspoon, sworn 10 December 2023 (and scene photographs);
- Affidavit – Alan Fitzpatrick, Transport Safety and Investigation Officer, sworn 1 November 2023; and
- Forensic and other evidence.

Introduction

1. AL died, aged just 16 years, as a result of massive, unsurvivable injuries sustained by him when he crashed a quad bike sometime early in the evening of 18 October 2023 at Wynyard.
2. An extensive investigation in relation to his death commenced at the scene and was thereafter carried out.
3. This finding is based on the evidence obtained as a result of that investigation.

What a coroner does

4. Before considering the circumstances of AL's death in further detail, it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death, and hold an inquest in relation to that death if it appears to have been "*unexpected, unnatural or violent or to have resulted directly or indirectly from an accident*".¹ The circumstances of AL's death meet this definition.
5. When conducting an investigation under the *Coroners Act* 1995, a coroner performs a role different to other judicial officers. The coroner's role is inquisitorial. Her or his job might be best described as a quest for the truth, rather

¹ Section 3 of the Act.

than a contest between parties to either prove or disprove a case. A coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 (the “Act”) asks. Those questions include who the deceased was, how they died, the cause of the person’s death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death. In any event, a coroner is required to make findings of fact about the death from which others may draw conclusions. A very important aspect of the role of the coroner is that he or she may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.²

6. It is important to recognise that a coroner does not punish or award compensation to anyone.³ Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.
7. As I said earlier, one matter that the Act requires, is a finding (if possible) as to how the death occurred.⁴ ‘How’ has been determined to mean ‘*by what means and in what circumstances*’,⁵ a phrase which involves the application of the ordinary concepts of legal causation.⁶ Any coronial investigation necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.
8. The standard of proof in a coronial investigation is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if the coroner reaches a conclusion where it is thought that findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.⁷

² Section 28(2) of the Act.

³ Section 28(4) of the Act.

⁴ Section 28(1)(b) of the Act.

⁵ *Atkinson v Morrow* [2005] QCA 353.

⁶ See *March v MH Stramare Pty Ltd and Another* [1990 – 1991] 171 CLR 506.

⁷ (1938) 60 CLR 336.

9. Finally, it is important to note that a coroner is not bound by the rules of evidence and may be informed and conduct an investigation in any manner the coroner reasonably thinks fit.

Circumstances of AL's death

10. AL left home at about 4.00 pm on Wednesday 18 October 2023. He was riding a red Honda TRX 250 quad bike which belonged to his father.
11. He did not have a licence (other than a L novice motor vehicle one). The quad bike was not registered to be used on the road. Despite this AL was apparently in the habit of riding it on the road as his father knew. Certainly, he rode on several public streets that afternoon and evening.
12. He was wearing a moto-cross style helmet, but no other protective equipment at all.
13. During the afternoon AL exchanged electronic messages with his friend DN, the last of which she received at 5.01 pm. She sent another message to him at 5.29 pm to which she did not receive a reply.
14. Several witnesses saw AL riding, probably, it is fair to say, a little too quickly.
15. One witness – Ms Manning – saw the quad bike twice and, particularly relevantly, parked near the intersection of Deep Creek and Aldersons Road at about 5.30 pm. The location where Ms Manning saw the quad bike – which contextually must have been AL's – was about 1.6 km from where AL was later found.
16. In all of the circumstances, I think it is reasonable to conclude that he crashed and died shortly after 5.30 pm.
17. When AL did not return home, his step-mother reported him missing to Police at 9.17 pm. A search was commenced immediately. At about 2.40 am on 19 October 2023 two police officers found the scene of the crash, at Minnies Road near Wynyard. Minnies Road is a forestry road, with a gravel surface. The spot where the quad bike left the road surface, unsurprisingly, does not have any barriers preventing vehicles from leaving the road.

18. The officers located the quad bike down an incline on the right side of the road and found AL's body pinned between the bike and a tree. He was cold to touch, showed no signs of life and rigor mortis had already set in.
19. Notably, the attending police officers found the right-hand rear wheel of the quad bike was missing from the bike, although the wheel nuts were still present on the studs. The wheel was located and, along with the quad bike, seized for further investigation.
20. AL's helmet was found some metres away from his body. It would appear that he did not have the chin strap attached or properly attached.

Investigation

21. AL's body was recovered and, following formal identification, taken by mortuary ambulance to the Royal Hobart Hospital. At the hospital mortuary the Tasmanian State Forensic Pathologist, Dr Andrew Reid, carried out a post-mortem examination. Following that examination, Dr Reid provided a report in which he expressed the opinion that the cause of AL's death was multiple chest, abdominal and pelvic injuries. Those injuries were consistent with a high impact injury to the right hemithorax which led to a pneumothorax with cardiac displacement/compression which was the most likely cause of AL's death. In plain English, AL suffered a massive crush injury of his chest which caused a fatal injury to his heart. I accept Dr Reid's opinion.
22. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. No signs of alcohol or illicit drugs (or indeed any drugs) were identified as being present in those samples as a result of that analysis.
23. Senior Constable Sven Mason an experienced crash investigator carried out an extensive investigation in relation to AL's death. Those investigations commenced at the scene, which Senior Constable Mason attended shortly after AL's body was found.
24. He did not find anything at the scene which suggested weather conditions or a defect in the road surface, caused or contributed to the happening of the crash. Given that sunset was 7.42 pm on 18 October, with last light at 8.10 pm, and given I am satisfied the crash likely happened shortly after 5.30 pm, I do not think the absence of any streetlights at the scene was a factor either.

25. Senior Constable Mason found a tyre mark in the surface of the road 17.5 metres long which ended at an up rooted guidepost, and then clear evidence of the bike's downward trajectory to the spot where it came to rest. The following day, when inspecting the scene in daylight, Senior Constable Mason found skid or 'wheelie' marks on Minnies Road. It is possible they were made by AL; it is just as possible they were made by someone else. Either way, I do not consider they cast any light on the happening of the crash.
26. Using information collected at the scene Senior Constable Mason was able to calculate that the quad bike was travelling at about 30 km/h before it left the road. This is well under the speed limit of 80 km/h for the road.
27. There is no evidence either of the involvement of any other person in the crash. Finally, I can categorically rule out the fact that AL's death was suicide.

What caused the crash?

28. Apart from the fact that quad bikes are, as many coroners have repeatedly said in many findings, inherently dangerous vehicles that should never be ridden by children, the cause of AL's death was the incorrect fitting of after-market rear wheels, one of which failed. The wheel coming off was the cause of him losing control of the bike and crashing.
29. The investigation revealed that the nuts used to secure the rear wheels were the incorrect type – tapered rather than flat.
30. Tragically, the after-market rims were bought off eBay and fitted by AL's father just two weeks before AL's death. He told investigators he was aware the nuts he used to attach the rims to the hubs were not the correct ones, but felt they were satisfactory for the job. Self-evidently they were not. In addition, the wheels are designed to be used with an additional separate hub once fitted. The purpose of the second hub is to lock the rims securely into place and stop any movement of the rim around the wheel studs to which the nuts are attached. There was nothing on the website from which the wheels were purchased to suggest that a second hub was a requirement.
31. Over the following two weeks, AL and his brother rode the bike. During that time the holes in which the studs on the hub went through became enlarged and elongated on both rims. Either would have failed. HY has to live with the consequences of his actions.

Conclusion and comments

32. I note that AL was not wearing a correctly fitted helmet. I do not consider in the circumstances of this case that fact caused or contributed to the happening of the crash.
33. The circumstances of AL's tragic death require me to make the following **comments**:
- a. It is essential that only the correct nuts are used to secure wheels to quad bikes.
 - b. It is essential that anyone buying equipment or parts for a quad bike off the internet ensure that they have purchased equipment that is fit for purpose.
 - c. No one should fit wheels to quad bikes without appropriate experience, expertise or qualifications.
34. I extend my appreciation to investigating officer Senior Constable Sven Mason for his investigation and report.
35. I convey my sincere condolences to the family and loved ones of AL.

Dated: 7 October 2025 at Hobart, in the State of Tasmania.

Simon Cooper
Coroner