



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 David Wade Archer Cooper

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

- (a) The identity of the deceased is David Wade Archer Cooper;
- (b) Mr Cooper died as a result of injuries sustained as the driver of a motorcycle in a crash on the East Derwent Highway, Geilston Bay on 26 September 2015;
- (c) The cause of Mr Cooper's death was chest injuries sustained in the crash;
- (d) Mr Cooper died on 26 September 2015 at Geilston Bay in Tasmania;
- (e) Mr Cooper was born in Latrobe, Tasmania, on 12 November 1993 and was aged 21 years.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Cooper's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; and forensic evidence. I have also been greatly assisted by a detailed report compiled by crash investigator, Sergeant Rod Carrick, whose conclusions I accept.

I make the following further findings regarding the circumstances of Mr Cooper's death.

Mr Cooper was 21 years of age and employed as a sales assistant. He lived with his mother, Kellie Willits, and her husband, Peter Willits, in Old Beach, Tasmania. His father is Scott Douglas Clark.

Mr Cooper was the holder of an L1 learner car licence, due to expire in 2017. A motorcycle extension was added to his licence on 23 July 2014 and due to expire on 22 July 2015. On 19 July 2015 Mr Cooper completed the pre-provisional motorcycle course and attended Service Tasmania the following day to upgrade his learner motorcycle licence to a provisional licence. Mr Cooper was unable to upgrade his licence due to a system error at Service Tasmania. Mr Cooper contacted Service Tasmania by telephone on 21 July 2015 and was advised that the error had been remedied and he could return to complete the upgrade. Mr Cooper did not return to complete the upgrade.

At approximately 4.45pm on Saturday 26 September 2015, Mr Cooper was riding a black

250cc Yamaha motorcycle registered number A882S in a northerly direction along the East Derwent Highway from the direction of Lindisfarne towards Old Beach. He was wearing appropriate motorcycle clothing including an approved crash helmet.

Mr Cooper was travelling on a downhill section of the East Derwent Highway approaching the junction of Pipers Road. The maximum speed at this location is 100km/h. The evidence suggests that Mr Cooper was travelling at about 80km/h. This section of the highway contains two south bound and two north bound lanes separated by a median strip and fencing. Mr Cooper was riding in the right-hand north bound lane.

At 4.45pm Mr Keith Rhodes was driving a blue 2002 Land Rover Discovery 4WD wagon registered number EO6534 in an easterly direction along Pipers Road, Geilston Bay towards its junction with the East Derwent Highway. He had one passenger in his vehicle, being his wife, Mrs Marilyn Rhodes. Both Mr and Mrs Rhodes were wearing seatbelts.

Mr Rhodes stopped his vehicle on Pipers Road at its junction with the East Derwent Highway. There was a give-way sign facing him and a give-way line painted on the roadway. He intended to turn right from Pipers Road onto the East Derwent Highway to travel in a southerly direction to Lindisfarne. To complete this turn it is necessary to cross the two north bound lanes of the highway to the ingress in the median strip in the middle of the highway and then turn right into one of the two south bound lanes.

As Mr Rhodes commenced to enter onto the East Derwent Highway, the front driver's corner of his Land Rover collided with Mr Cooper's motorcycle on the eastern side of the right-hand north bound lane. Mr Cooper was thrown from his motorcycle onto the road as a result of the impact. Members of the public commenced resuscitation upon Mr Cooper until paramedics arrived and took over. Paramedics continued resuscitation for 45 minutes but could not revive him. Mr Cooper was then pronounced deceased at the scene.

State Forensic Pathologist, Dr Christopher Lawrence, conducted an autopsy upon Mr Cooper. He observed multiple injuries including a lacerated aorta and haemorrhage into the left pleural cavity which he stated would have been rapidly fatal. He concluded that the chest injuries sustained in the crash caused death. I accept the conclusions of Dr Lawrence.

On 22 September 2016 Mr Rhodes appeared in the Magistrates Court in Hobart before Magistrate Chris Webster and pleaded guilty to the charge of causing the death of Mr Cooper by negligent driving. In his sentencing comments His Honour stated that the culpability of Mr Rhodes was low, being a momentary failure to keep a proper lookout. He also noted the lack of other aggravating features on the part of Mr Rhodes, such as the consumption of alcohol or drugs. He also took into account that Mr Rhodes had an exemplary driving record.

His Honour imposed upon Mr Rhodes a sentence of 4 months imprisonment, wholly suspended on good behaviour for a period of 2 years, and disqualified him from driving for a period of 2 years.

The evidence contained in the crash analysis by Sergeant Carrick shows that Mr Cooper had insufficient time to take any meaningful evasive action to avoid the collision. The

evidence indicates that Mr Cooper would have been visible to Mr Rhodes for between 7.5 and 9 seconds before Mr Rhodes commenced to enter onto the East Derwent Highway into the path of Mr Cooper's motorcycle. This would have allowed Mr Rhodes ample time to make decisions as to how to safely cross the intersection.

Mr Rhodes stated that he initially looked to his right and did not see any approaching traffic. He stated he then looked to his left and observed a number of vehicles. He then commenced to drive across the two northbound lanes without looking back to his right. If he had done so, he would have seen Mr Cooper's motorcycle.

Sergeant Carrick, in his investigation report, stated that all of Mr Rhodes' attention was directed towards the traffic approaching from the left, noting that it was one of these lanes into which he intended to make his right hand turn. I accept Sergeant Carrick's view in this regard. Mr Rhodes was not able to provide any explanation as to why he did not see Mr Cooper before the crash when the evidence clearly demonstrates that he should have done so. Unfortunately, such driving errors occur not infrequently, even on the part of the most experienced and competent drivers. Very sadly, Mr Rhodes' inadequate lookout in this instance resulted in the death of a young man.

Comments and Recommendations:

Statistics provided in the investigation revealed that there has only been one other crash reported as occurring at the junction in question. This crash resulted in property damage only. Following Mr Cooper's death the Department of State Growth conducted a post-crash review of the crash scene. The review noted, in particular, that residential developments have significantly increased the number of vehicles turning right out of Pipers Road and thus the potential for crashes. The review recommended that a right turn out of Pipers Road be prohibited.

In October 2015 regulatory signage was installed on Pipers Road at the East Derwent Highway to prevent traffic from turning right. Motorists are now required to make a left turn, proceed to the roundabout at Grass Tree Hill Road and carry out a U-turn at that point.

I extend my appreciation to Sergeant Rod Carrick who has provided me with a most thorough and comprehensive report covering all relevant aspects of the circumstances surrounding this tragic death.

I convey my sincere condolences to Mr Cooper's family and loved ones.

Dated: 19 December 2016 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner