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 Jason Lee Patmore

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

(a) The identity of the deceased is Jason Lee Patmore;
(b) Mr Patmore died in the circumstances set out in this finding;
(c) Mr Patmore died as a result of a haemorrhagic stroke complicating anticoagulation and intravenous antibiotic therapy in the setting of right upper arm deep vein thrombus that developed during hospitalisation for traumatic brain injury sustained in a bicycle crash; and
(d) Mr Patmore died 25 August 2015 at the Royal Hobart Hospital, Hobart in Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Patmore's death. The evidence included the police report of death; affidavits of Mrs Sheridan Patmore, eyewitnesses, attending police officers, crash investigators and a transport inspector; an affidavit and footage from a simulation ride; an opinion of the forensic pathologist as to cause of death; ambulance and medical reports; and investigative statements provided by the Motor Accidents Insurance Board.

Jason Lee Patmore was born in Hobart, Tasmania on 19 November 1970 and was aged 44 years at the time of his death. He was married to Sheridan Rose Patmore and the couple have an adult son, Brady. Mr Patmore was a musician at the date of death. He lived with his family at 69 Rosehill Crescent in Lenah Valley. He had lived at that address for almost 15 years. He was in good physical health. He had been diagnosed with depression by his general practitioner and was taking prescribed anti-depressant medication. His mental health was stable.

Prior to August 2014 Mr Patmore rode his bike on an occasional basis. In August 2014 Mr Patmore bought a new bike and significantly increased his bike riding for fitness reasons. In the several months before his death he rode nearly every day from his house for a duration of between an hour and an hour-and-a-half on each occasion.

Mr Patmore had his bike serviced on 19 December 2014 where he had the derailleur replaced and the gears and brakes tuned.

At approximately 8.40am on 29 July 2015, Mr Patmore left home for his regular bike ride, informing his wife that he would be home by 10.00am. Mr Patmore was wearing a bike helmet, black bike tights and shorts with other layers of clothing over the top. He rode down Rosehill Crescent in an easterly direction towards the city.

Three workmen were working on the road for the NBN installation in front of 23 Rosehill Crescent at the time. Mr Michael Triffitt was one of the workers. In his affidavit for the coronial investigation, Mr Triffitt stated that he heard Mr Patmore approaching before he saw him. Mr Triffitt said that he heard the roaring sound of tyres coming down the street, almost like a 4-wheel drive vehicle. Mr Patmore then went past on his bicycle at a speed that Mr Triffitt estimated as being between 60kmh and 70kmh. He stated that he had noticed Mr Patmore on his bicycle because he was going so fast.

At this time Ms Louise McKinnon was driving a blue Ford Laser hatch, registration number EM 6270, in a westerly direction on Rosehill Crescent, this being the opposite direction of travel to Mr Patmore. Also in the vehicle was Ms McKinnon's 5-year-old daughter. Ms McKinnon had dropped her son to school and was intending to return to her residence at 25 Rosehill Crescent.

In her affidavit for the investigation, Ms McKinnon said that she was approximately 100 metres from her home when she saw Mr Patmore on his bicycle. She said that she was travelling on her correct side of the road at a speed between 20kmh and 40kmh and that Mr Patmore was going very fast and travelling on his correct side of the road. She said that Mr Patmore passed her vehicle as she was just short of the bend near number 25 Rosehill Crescent.

After Mr Patmore had gone past, Ms McKinnon said that she immediately looked in her rear vision mirror and saw Mr Patmore's bicycle wobbling as though he had lost control of it. Ms

McKinnon stated that Mr Patmore was still travelling very fast. She also stated that hers was the only vehicle travelling on the road at the time. Ms McKinnon was concerned for the safety of Mr Patmore and so she drove a very short distance, turned around in the driveway at her home and returned to the location of Mr Patmore. In the process of this manoeuvre she spoke to the workmen in front of number 23 and told them about her concerns for Mr Patmore.

Mr Patmore had come off his bicycle and was lying on the road outside number 36 Rosehill Crescent, the home of Nicholas Arnott, a nurse. In his affidavit, Mr Arnott stated that he was at his garage and putting his children in his car when he heard two short skidding sounds. Mr Arnott described the sounds as the skidding of a bike tyre when braking and they came from about 20 to 30 metres west up Rosehill Crescent. He stated that these skids were followed by a crash sound that was in front of his house. He walked to the road to assist.

When Ms McKinnon arrived at the crash scene and saw Mr Patmore she rang '000' for help. At this time Mr Patmore was lying face down on the road next to a parked blue Holden Nova with his head tilted to the right. His head was aligned to the east and his feet to the west. Mr Patmore's bicycle was towards the centre of the road, approximately 2 metres west of his feet.

Mr Triffitt arrived at the scene and moved Mr Patmore's bicycle to the side of the road as other vehicles were attempting to get past.

Mr Arnott administered first aid to Mr Patmore and stated that his eyes were closed and he was non-verbal but breathing audibly. He stated that Mr Patmore had blood coming from his nose and possibly his mouth. He noted that Mr Patmore was still wearing his bike helmet.

An ambulance arrived at the scene at 8.52am, shortly after the crash. Police officers also arrived at the accident scene and closed the road to preserve the area and secure the safety of all persons present.

Mr Patmore appeared to have sustained significant life threatening injuries and was stabilised by paramedics before being transferred to the Emergency Department of the Royal Hobart Hospital where he received immediate attention and treatment.

A CT scan of Mr Patmore's brain showed a traumatic subarachnoid haemorrhage and diffuse brain injury. After initial treatment, Mr Patmore was stabilised and transferred to the

Intensive Care Unit. Mr Patmore underwent significant treatment in the weeks that followed. He remained unconscious.

On 24 August 2015, Mr Patmore suffered a major intracerebral haemorrhage and, sadly, died the next day, being 25 August 2015.

An autopsy was conducted by forensic pathologist, Dr Donald Ritchey. Dr Ritchey determined that the cause of Mr Patmore's death was haemorrhagic stroke complicating anticoagulation and intravenous antibiotic therapy in the setting of right upper arm deep vein thrombus that developed during his hospitalisation for traumatic brain injury. I accept Dr Ritchey's opinion as to cause of death.

I note that blood samples taken from Mr Patmore after the crash did not reveal the presence of any illicit drugs or alcohol.

At 9.50am on the day of the crash, Senior Constable Adam Hall, a trained crash investigator, attended the scene. He then commenced to examine the scene with a view to forming conclusions as to how the crash may have occurred. Amongst other matters, he noted the presence of a 50 millimetre wide tyre scuff mark 1.8 metres long at the exit of the relevant right hand curve. The scuff mark was consistent with that of a bicycle.

Just to the west of the scuff mark, two unattended vehicles were parked legally in an easterly direction and on the northern side of the road.

Approximately 26 metres east of the tyre scuff mark were the presence of two gouge marks in the road that Senior Constable Hall assessed as being caused by the crash. A further 2.7 metres south of the gouge marks was an amount of blood on the road surface.

The blue Holden Nova hatch vehicle (referred to earlier) was legally parked and unattended in the area of the blood and gouge marks. It was parked facing east and on the northern side of the road. The blood on the road was located 1.3 metres east of the front of the Holden.

Senior Constable Hall examined the Holden and, after speaking to the owner of the vehicle, was satisfied that it had not been struck by Mr Patmore's bicycle.

Senior Constable Marisa Milazzo from Forensic Services attended the scene at 9.35am, took photographs and made observations. Once the scene was processed, attending officers took Mr Patmore's bicycle to the police garage to enable further examination by a transport inspector.

On 11 September 2015, crash investigators Sergeant Rodney Carrick, Senior Constable Hall and Senior Constable Kelly Cordwell attended the scene for the purpose of conducting bicycle ride-through simulations by First Class Constable Ralph Newton, an experienced mountain biker. The road was closed for the purpose of the simulations. First Class Constable Newton had a GoPro recording device attached to the helmet he was wearing.

First Class Constable Newton rode a bicycle that closely resembled that used by Mr Patmore on 29 July and travelled west to east on three separate occasions. First Class Constable Newton took what can be described as a "racing line" on each occasion, riding close to the middle of the road to keep a tight line as he negotiated the right hand bend.

He rode the same course at three separate speeds: 50kmh, 55kmh and 60kmh. In his subsequent affidavit for the investigation, First Class Constable Newton provided the opinion if he had altered his line of travel, loss of control would have been possible.

Mr Noel Clarke, Transport Inspector, inspected Mr Patmore's bicycle on 4 September 2015. Mr Clarke stated that the quick release locking mechanism for the front wheel axle and hub assembly was not correctly adjusted, but could not say what effect this would have had on the handling characteristics of the bike. Senior Constable Hall, in his affidavit, states that he was satisfied that this did not play a critical part in the crash due to the speed that the bicycle would have reached prior to the collision. Upon inspection of the remainder of the bicycle, Mr Clarke found no fault.

Senior Constable Hall provided a comprehensive affidavit regarding his crash investigation. In the affidavit he stated that, after reviewing the evidence he had collected, he was satisfied that no other vehicles, stationary or mobile, were involved in the crash.

Senior Constable Hall stated that the scuff mark that was left at the scene amounted to physical evidence that speed may have been a factor, this being the spot where Mr Patmore would have applied the rear brake whilst negotiating the curve.

However, there was insufficient physical evidence for Senior Constable Hall to calculate the speed of Mr Patmore's bike prior to the crash.

Based upon the totality of the evidence in the investigation, including that of all eye witnesses, I am satisfied that Mr Patmore was riding his bike down Rosehill Crescent at a very high speed, likely well in excess of 50kmh. He then lost control and crashed, the consequent injuries ultimately causing his death.

In coming to this conclusion, I accept the account of Ms McKinnon. I am satisfied that she was driving at a slow speed approaching the driveway to her house and on her correct side of the road when Mr Patmore passed her on his bike at a fast speed. I also accept the calculations, observations and conclusions of the crash investigator, which are comprehensive and consistent with the evidence as a whole.

Mrs Patmore made application for a public inquest to be held. In my written reasons of 17 November 2017 I decided that it was not desirable to hold an inquest into the death of Mr Patmore. In particular, I set out in those reasons why I was satisfied of the credibility of Ms McKinnon's account. I also set out reasons for my conclusion that there was no contact between her vehicle and Mr Patmore's bike as well as reasons for the conclusion that she was driving prudently.

In those reasons I stated:

> *"On the evidence I could not rule out that Mr Patmore's loss of control might have been prompted by his reaction to seeing Ms McKinnon's vehicle travelling in the opposite direction even though Ms McKinnon was travelling on the correct side of the road and in other respects in accordance with her duty as a reasonable driver. However, the evidence indicates that Mr Patmore did not significantly change his line of travel whilst passing Ms McKinnon. Other possible causes of his loss of control at speed may have been his reaction to the parked cars on his left hand side of the road, a slight alteration in his line of travel, braking too hard or travelling onto a different part of the bitumen surface of the road. Unfortunately, errors in respect of speed or judgement with fatal consequences may be made by experienced riders with an otherwise good safety record."*

These comments remain pertinent in this finding.

On 27 November 2017, shortly after delivering my reasons for deciding not to hold an inquest, I received two further affidavits from Mrs Patmore's counsel, Mr Andrew Gaggin. The first of these was an affidavit of Mr Gaggin himself and an affidavit of Mrs Patmore. These affidavits related to comments allegedly made by Senior Constable Hall during a scene visit, attended by counsel, to the effect that he believed that Mr Patmore was startled by Ms McKinnon's vehicle and this caused him to lose control of his bike and crash. Mr Gaggin submitted, as a result of the material in these affidavits, that further information should be obtained from Senior Constable Hall.

On 18 December 2017, Mr Gaggin sent to the Coroner's Office a short statement made by Senior Constable Hall two days earlier, presumably at Mr Gaggin's request and for the purpose of supporting his client's contention that this was an accident which "involved two vehicles". Relevantly, in paragraphs 12 to 16 of this statement Senior Constable Hall states:

> *"As a result of encountering Ms McKinnon's vehicle Mr Patmore has altered the position of his bicycle on Rosehill Crescent to move the bicycle further to the left hand side of the road.*
>
> *As a result of taking this action Mr Patmore has lost control of his bicycle, causing him to go into a high speed wobble.*
>
> *This is consistent with Ms McKinnon seeing the Plaintiff's bicycle wobbling in her rear vision mirror.*
>
> *Mr Patmore has attempted to slow the bicycle which has resulted in the short skid mark noted near the Second Corner.*
>
> *The attempt to slow has been unsuccessful and the accident has occurred."*

I observe that Senior Constable Hall incorrectly refers to Mr Patmore as "the Plaintiff" rather than "the deceased" although nothing turns upon that error. In his initial detailed crash investigation affidavit Senior Constable Hall's conclusions relating to the reasons for Mr Patmore's loss of control are less definite. He indicated there that it was a *possibility* that Mr Patmore changed his line of travel upon encountering Ms McKinnon's vehicle.

With respect to Senior Constable Hall, his recent short statement contained no detailed reasoning from the scene examination to support the conclusion. It may well be that his view about the reasons for Mr Patmore's loss of control are the most obvious explanation in the circumstances. However, the visible evidence at the scene does not allow this conclusion in itself.

Thus, to summarise, the scenario posited by Senior Constable Hall as to the reason for Mr Patmore's loss of control is open, as I have set out above. Other possibilities are also open as described. My functions do not require me to make more detailed findings in this regard, nor do the facts allow it.

I am also satisfied, for the reasons given in my decision not to hold an inquest, that the investigation has been thorough and that there is no avenue of investigation that could reasonably assist in elucidating any important factual matters as to how Mr Patmore's death occurred.

Comments and Recommendations:

The circumstances of Mr Patmore's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I express my appreciation to Senior Constable Hall, First Class Constable Newton and all other officers assisting with this investigation. I also thank Coroner's Associate Constable Kathryn Luck for her valuable assistance during the progress of the case in the Coronial Division.

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

Dated: 28 February 2018 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner