



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3905

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Coroner
Deceased:	Andrew John Harman
Date of birth:	20 October 1966
Date of death:	8 August 2016
Cause of death:	I(a) Complications of heatstroke I(b) Hyperthermia
Place of death:	Maui Memorial Medical Center Wailuku, Hawaii, United States of America

BACKGROUND

1. Andrew John Harman was a 49-year-old man who lived in Woodend with his wife and three children at the time of his death.
2. On 5 August 2016 Mr Harman travelled to Hawaii and on 6 August 2016 he went on a guided dirt bike tour on the island of Maui. Mr Harman began to struggle and became ill during the ride, and was taken to hospital after suffering a cardiac arrest.
3. He did not recover and life support was ceased on 8 August 2016.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Harman's death was reported to the Coroner as it was unexpected and so fell within the definition of a reportable death in the *Coroners Act 2008*.
5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
6. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family members, the forensic pathologist who examined Mr Harman, treating clinicians and investigating officers.
7. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.¹

IDENTIFICATION OF THE DECEASED

8. On 23 August 2016, Barbara Harman visually identified Mr Harman's body as being that of her husband Andrew John Harman, born 20 October 1966.
9. Identity is not in dispute and requires no further investigation.

¹ This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

10. Mr Harman worked as a farrier until suffering a back injury around 2010, which resulted in him having three bulging discs in his back. He was told he had osteo-arthritis and the '*back of a ninety-year old*'.²
11. Aside from his back problems, Mr Harman had experienced very few health issues and around the time of his death was taking medication for hyperlipidaemia, reflux oesophagitis and depression.³
12. On 5 August 2016 Mr Harman, along with Mrs Harman and a large group of family and friends, travelled to Hawaii to celebrate Mr Harman's upcoming 50th birthday, arriving in Honolulu on the island of O'ahu.
13. At approximately 1.00pm (Hawaii-Aleutian Standard Time (HST)) on 6 August 2016 Mr Harman and his family boarded the Norwegian Cruise Liner '*Pride of America*' in Waikiki. Between 1.00pm and midnight Mr Harman consumed around ten full-strength beers and one glass of red wine with dinner. Mrs Harman reports that this was not an unusual amount of alcohol for Mr Harman.⁴

Events proximate to death

14. After disembarking on the island of Maui, at around 9.00am on 7 August 2016 Mr Harman went on an all-day guided dirt bike ride with a small group of friends led by a tour guide from Maui Moto Adventures. The group rode in a truck to the town of Lahaina near the West Maui Forest Reserve before continuing on bikes.
15. Mr Harman was issued equipment by Maui Moto Adventures. Another rider, his friend Darryl Karp, recalled that:

At the start of the ride, Andrew was wearing a full-face motorcycle helmet, with goggles, a plain T-shirt, plastic chest/back armour over the top of his T-shirt, a cotton motorcycle jersey over the top of the armour, elbow and knee guards, nylon moto-cross pants, and moto-cross boots. He also was carrying a Camelback water pouch. ... In my opinion, wearing that amount of equipment is standard equipment in

² Ibid.

³ Statement of Dr Robert Hetzel dated 26 September 2016, Coronial Brief.

⁴ Statement of Barbara Harman dated 25 October 2016, Coronial Brief.

*Australia and is the minimum standard that I would think any tour company would expect.*⁵

16. Mr Karp estimated the temperature to have been around 28-29 degrees Celsius and the weather was humid. Mr Karp recalled the conditions of riding as *'single-trail riding, in and out of trees. None of the riding was fast, rather it was slow and steady work'*.⁶ Another rider, Fergus Shaw, described the ride as going over *'steep terrain in scrubby bush, what I would consider a hard bush ride'*.⁷

17. Mr Karp stated:

*Andrew was a competent and capable rider. Andrew would in my opinion have had a minimum of thirty years of experience riding dirt bikes... Up until Andrew had his back complaint, he was a frequent dirt-bike rider... The frequency of his dirt-bike riding reduced after this time.*⁸

18. Although the weather was warm and humid, in Mr Karp's opinion it was *'no more difficult than conditions of an Australian summer'*.⁹ However, Mr Shaw felt that Mr Harman *'might not have been up to the task of riding in those conditions'*.¹⁰

19. Go Pro footage of the ride taken by Mr Karp reveals a rugged and steep terrain.¹¹ Mr Karp stated, and the footage bears out, that *'We would ride about 100-200 metres and then have to stop and wait for Andrew to catch up.'*¹²

20. At around one and a half hours into the ride, Mr Harman began to visibly struggle. The group stopped and waited for Mr Harman to catch up on a number of occasions. At around 11.30am Mr Harman said to Mr Karp *'I'm struggling'* and that he wished to return to the car. The group decided to return together.

21. At around midday, the group stopped again as Mr Harman was struggling to continue. Mr Harman at this point told Mr Karp that he could not get water out of his CamelBak water pouch as the rubber teat was blocked. Mr Karp recalled Mr Harman's pouch as being a 3-4litre pouch which appeared about one-quarter full. Mr Karp gave his water pouch to Mr

⁵ Statement of Darryl Karp dated 25 October 2016, Coronial Brief.

⁶ Ibid.

⁷ Statement of Fergus Shaw dated 25 October 2016, Coronial Brief.

⁸ Statement of Darryl Karp dated 25 October 2016, Coronial Brief.

⁹ Ibid.

¹⁰ Statement of Fergus Shaw dated 25 October 2016, Coronial Brief.

¹¹ Coronial Brief 'Go Pro footage' Exhibit 1.

¹² Statement of Darryl Karp dated 25 October 2016, Coronial Brief.

Harman who drank from it at this point. Mr Karp urged Mr Harman to eat, but he only had a few bites of a sandwich.¹³

22. Mr Harman told Mr Karp that he felt dizzy and lay on the ground. Approximately fifteen minutes later, the group continued. Mr Karp described Mr Harman as looking '*spent*'.¹⁴
23. As the group travelled downhill, Mr Harman fell off his bike several times, after which point he stopped riding his own bike and rode on Mr Karp's bike as a pillion passenger.
24. While the group was around half a kilometre from the Maui Moto Adventures truck, Mr Harman told Mr Karp he needed to get off. Mr Karp stopped and let Mr Harman off. The tour guide went to collect the Ute. Mr Karp reported that at this time Mr Harman was unable to stand up and did not seem to know where he was. Mr Karp stripped Mr Harman and poured water on him in an attempt to cool him down, and noticed that Mr Harman had an extremely fast heart rate. Mr Harman began to vomit and Mr Karp rolled him onto his side.¹⁵
25. When the tour guide returned with the Ute, Mr Karp told him to call an ambulance. The tour guide then contacted emergency services who arrived several minutes later. Mr Harman went into cardiac arrest, requiring CPR and defibrillation, after which he was stabilised and taken to the Maui Memorial Medical Center.
26. Mr Harman was admitted to the Intensive Care Unit and presented with hyperkalaemia, acute renal failure, acute respiratory failure, anoxic encephalopathy and presumed septic shock. He was kept on life support until family members could travel from Australia to Hawaii and at 6.00pm (HST) on 8 August 2016 life support was removed.

CAUSE OF DEATH

27. On 24 August 2016, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Harman's body and provided a written report, dated 3 February 2017. In preparing his report, Dr Young referred to medical notes from Maui Memorial Medical Center and a Medical Certificate of Death issued by the State of Hawaii Department of Health.

¹³ Statement of Darryl Karp dated 25 October 2016, Coronial Brief.

¹⁴ Ibid.

¹⁵ Ibid.

28. In that report, Dr Young concluded that a reasonable cause of death was '*I(a) Complications of heatstroke; I(b) Hyperthermia*'.

29. Dr Young commented that:

Heatstroke is a condition caused by overheating of the body (hyperthermia), usually as a result of prolonged exposure to, or physical exertion in high temperatures. Symptoms may include headache, dizziness, hot skin and muscle weakness, and complications may arise from dehydration, nausea, vomiting, rapid heartbeat and rapid shallow breathing. Hyperthermia is where the body temperature is greater than 37.5 – 38.3 degrees Celsius. In this case, the clinical presentation was consistent with heatstroke. Although not able to be ascertained at autopsy, the possibility that diarrhoea may have contributed to dehydration or electrolyte imbalance, thus exacerbating the effects of the heatstroke, cannot be excluded.

30. Dr Young additionally commented that '*there was no post mortem evidence of any injuries which may have caused or contributed to death*'.

31. I accept Dr Young's formulation of the cause of death.

32. Toxicological analysis of the post mortem samples taken from Mr Harman did not identify the presence of ethanol (alcohol) or any other common drugs or poisons.

FAMILY CONCERNS AND INVESTIGATION

33. Mrs Harman raised several concerns regarding Maui Moto Adventures in her statement for the coronial investigation dated 25 October 2016. She noted that Mr Harman had been struggling with the ride for some time before the ride stopped, and questioned whether the tour guide should have recognised that it was unsafe for Mr Harman to continue in those conditions.

34. Mrs Harman was also concerned that the tour guide did not have a mobile phone to call for help and that Mr Harman was apparently unable to get water from his backpack water pouch which was provided by Maui Moto Adventures. She questioned whether the tour guide was trained in first aid.

35. The Coroner's Investigator, Sergeant Karen Connell, made a number of inquiries with Maui Moto Adventures to obtain material for the coronial investigation and to address

Mrs Harman's concerns. Although Sergeant Connell's initial request was acknowledged, all further correspondence was ignored.

36. The Court does not have jurisdiction to enforce compliance with these requests. Consequently there is no statement from the tour guide or Maui Moto Adventures to answer or address the concerns raised by Mrs Harman.
37. As such I cannot make any findings regarding the actions or policies of Maui Moto Adventures with respect to Mr Harman's deterioration during the ride and subsequent death.
38. Their website at 'www.mauimotoadventures.com' describes the equipment and provisions provided to riders but does not give any further details regarding safety issues or their guides' training or awareness of first-aid.
39. Accordingly I find that there is a public interest in publishing this Finding on the internet.

FINDINGS AND CONCLUSION

40. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Andrew John Harman, born 20 October 1966, died on 8 August 2016 at Wailuku, Hawaii, United States of America, from I(a) Complications of heatstroke; I(b) Hyperthermia in the circumstances described above.
41. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.
42. I direct that a copy of this finding be provided to the following:

Mrs Barbara Harman, senior next of kin.

Sergeant Karen Connell, Victoria Police, Coroner's Investigator.

Signature:



CAITLIN ENGLISH
CORONER

Date: 31 October 2017

