MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Keith Thomas Stewart

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

a) The identity of the deceased is Keith Thomas Stewart;
b) Mr Stewart died as a result of injuries sustained in a single mobility scooter crash;
c) The cause of Mr Stewart's death was a brain haemorrhage; and
d) Mr Stewart died on the 4 July 2018 at the Launceston General Hospital in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Stewart's death. The evidence includes an opinion of the forensic pathologist who conducted the autopsy; a crash investigation into the accident; relevant police and witness affidavits; medical records and reports; and forensic and photographic evidence.

Mr Stewart was born on 5 January 1945. He was aged 73 years at the time of his death. He was never married and had no children. Born with a significant intellectual disability, Mr Stewart suffered from a number of comorbidities including Tourette's Syndrome, osteoarthritis and congestive cardiac failure. He was unable to read or write because of this intellectual disability and had a limited capacity to look after himself.

After the death of his parents, Mr Stewart was moved into a unit opposite the Beaconsfield District Health Service (BDSU). In 2011, he was moved into the BDSU as a permanent aged care resident. His movement and ability to travel was unrestricted at this facility. Mr Stewart was free to come and go as he pleased if he signed in and out at the front office to keep staff informed of his movements.

In 2014, Mr Stewart was given access to a mobility scooter by his sister-in-law, Anne Stewart. He was permitted to use the mobility scooter by the BDSU, if he complied with a number of guidelines and rules for the use of the scooter. The guidelines - "Keith's Rules for Scooter Use"

- required Mr Stewart to wear a helmet and a high visibility vest, navigate using the flattest pathways possible, and to not go outside a 50km/h or 60km/h speed limit zone.

The evidence suggests that Mr Stewart used his scooter frequently, at least once or twice a week. His normal practice seems to have been to drive his scooter down a steep driveway to the northern end of the BDSU, before making a right turn onto Bolton Street. Staff at the BDSU indicate that when seen doing this he appeared to operate his mobility scooter in a safe manner and at an appropriate speed.

On 1 July 2018, on or about 10.20am, Mr Stewart signed off at the front office and rode his mobility scooter down the steep driveway at the northern end of the BDSU. CCTV footage shows he was not wearing a helmet. As he turned right onto Bolton Street, he lost control of the scooter and impacted with a parked Toyota Prius in an angled parking bay adjacent to Bolton Street.

Shortly after, Mr Colin Bender who was passing by found Mr Stewart. Mr Bender immediately alerted the staff at the BDSU. Mr Bender later told investigators that Mr Stewart was not wearing a helmet when he found him.

The first member of staff from the BDSU on the scene was Nurse Roslyn Dowling. She later told investigators that Mr Stewart (whom she knew very well) muttered words, as she was tending to him, about having 'pressed the wrong pedal'. Other staff were quickly on the scene and provided assistance. Mr Stewart was seen to have sustained extensive injuries to the left side of his head with a gash above his left eye. He had also suffered abrasions to his hands. An ambulance was called and Mr Stewart made comfortable. He was taken from the scene of the incident around 11.40am to the Launceston General Hospital (LGH).

After admission to the LGH, Mr Stewart's condition deteriorated. The following day, 2 July 2018, he was transferred to the Neurological Unit at the Royal Hobart Hospital (RHH). At around this time, the BDSU staff were contacted by hospital staff and were informed that Mr Stewart's prognosis was poor and he was not expected to survive. The following day Mr Stewart was readmitted to the LGH for palliative care. He died the next morning 4 July 2018 at about 6.30am.

After formal identification, Mr Stewart's body was transported by mortuary ambulance to the RHH. At the RHH an autopsy was carried out by forensic pathologist, Dr Christopher Lawrence. Dr Lawrence expressed the opinion, which I accept, that the cause of Mr Stewart's

death was a head injury he had sustained in the mobility scooter collision. He noted in addition that Mr Stewart suffered from congestive cardiac failure.

Officers of Tasmania Police carried out an investigation in relation to the circumstances of Mr Stewart's death. Experienced Crash Investigation Services officer, Constable Nigel Housego, conducted that investigation.

An inspection of the mobility scooter was undertaken by Transport Safety and Investigations Officer, Mr Wayne Rice, on 11 and 12 July 2018. Mr Rice expressed the opinion that the mobility scooter had no defects which could have caused, or contributed to, the accident. I accept Mr Rice's opinion in this regard. I am satisfied that no mechanical defect caused or contributed to the happening of the fatal crash.

As part of the investigation CCTV footage taken from the BDSU was obtained. The CCTV footage assisted in calculating Mr Stewart's estimated speed at the time of his fatal crash. I am satisfied that in the immediate lead up to the crash Mr Stewart was travelling at an estimated range of 27km/h to 29km/h.

It seems clear that Mr Stewart lost control of the mobility scooter when he attempted to make the right turn onto Bolton Street. Mr Stewart disengaged the gear lock on the scooter and freewheeled down the driveway, enabling it to build up speed. The speed at which Mr Stewart was travelling at the time (rather fast for a mobility scooter) caused the mobility scooter to reach its roll over threshold when making the turn. As a result, the mobility scooter rolled counter-clockwise to the left and Mr Stewart was thrown out of his seat and onto the roadway, causing his fatal injury. The left side of the scooter then proceeded to collide with the road surface and slide into the parked Toyota Prius in the parking bay adjacent Bolton Street. Mr Stewart did not hit the Prius himself.

It is also apparent from the CCTV footage that Mr Stewart appeared relaxed when travelling down the driveway. It also illustrates, as I have already mentioned, that Mr Stewart was not wearing his helmet. It is certainly possible that had he been he would not have suffered the injuries which caused his death.

I am satisfied that the weather conditions did not cause or contribute to the fatal accident. Witness accounts indicate the weather and road conditions at the time of Mr Stewart's crash were fine. Further, I am satisfied that the medical treatment Mr Stewart received whilst in the care of both the LGH and the RHH was of a satisfactory standard and did not cause or

contribute to Mr Stewart's death. I am also satisfied on the evidence that the BDSU took all reasonable precautions to ensure that Mr Stewart operated his scooter safely. Finally, I am satisfied that there are no suspicious circumstances surrounding Mr Stewart's death and that no other person caused or contributed to it.

Comments and Recommendations

The circumstances of Mr Stewart'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 thank First Class Constable Housego for his investigation and report.

I extend my particular thanks to Mr Shaun Hancl, graduate legal trainee, for his assistance in relation to the preparation and finalisation of this finding.

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

Dated 28 October 2019 at Hobart in the State of Tasmania.

Simon Cooper
Coroner