MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of John Douglas Pettigrew

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

a) The identity of the deceased is John Douglas Pettigrew ("Mr Pettigrew");
b) Mr Pettigrew died as a result of hypovolemic shock caused by multiple injuries of the chest, abdomen and pelvis sustained in a motor vehicle crash;
c) Mr Pettigrew's cause of death was hypovolemic shock and:
d) Mr Pettigrew died on 7 May, 2019 at Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Pettigrew's death. The evidence includes:

- the Police Report of Death;
- affidavits establishing identity and life extinct;
- affidavit of Dr Donald Ritchey State Forensic Pathologist;
- Forensic Science Service Tasmania – toxicological and analytical report;
- Ambulance Tasmania patient care report;
- affidavits of Mr Jason Hardy, transport inspector, who inspected both vehicles involved in this crash;
- affidavit of Mr Seth Stallknecht;
- affidavit of Ms Julie-Anne Booth;
- affidavit of Ms Cheryl Ambrose;
- affidavits of Anna Gebka;
- affidavit of Constable Angela Lang;
- affidavit of Richard Young;
- affidavit of Sergeant Luke Walker and his scene notes and diagrams;
- affidavit of Senior Constable Adam Hall and the scene survey he prepared;
- affidavit of Tara Kurrajong - senior next of kin;

- affidavit of Constable Tania Curtis together with photographs of the accident scene she took on 6 May 2019;
- affidavit of Matthew Streat (rank not stated) together with photographs of the accident scene he took on 8 May 2019;
- affidavit of Tammy Lynd;
- papers with respect to blood samples taken from Mr Pettigrew and Ms Gebka;
- Tasmania police traffic crash report prepared by Constable Lang;
- weather observations for the date of the accident obtained from the Bureau of Meteorology;
- report obtained from the Department of State Growth with respect to crash history at the crash scene;
- report from the State Roads Division of the Department of State Growth with respect to this motor vehicle crash;
- Department of State Growth road construction plans at the site of this crash;
- Mr Pettigrew's medical records obtained from the Snug Medical Centre, General Practice Plus clinic at Kingston, Dr Georgie Stilwell, consultant endocrinologist, and the Royal Hobart Hospital;
- documentation with respect to Mr Pettigrew's fitness to drive assessment;
- driver licence history of Mr Pettigrew and registration history of his motor vehicle;
- Bosch crash data and police incident log; and
- CCTV footage and the results of a forensic examination of Mr Pettigrew's mobile telephone.

This investigation concerns a fatal two vehicle crash that occurred on the Midland Highway, Kempton at the entrance to the Mood Food service station on 6 May 2019 at approximately 16:45 hours. At that time Ms Anna Gebka was the driver and sole occupant of a Toyota Hilux utility registration number H12WY which was travelling north on the Midland Highway just north of Kempton. Mr Pettigrew was the driver and sole occupant of a Toyota Prius hatchback registration number H64WD which was exiting the southern driveway of the Mood Food service station at Kempton. The weather at the time of the crash was fine and the road was dry. The speed limit in this area of the Midland Highway is 110km/h and a 110km/h speed sign is present for northbound vehicles approximately 100 metres north of the intersection of the Midland Highway with Main Street, Kempton.

Background

Mr Pettigrew was born on the 2 of October 1943 at Wagga Wagga, in NSW and was 75 years of age, single and he resided alone at the date of his death. He was the eldest of three children.

At the age of 2 he moved with his family from Wagga Wagga to Katoomba in NSW where he lived until he studied medicine at the University of Sydney. After Mr Pettigrew completed his studies he completed an internship at the Prince Alfred Hospital before working at a neuroscience laboratory in Sydney.

While studying at university in the 1960's Mr Pettigrew met Iluna Bluwater and they married in 1968. Following their marriage, the couple moved to California where Mr Pettigrew worked for approximately 9 years at the Californian Institute of Technology as a Professor of Physiology. They had three children Tara Kurrajong and Galen Greenleaf who were both born in the USA, and Chloe Callistemon who was born in Brisbane, QLD.

On returning to Australia Mr Pettigrew worked at Monash University for approximately 4 years before the family moved to Brisbane where he worked as the Professor of Physiology at the University of Queensland. Mr Pettigrew continued working at the University of Queensland until he retired in 2011.

In 1993 he and Ms Bluwater divorced. Mr Pettigrew did not have any other significant relationships after this time and he never remarried. In 1988 Mr Pettigrew was diagnosed with Bipolar Disorder and spent one month in hospital. This was the only admission to hospital for this condition which was primarily managed with medication. When he was young Mr Pettigrew broke both his ankles in a rock-climbing accident and they were both fused. He did suffer some arthritis however fusing his ankles did not affect his walking or his ability to drive. In or about August 2018 he moved to Tasmania and lived with his son, Galen, before he moved into his own unit in late 2018. Prior to that time he had been living with his son and travelling backwards and forwards from Brisbane.

Ms Kurrajong says *"I very rarely got in the vehicle with dad, even from a young age we didn't like his driving, I feel he was very easily distracted and he would often drift in and out of his lane and sometimes drive too fast"*.

Mr Pettigrew's medical records primarily record the fact he had insulin dependent diabetes and as a consequence neuropathy of the feet. On 12 November 2018 Mr Pettigrew received notification from the Department of State Growth that due to this condition he was required to undergo a medical fitness to drive assessment. By letter of 14 January 2019 the general practitioner Dr Madelaine Hanson advised the Department that Mr Pettigrew was medically fit to drive to a private standard. Mr Pettigrew was also required to undergo a diabetic foot assessment conducted by a podiatrist. This assessment was conducted by Mr Daniel Lewis. The general practitioner, Dr Robert Hamilton, reported on that assessment by way of a letter to the Department of State Growth on 14 January 2019. As a result of that assessment Dr Hamilton said Mr Pettigrew's medical condition did not interfere with his ability to drive a motor vehicle.

The Circumstances Leading to Mr Pettigrew's Death

Mr Stallknecht worked as a computer technician and salesperson for Jessups IT and Computers which is located in Wellington Street, Launceston. Mr Pettigrew had driven from his home in Woodbridge to Jessups to have a mobile phone screen replaced. Email correspondence between Mr Pettigrew and Jessups indicates that although it is a considerable distance to drive for electronics repairs, Jessups was Mr Pettigrew's provider of choice.

Mr Pettigrew arrived at Jessups at approximately midday and presented his iPhone to Mr Stallknecht. After inspecting the phone Mr Stallknecht determined it could not be repaired and thereafter he assisted Mr Pettigrew in selecting a new phone to purchase and he assisted Mr Pettigrew in setting the phone up and transferring data between the old and new phones. Mr Pettigrew remained in the store for the entire time until these matters were attended to. Mr Pettigrew left the store at approximately 13:30 hours.

CCTV footage from Mood Food at Kempton captures Mr Pettigrew driving his vehicle into the carpark at 16:15 hours. He is observed in the customer service area of the service station at 16:41 hours. At 16:43 hours he is observed walking to his motor vehicle.

The Circumstances of the Crash and its Aftermath

At approximately 16:45 hours Ms Gebka was driving the Toyota Hilux utility north on the Midland Highway towards the entrance to the Mood Food service station at Kempton. Mr Pettigrew reversed his Toyota Prius from its parked position adjacent to the customer service area of the

service station and drove across the southern driveway entrance/exit to the service station to a position where his vehicle was facing east towards the highway. He stopped just prior to the slip lane which permits vehicles travelling north to exit the highway and enter the forecourt and car park of the service station. Ms Ambrose was the driver of a blue Kia motor vehicle which was parked in a position in the forecourt immediately adjacent to the highway facing in a northerly direction. When Mr Pettigrew was reversing his motor vehicle Ms Ambrose performed a U-turn and stopped at the give way line of the southern entrance/exit to the service station, facing east where she waited to turn right and head in a southerly direction on the Midland Highway. She observed Mr Pettigrew's vehicle behind and to the west of her vehicle and she says it appeared to be blocking the slip lane. The CCTV footage shows Mr Pettigrew's vehicle partially blocking that lane however 2 vehicles exit the highway via the slip lane and pass by Mr Pettigrew's vehicle and into the forecourt and car park of the service station. Ms Ambrose tried to get Mr Pettigrew's attention by waving her arms and saying out loud *"get behind me get behind me"* but she says he appeared to take no notice of her. Mr Pettigrew's vehicle remained stationary for a period of 28 seconds and it then leaves that position just after the 2 vehicles exit the highway via the slip lane and pass his vehicle. While Ms Ambrose was stationary and waiting to turn right onto the highway she says Mr Pettigrew's vehicle came up beside her, on her right hand side. She looked directly at him but he appeared to be looking straight ahead. She says *"he did not look left or right and suddenly accelerated and pulled straight out onto the highway"*. She observed a collision between the 2 vehicles and she reversed back into the car park, told her grandchildren to stay in the car and ran over to the Toyota Prius. By that time 2 workmen were at that vehicle asking Mr Pettigrew whether he could hear them but he was not responding. She also spoke briefly to Ms Gebka and Ms Ambrose observed Ms Gebka was very upset.

Ms Gebka says she was travelling at or about the speed limit. The cruise control of the Toyota Hilux was not activated. As she approached the entrance to the service station she observed a blue stationary vehicle at the stop line giving way prior to entering the highway. As she got close to the entrance she observed a white Toyota Prius come from behind the blue car and drive past the driver's side of the blue vehicle. As the Toyota Prius continued to drive slowly towards the highway she took her foot off the accelerator and as she got closer she realised the driver was not going to stop and when he was at or about the stop line *"he accelerated fairly quickly and straight in front of my vehicle. At this stage I would have only been a really short distance from the other vehicle may be only around 20 m"*. At the point at which Mr Pettigrew accelerated Ms Gebka engaged the brake of her vehicle as hard as she could. This version of events is consistent with what is captured on the CCTV footage.

The first police on the scene were from the Kempton police station and one of those officers, Constable Lang, arrived shortly after 16:55 hours which is when she was notified of the crash. Officers also attended from the road and public order service and the road was closed soon after their arrival. Ambulance Tasmania, the Tasmania Fire Service and SES also attended the scene. Constable Lang went to the driver's side of the Toyota Prius and observed Mr Pettigrew in the driver's seat wearing his seatbelt. The airbags in the vehicle had deployed. Due to the damage to the vehicle the driver's side door could not be opened. She spoke to Mr Pettigrew however he did not respond. His head was slumped forward so she lifted up his chin in an effort to maintain his airway and continued to speak to him however there was no response. Shortly afterwards Mr Young introduced himself as a trainee paramedic and he assisted Constable Lang by sitting in the back of the vehicle behind Mr Pettigrew where he held Mr Pettigrew's head upright while they waited for assistance. Constable Lang then directed her attention towards maintaining the scene, directing traffic and taking the details of potential witnesses. Mr Pettigrew's extraction from the Toyota Prius was prolonged as emergency services had to remove its roof. Once he was removed from the vehicle Mr Pettigrew was airlifted to the Royal Hobart Hospital in a critical condition.

Sergeant Walker and Senior Constable Hall from crash investigation services arrived at the scene at 18:45 hours. The scene was marked and a scene diagram was prepared. Measurements of relevant incident marks were recorded and Constable Curtis photographed the scene at the direction of both Sergeant Walker and Senior Constable Hall. A preliminary inspection of both vehicles was undertaken and they were both conveyed to the police garage in Hobart for inspection. Officer Streat attended the scene on 8 May 2019 at approximately 4:30 pm where he was briefed by Sergeant Walker. Sergeant Walker directed him to take photographs of the scene at this time of the afternoon so that the approximate light conditions at the time of the crash could be considered. Officer Streat says there was sufficient natural lighting to see well beyond 600 metres looking in any direction.

Post-Mortem Examination

A post-mortem examination was conducted by the State Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey notes CT scans confirmed severe injuries had been sustained by Mr Pettigrew who was sent to the operating theatre for an emergency laparotomy however he died from his multiple injuries. Dr Ritchey's opinion is Mr Pettigrew's cause of death was hypovolemic

shock arising out of multiple injuries to the chest, abdomen and pelvis which were sustained in this motor vehicle crash. I accept Dr Ritchey's opinion.

An analysis of samples taken at autopsy confirmed Mr Ritchey had no alcohol or illicit drugs in his blood. The only results of note were sub therapeutic concentrations of tadalafil and ketamine. Cotinine was also detected. Mr Pettigrew's medical records indicate he had previously undergone a prostatectomy and this may well explain the presence of tadalafil. Ketamine was administered during treatment and cotinine accumulates in the body as a result of exposure to tobacco. None of these drugs had any effect on Mr Pettigrew's ability to drive a motor vehicle.

Crash Investigation

The crash investigation in this matter is essentially contained in the affidavits of Sergeant Walker and Senior Constable Adam Hall. Senior Constable Hall also provided a subject report. I am satisfied that both officers are qualified to express the opinions contained in those documents.

Both Sergeant Walker and Senior Constable Hall attended and inspected the scene of the crash. They both undertook a number of investigations at the scene. It was noted the highway in the vicinity of the crash has a general north/south orientation. There is one lane of travel for southbound traffic, towards Hobart, a turning lane into the Mood Food service station and one lane of travel for northbound traffic towards Launceston. There is also the slip lane which permits vehicles to leave the northbound lane and enter the service station. The bitumen road surface was in good condition. The north and south lanes are separated by a steel rope barrier. The crash occurred in the northbound lane directly adjacent to the southern driveway entrance/exit to the Mood Food service station.

The northbound lane is 4.2 metres wide and is separated from the southbound turning lane (into the service station) by a steel rope barrier. The turning lane is 4 metres wide and the southbound lane is 3.1 metres wide from the turning lane to the eastern fog line. The turning lane and the southbound lane are separated by a solid white line. When approaching Mood Food from the South the Midland Highway is a straight stretch of road for about 300 metres.

After the crash the Toyota Hilux came to rest at the southern end of the southbound turning lane facing south. It had significant damage to the front end which had been pushed rearward. The bonnet was creased and folded rearward with the most significant damage toward the

passenger side. White paint transfer was present on the bonnet and this was determined to be as result of the collision with the white Toyota Prius. Front, curtain and knee airbags had been deployed in the vehicle. There was evidence of burning and stretching to the driver's seat belt indicating it had been worn at the time of the crash.

In the southbound lane was the Toyota Prius which was facing generally east. It had extensive driver-side damage. The rear driver side door and the B pillar had been removed, and the roof cut at the A and B pillars and folded backwards to extricate Mr Pettigrew. The driver's door and wheel arch panel displayed heavy contact damage and were buckled and folded. Black and blue paint transfer was present on the driver's door from the bumper and registration plate of the Toyota Hilux. Both front airbags had deployed. The seatbelt had been cut by emergency services and the tongue was in the driver's buckle indicating it had been worn at the time of the crash. The entire dash panel including the instrument cluster and steering column was extensively damaged by the impact.

Several tyre scuff marks were identified. The first set of tyre marks were observed on the eastern fog line of the northbound lane at the conclusion of the southern wire safety barrier. This mark commenced 5.37 metres east of the give way line exiting Mood Food and continued 4.95 metres in a north-east direction towards the final resting position of the Toyota Prius. This scuff mark was caused by the front right tyre on the Toyota Prius as it was pushed sideways by the Toyota Hilux. Two other tyre scuff marks were identified from this vehicle, one from the front left tyre measuring 4.5 metres in length and one from the rear left tyre measuring 6 metres in length. All 3 tyre scuff marks were caused by the Toyota Prius being pushed from the point of impact towards its final resting position. At the end of the scuff marks the vehicle continued in an easterly direction for about 10 metres to where it came to rest against the eastern most wire barrier.

Two tyre scuff marks were identified from the Toyota Hilux as it rotated to its final resting position after impact. The first mark was identified 7.6 metres north of the conclusion of the southern wire safety barrier and 5 metres east of the give way line exiting Mood Food. This scuff mark was 3.2 metres in length and rotated in a north-easterly direction. It was made by the front right tyre of this vehicle. The second mark identified was 9.8 metres north of the conclusion of the southern wire safety barrier and 4.2 metres east of the give way line exiting Mood Food. It was 3.7 metres in length and it also rotated in a north-easterly direction and was made by the left rear tyre of the vehicle as it rotated in a clockwise direction to its final resting position. This

vehicle came to rest facing south and it was approximately 7.8 metres north east of the approximate point of impact which was in the centre of the 2 lanes.

There were no pre-impact tyre skid marks identified on the highway from either vehicle. Given the evidence it was Senior Constable Hall's opinion Mr Pettigrew was not aware a collision was imminent and as such he would not have applied emergency braking. Both vehicles were fitted with anti-lock braking systems and they rarely leave any evidence of braking on the road surface.

The Toyota Hilux collided heavily with the driver's side door of the Toyota Prius. Due to the forward momentum of the Prius as it attempted to cross to the southbound lane that vehicle was pushed slightly north after impact as it continued east into the southbound lane between the gap in the steel wire barrier. That barrier allows vehicles to turn right into the service station from the southbound turning lane and it permits vehicles exiting the service station to turn south. The Prius came to rest over the eastern fog line facing east approximately 12.7 metres from the point of impact.

Following impact the Toyota Hilux rotated approximately 170° and came to rest at the end of the southbound turning lane into the service station, approximately 7.8 metres from the point of impact. The cause of this vehicle's rotation is attributed to by the forward momentum of the Prius in an east bound direction. As the vehicles collided the forward momentum of the Hilux pushed the Prius slightly north as it continued east. The forward momentum of the Prius towards the east has caused the Hilux to rotate clockwise at impact as the Prius continued across the northbound lane.

Senior Constable Hall says many vehicles are fitted with what is known as an Event Data Recorder (EDR) which is installed to record technical vehicle and occupant information for a brief period of time before, during and after a crash for the purpose of monitoring and assessing vehicle safety system performance. This data is often stored within the Airbag Control Module (ACR) the primary function of which is to control the deployment of supplementary restraint devices fitted to the vehicle. Such devices include seat belt pre-tensioners and front, side, knee, curtain and rollover airbags if fitted. The recording of data within the ACR is a secondary function. The Toyota Hilux was fitted with an EDR but the Toyota Prius was not. On 13 May 2019 Senior Constable Hall attended the police garage and using a Bosch crash data retriever tool he downloaded that data from the EDR. Senior Constable Hall analysed that data and determined the following:

- 5 seconds of pre-impact data had been captured with a snapshot every half a second;
- 4.95 seconds prior to impact the Toyota Hilux was travelling at 108 km/h;
- 2.95 seconds prior to impact Ms Gebka took her foot from the accelerator;
- 0.95 seconds prior to impact Ms Gebka applied the vehicle's brake;
- the emergency application of the brake slowed the Toyota Hilux to a speed of 67 km/h at impact.

Senior Constable Hall's investigations also determined in the five-year period to 6 May 2019 there had been a total of 6 crashes, including this one, on the Midland Highway at Kempton but all the other crashes apart from this one are listed as causing minor injury or property damage only. There is no history of previous crashes involving vehicles turning out of Mood Food. The State Roads Division of the Department of State Growth provided a report with respect to the engineering and road environment at the crash scene. The conclusion in that report is the sight distance to the south from Mood Food exceeds that recommended by Austroads Guidelines. A single recommendation is made that *"[a] right turn arrow should be provided at the exit from Mood Food"*. The report notes the design drawing shows an arrow on the exit from Mood Food but no such marking had been provided at the date of this crash.

Inspection of the Vehicles

Jason Hardy is a qualified diesel fitter with 34 years experience and he has been employed as a transport inspector for 13 years. During that time he has inspected numerous vehicles involved in both serious and fatal crashes. On 16 May 2019 he inspected the Toyota Hilux utility. His inspection revealed that vehicle to be in a well maintained roadworthy condition prior to this crash. His opinion is the mechanical state of that vehicle did not contribute to this crash. He inspected the Toyota Prius on 14 May 2019. His inspection revealed that vehicle to be in a well-maintained and roadworthy condition prior to this crash. His opinion is the mechanical state of this vehicle did not contribute to this crash. I accept Mr Hardy's opinions.

Accident Cause

Senior Constable Hall has expressed the opinion that as a result of his inspection of the scene, the vehicles and after analysing all the evidence available he is satisfied excessive speed was not a factor in the crash. He is also satisfied Ms Gebka did not cause or contribute to the crash. He says she was abiding by the *Road Rules* at the time of the crash and was left with insufficient time to avoid it. In addition he says there is no evidence to suggest Mr Pettigrew was suffering any

form of medical condition or sudden medical episode which contributed to the crash and there is no evidence to suggest he was using his mobile telephone at the time. It is Senior Constable Hall's opinion this crash was solely caused by inattentiveness on the part of Mr Pettigrew who failed to give way as required to the oncoming Toyota Hilux which was travelling at below the posted speed limit.

I accept the opinions of Senior Constable Hall as set out above.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Adam Hall for his investigation and report.

I commend the efforts of Constable Lang and the final year paramedic student Mr Young who went to Mr Pettigrew's aid prior to the arrival of Ambulance Tasmania personnel.

The circumstances of Mr John Pettigrew's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the Coroners Act 1995 although I had intended to make 1 recommendation. Although not causative of this crash I intended to recommend the State Government which owns and maintains the Midland Highway provide a right turn arrow at the exit from Mood Food. A recent trip to the scene while on other business revealed that arrow had been marked on the roadway pavement since this crash. A recommendation is therefore not required.

This case serves as a timely reminder that momentary lapses in concentration or inattentiveness by drivers of motor vehicles can have tragic consequences.

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

Dated: 4 January 2022 at Hobart Coroners Court in the State of Tasmania.

Robert Webster
Coroner