
FINDINGS, COMMENTS and RECOMMENDATIONS
of Coroner McTaggart following the holding of an
inquest under the *Coroners Act 1995* into the death of:

CYNTHIA STEVENS

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Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Cynthia Stevens with an inquest held at Hobart in Tasmania make the following findings.

Hearing dates

14 April 2022 and 18 May 2022, final closing submissions received 9 September 2022.

Representation

Counsel Assisting the Coroner: E Belonogoff

Counsel for Hobart Eye Surgeons: K Cuthbertson SC

Counsel for Mr Wing Chung Yim: P Morgan

Introduction and scope of inquest

1. Mrs Cynthia Stevens, aged 90 years, died on 1 December 2019 as a result of multiple rib and pelvic fractures following a fall from her wheelchair in the car park of Hobart Eye Surgeons (HES) premises in Argyle Street. Mrs Stevens had been taken by taxi to her appointment at HES accompanied by her daughter, Ms Kristine Steele. She had been receiving treatment for macular degeneration and was dependant on a wheelchair for mobility.
2. Upon arrival at the premises she was taken out of the taxi in the allocated disability car parking space and wheeled a short distance away to an area of the car park with a downhill slope. The sign on the fence at this area depicted a wheelchair and may have suggested that it was safe for Mrs Stevens to remain there. She was briefly left in that area in her wheelchair whilst her daughter paid the taxi driver near the taxi. It was during this time that she suffered her fatal fall.

3. Mrs Stevens' death was a death reportable to the coroner under the *Coroners Act 1995* (the Act) as a death occurring in Tasmania that appeared to have resulted directly or indirectly from an accident or injury. After investigation, I considered it desirable to hold an inquest into Mrs Stevens' death, particularly as there remained issues concerning the application of brakes on the wheelchair and the safety of the car park.¹
4. The inquest considered the circumstances surrounding Mrs Stevens' fall to enable the requisite findings to be made under s 28(1) of the Act. The inquest involved particular consideration of the following matters:
 1. The actions of Ms Steele and Mr Yim before Mrs Stevens' fall;
 2. Mr Yim's training and experience regarding wheelchair accessible taxis and wheelchairs;
 3. The condition and use of Mrs Stevens' wheelchair; and
 4. Issues regarding the car park of HES, including its disability car parking space, slope, and signage.

Evidence in the investigation

5. The documentary evidence tendered at inquest comprised 16 separate exhibits. These exhibits can be categorised as follows:
 - Police Report of Death to the Coroner;
 - Affidavits confirming life extinct and identification;
 - Affidavit of forensic pathologist, Dr Donald Ritchey, regarding cause of death;
 - Three affidavits of Kristine Steele, daughter of Mrs Stevens;
 - Two affidavits of Wing Chung Yim, wheelchair taxi driver;
 - Photographs of the location of the fall taken by Constable Brett Suttor;
 - CCTV footage from HES depicting the fall and car park area;
 - Wheelchair inspection report and photographs provided by Ronan Dawe of TasMobility;
 - Email correspondence from the wheelchair supplier about the owner's manual;
 - Report by Matthew Cordwell, wheelchair specialist;
 - Affidavit of Dr Paul McCartney, director of HES Pty Ltd, trading as HES; and
 - Statement and photographs provided by Mrs Stevens' family.

¹ *Coroners Act 1995* s 24(2).

Mrs Stevens' background and health

6. Mrs Stevens was born in Hobart in Tasmania on 13 May 1929 and was the youngest of ten children. She was married to Mr William Stevens in 1956 and they had two daughters. Mrs Stevens' daughters, Kristine Steele and Lindy Devereux, remember many good times and activities as a family. They describe Mrs Stevens as a loving, dependable and selfless mother who was very proud of her daughters.
7. Mr Stevens passed away in 2000, following which Mrs Stevens continued to live in the family home until a series of falls resulted in her needing home care. At about this time, her macular degeneration in both eyes caused deteriorating vision. Mrs Stevens' daughters would take turns accompanying her to her monthly eye injections at Hobart Eye Clinic. Mrs Stevens also suffered emphysema and Sjogren's syndrome which limited her ability to care for herself. Sjogren's syndrome is a complex, multisystem immune disorder with sufferers at increased risk of bone fragility and fractures. Mrs Stevens' daughters also reported that she had significant arthritis in both hands.
8. In 2018 Mrs Stevens had a particularly serious fall requiring a four month inpatient admission in hospital. It was during this time that she lost her mobility, was unable to return home and became a resident at Barossa Park Lodge facility in Glenorchy (Barossa Park). Mrs Stevens would receive a visit from one or both of her daughters at Barossa Park on a daily basis. During her residency at the nursing home she was limited in her capacity to care for herself due to her medical conditions.

Circumstances surrounding death

9. On the morning of 28 November 2019, Ms Steele travelled to Barossa Park Lodge to meet her mother, Mrs Stevens. She had arranged a wheelchair accessible taxi to take them both to Mrs Stevens' appointment at HES at 182 Argyle St, Hobart.
10. The taxi that arrived was driven by Mr Wing Chung Yim. Ms Steele wheeled Mrs Stevens over to the taxi where Mr Yim took over. Mr Yim moved Mrs Stevens into the rear of the taxi and secured her wheelchair with straps before driving to HES.
11. When the taxi arrived at HES, Ms Steele indicated to Mr Yim where they would normally park – in a 5 minute public “drop-off” zone on Argyle St directly outside the lower street front entrance of HES. This drop-off zone has space for two or three vehicles and was situated on a level part of the street. The evidence at inquest indicated that HES had reached agreement with the Hobart City Council in 2007 to create the drop-off zone so that HES patients, particularly those with mobility

difficulties, were able to enter HES and use the internal lift to travel to the upper reception area.

12. On that day, however, Mr Yim and Ms Steele saw that there were other vehicles occupying the drop-off zone and the taxi was not able to park there upon reaching the premises.
13. Mr Yim therefore turned left from Argyle Street into the HES car park adjacent to the HES building and reversed into the specifically marked disabled car park. At that time, Ms Steele commented to Mr Yim that she had concerns about going into the car park due to it being steep. She gave evidence at inquest, which I accept, that her mother had never been taken into the HES car park on the approximately eight previous occasions she had accompanied her to her appointments. Instead, Mrs Stevens had been dropped off at the drop-off zone on the street.
14. The HES car park is located on sloping land and the main entrance of the building is accessed from this sloping car park. There is one disability car parking space together with numerous other car parking spaces sufficient for patients of the practice. The disability car parking space, which was compliant with regulations when it was created in 2007, was selected for its proximity to the main entrance of the building and a less steep gradient in that area.
15. Having reversed into the disability car parking space, Mr Yim assisted Mrs Stevens out of the taxi by partly releasing her from straps that secured her within the taxi and wheeled her to a spot several metres to the rear of the taxi in the direction of the main entrance of the building. Again, the area in which the wheelchair was situated was on downward sloping land. Mr Yim said that he applied all of the brakes on Mrs Stevens' wheelchair – both attendant brakes, and both wheel lock brakes. Ms Steele believed Mr Yim applied brakes on the wheelchair, but could not recall which ones. The application of the brakes on the wheelchair became the most significant issue at inquest. I will deal with the configuration of the wheelchair and this issue in more detail below.
16. Whilst Mrs Stevens' wheelchair was placed in this position, Mr Yim unhooked the remaining two straps securing the wheelchair to the taxi. These straps had extended some distance from the rear of the taxi. Ms Steele then retrieved a taxi assistance card from Mrs Stevens' handbag. Both Mr Yim and Ms Steele went back to the taxi to arrange payment for the fare.

17. From the CCTV footage of the incident, it appears that the wheelchair began to move several metres down the slope, before Mrs Stevens toppled out and landed on her left side. Ms Steele and Mr Yim, who were still standing at the front passenger side of the taxi, rushed to help Mrs Stevens.
18. Ambulance Tasmania paramedics attended and noted that Mrs Stevens was alert, though complaining of pain. She was taken to the Royal Hobart Hospital. A CT scan confirmed that Mrs Stevens suffered multiple bone fractures to her left clavicle, T6 vertebra, pelvis, greater trochanter and ribs. Her injuries were not operable and she was given pain relief. Mrs Stevens died on 1 December 2019.

Movements of Ms Steele and Mr Yim

19. Mr Yim moved to Tasmania from Hong Kong in 2017. His native language is Cantonese. At that time, he had a basic understanding of English, and undertook more language tests once in Australia. He required an interpreter for his evidence at inquest, although he had the ability to answer some questions directly and, in general, he was able to understand a significant amount of the evidence without the aid of an interpreter. Relevantly, in November 2019, I find that his lack of fluency in the English language and communication likely posed some impediment at times when situations demanded more complex communications with users of taxis.
20. Mr Yim started driving taxis in mid-2017. His induction training occupied three days, mainly relating to the geography of Hobart and driving instructions. Part of this training addressed wheelchair accessible taxis. At the time of the incident, Mr Yim had been driving the particular wheelchair accessible taxi used to transport Mrs Stevens for six months as his primary vehicle. He was working part-time and averaged two fares per day that involved a wheelchair user. He said he was comfortable with applying wheelchair strapping restraints in the taxi but noted that all wheelchairs he encountered were different and required different strapping to stop them from moving inside the taxi.
21. It is not clear what training Mr Yim had received from his employer regarding the safe unloading of wheelchair users and application of brakes on wheelchairs. However, Mr Yim's experience demonstrates an appreciation for the variations of wheelchairs and the safety of their users during his transportation. There is no evidence to suggest that Mr Yim lacked the experience or training to safely transport and unload Mrs Stevens.

22. Mr Yim presented during all phases of the investigation and inquest as a genuine and caring person, respectful of the court processes and the family of Mrs Stevens. It was apparent that the incident involving Mrs Stevens and her death significantly affected him. He ceased driving taxis in August 2021. His evidence will be discussed below. I find that he was trying to assist the court in its inquiry and was not attempting to exaggerate or mislead the court in relation to circumstances surrounding Mrs Stevens' fall.
23. On 28 November 2019, the taxi driver usually engaged by Ms Steele was unavailable and had made arrangements for Mr Yim to transport Mrs Stevens to HES. Although Mr Yim had never transported Mrs Stevens previously, he had transported a client to the HES premises on one prior occasion and had parked in the five minute drop-off zone. Ms Steele gave evidence that Mr Yim alone put Mrs Stevens in the taxi, and noted that it took longer than usual for Mr Yim to apply the straps to Mrs Stevens' wheelchair.
24. Mr Yim gave evidence that, upon arriving at HES, he had to think quickly about where to park given the unavailability of the drop off zone. He therefore drove into the HES car park. Ms Steele did not direct Mr Yim to the car park. The HES footage captured the arrival of the taxi and appears to show the taxi pause before it turned into the car park, consistent with Mr Yim's evidence.
25. Ms Steele said at inquest that she did not think Mr Yim understood her articulated concern about the steep car park due to the language barrier. Mr Yim said in evidence that there was no conversation between himself and Ms Steele about the car park because there were no other options for parking. Mr Yim accepted in cross-examination that he did not wait long in the drop-off zone because the other vehicles did not look like they were moving.
26. Mrs Stevens was on time for her appointment, and had never been turned away for being late. It did not appear to me that time pressure to attend her appointment was a significant factor in the circumstances surrounding her fall. Ms Steele gave evidence that the appointment time was 10.10am and the footage indicates that the taxi arrived in the car park at that time.

27. After reversing the taxi into the disability car park, Mr Yim alighted quickly and opened the rear door of the taxi, where he commenced the process of assisting Mrs Stevens out of the taxi in the wheelchair. He gave evidence that he pressed a button to release a belt securing the wheelchair in the taxi and unlocked the brakes on her wheelchair. He positioned the wheelchair ramp from the taxi to the ground and brought Mrs Stevens down the ramp. Mr Yim wheeled Mrs Stevens to a space in front of a sandstone retaining wall and fence, a distance appearing to be no greater than 5 metres from the rear of the taxi. At this point, there were four straps from the taxi still attached to Mrs Stevens' wheelchair. Mrs Stevens was positioned at the point of almost full extension of these straps.
28. Mr Yim then applied at least one of the attendant brakes on the wheelchair and removed the straps. This completed what I will term the unloading process. I will discuss and make findings below regarding the application of the brakes. Ms Steele had alighted from the taxi and was in the vicinity of Mr Yim and her mother during the unloading process. From the footage, I can determine that the period of time from the parking of the taxi (2.44 minutes into the clip) to the completion of the unloading process (4.20 minutes) took a little over one and a half minutes.
29. After the unloading process, Mr Yim and Ms Steele moved to the passenger side front of the taxi and remained there for approximately 45 seconds to complete payment of the fare, during which time Ms Steele can be seen frequently looking back at her mother. Mr Yim and Ms Steele were then alerted to Mrs Stevens falling down the slope.
30. The footage indicates that, prior to the commencement of her fall, Mrs Stevens appears to place a foot down and lean forward in her wheelchair. It appears that this movement may have precipitated forward momentum of the wheelchair, and subsequently it moved down the slope in an uncontrolled manner, initially travelling in an arc to Mrs Stevens' left side and then swinging back in an arc to her right side. As the wheelchair moved in the right-hand arc Mrs Stevens was thrown from the wheelchair and landed on her left side. She was initially conscious and all parties remained with her until the ambulance arrived 24 minutes later. I note that the police investigator in this case estimated the distance travelled by Mrs Stevens was approximately 4 metres with a drop of 500 mm in height in that distance. Having viewed the slope, I consider it to be reasonably steep regardless of its precise gradient.

31. I should note several matters at this stage, which I acknowledge are points made with the benefit of hindsight and knowing of the sad outcome.
32. Firstly, it is the case that once the straps from the taxi were removed from the wheelchair, and Ms Steele and/or Mr Yim had the opportunity to move Mrs Stevens in her wheelchair to a safe and flatter location a short distance down the slope and just outside the front entrance to HES. They could have left her unattended in this location whilst the taxi fare transaction completed. However, this location placed Mrs Stevens further away from them. Ms Steele did not direct Mr Yim where to place Mrs Stevens outside the taxi. Neither she nor Mr Yim considered parking her wheelchair on any flatter areas. Mr Yim said there was no conversation about where to place the wheelchair and that Ms Steele did not raise any concern with where Mrs Stevens was placed. There was no sufficient space within the markings of the disability car parking space. Mr Yim believed that Mrs Stevens was safe where she was, and he was satisfied the brakes were on.
33. Secondly, there was no discussion between Mr Yim and Ms Steele about when payment was to be made. Ms Steele assumed that payment would occur after the journey because Mr Yim got out of the taxi straight away upon reaching HES, and she said that she felt governed by what the taxi driver decided to do. In her experience, payment occurred either before or after Mrs Stevens was assisted out of the taxi, depending on the driver.
34. Mr Yim's usual process was for payment to occur after unloading the passenger. Mr Yim gave evidence that he would accept payment at either time but would not impose upon the customer one option over the other, as it would be culturally impolite. Ms Steele accepted that she had not asked to pay for the taxi before Mrs Stevens was removed.
35. Thirdly, Mr Yim and Ms Steele did not consider waiting for the drop-off zone to become available. I do not consider that this was a reasonable option in the circumstances.
36. These matters form part of the facts and circumstances surrounding Mrs Stevens' fall. Comment may be made that it was unwise, given the slope of the land, to leave Mrs Stevens unattended. This fact was, of course, connected with the timing of the fare payment and the less than optimal parking options for the taxi. Unfortunately, the combination of these factors set the preconditions for the event that followed. None of these decisions were made by Ms Steele and Mr Yim with anything but good intentions to deliver Mrs Stevens safely to her appointment.

Application of the wheelchair brakes

37. This inquest focused significantly upon the important issue of which, if any, of the four wheelchair brakes were applied at the time it travelled in an uncontrolled manner down the slope.
38. Prior to dealing with this issue, some discussion regarding the wheelchair itself is warranted.
39. The wheelchair was of a standard design and was a RedGum brand, model RG17 HBD. It was purchased new in January 2019 for Mrs Stevens from the TasMobility shop in Moonah. It had not been subjected to a great deal of use and had not been altered or adjusted since it was purchased.
40. In the investigation, I received reports from Mr Matthew Cordwell, experienced wheelchair technician from Aidacare, and Mr Rohan Dawe, technician from TasMobility Tasmania. Both inspected the wheelchair. I am satisfied that both have expertise in wheelchair operation. I am also satisfied upon the evidence that at the time of their respective inspections, the wheelchair was in exactly the same condition as used by Mrs Stevens and had not been further used.
41. Both Mr Cordwell and Mr Dawe, in providing their reports, commented that Mrs Stevens' wheelchair was in good working condition and not defective.
42. The brake mechanisms on the wheelchair comprised attendant control brakes which are used individually and operated from manual levers under the attendant handles, as well as manual wheel lock brakes which are operated individually by handles on top of each wheel of the wheelchair.
43. Therefore, four separate manual actions are required to apply both sets of brakes. In the case of each set of brakes, the activation of the brake mechanism results in application of pressure to the solid rubber wheel by a metal bar to prevent rotation of the wheel. However, the pressure to the wheel when the attendant brakes are activated is necessarily less than the wheel lock brakes.
44. Mr Cordwell explained that the attendant brakes are used primarily for control when moving the wheelchair and are not designed, by themselves, to hold the wheelchair on a slope. He said, and I accept, that the wheel lock brakes must always be applied to hold the wheelchair stationary. He said that, almost universally, wheelchairs are fitted with wheel lock brakes as they are the most secure.

45. He said, and I accept, that the four available brakes on the wheelchair should be applied to hold a wheelchair stationary and particularly so on a slope. Both Mr Cordwell and Mr Dawe observed, in any event, that the wheel lock brakes were the primary brake mechanism.
46. Mr Dawe commented in his report that the wheel lock brakes, even without the application of the attendant brakes, should be sufficient to hold a wheelchair on a slope.
47. Both Mr Cordwell and Mr Dawe concluded that the right-hand side attendant brake on Mrs Stevens' wheelchair required some adjustment by a tightening of the cable. Mr Cordwell explained that this issue caused the brake to produce less pressure to the wheel than it should have done. Mr Cordwell acknowledged that the need for adjustment may not be obvious to first time users and may take some time to notice. He could not say what caused the need for the adjustment or when it arose. Ms Steele was not aware of any weakness in the attendant brake and, upon the evidence, could not have reasonably known of the issue.
48. Mr Cordwell demonstrated at the inquest with the wheelchair how, when both attendant brakes were locked, the right-hand side wheel could still rotate when some forward moving pressure was applied. When the wheel lock brake was also applied, this greatly restricted the movement of the tyre, because it applied significantly more pressure than the attendant brake.
49. It was difficult, prior to the inquest, to reconcile the available evidence to determine whether the critical wheel lock brakes were applied to the wheelchair. Mr Yim maintained in his affidavits and statements that he applied both wheel lock brakes. However, the footage of the incident did not appear to support that fact. It appeared that a clear movement is visible on the footage when Mr Yim applied at least the left hand attendant brake, but not the expected movement of applying the wheel lock brakes.

50. Ms Steele's evidence was unable to assist resolve this issue. She did see Mr Yim apply brakes but could not recall which brakes were applied. She said that she was concentrating upon other aspects of the situation with her mother. She stated in her affidavit that, at the time of leaving Mrs Stevens stationary, she asked Mr Yim if he had applied the brakes but could not recall his response. She did not physically or visually check whether the brakes were applied. She herself did not apply any of the brakes.
51. At inquest, Mr Yim gave evidence that he remembered applying all four brakes, but even after multiple viewings of the footage, I found it difficult to identify when exactly the wheel locks were applied and in what order. In evidence, he commented on his movements as he viewed the footage. He identified that he initially applied both attendant brakes at the same time for two seconds between 4.02 and 4.04 as he was standing directly behind the wheelchair. He then, at 4.06, stepped to the right-hand side of the wheelchair. He said that in the three seconds between 4.08 and 4.11 he removed the taxi straps and applied both wheel lock brakes.
52. Mr Yim could not remember the order in which the actions he said he undertook between 4.08-4.11 occurred. He may have applied the wheel locks first before removing the straps, or may have done both at the same time. He was standing on the right-hand side of the wheelchair when applying the wheel locks.
53. Mr Cordwell's evidence at inquest on this point provided assistance. His lengthy experience with wheelchairs includes many instances of observing others applying wheel lock brakes. Having viewed the footage, Mr Cordwell could identify at 4.04 a clear downward movement by Mr Yim, indicating the locking of the attendant brakes. I am able to find, upon all of the evidence, that at least the left attendant brake was applied and possibly the right attendant brake. The fact of application of the attendant brakes was not the subject of dispute between counsel.
54. However, Mr Cordwell said that he did not see the kind of movement that, in his experience, would indicate application of wheel lock brakes. Mr Cordwell could not see any bending towards the wheel locks, an action he expected to see if they were applied. Mr Cordwell could not conclude that the wheel locks were *not* applied, but that in his opinion only the attendant brakes were applied.
55. Counsel for Mr Yim, Mrs Morgan, submitted that it cannot be positively established that the wheel lock brakes were not applied by Mr Yim. I accept her submission that, in order to make such a finding, I should be guided by the standard of proof required as articulated in *Briginshaw v Briginshaw*.²

² (1938) 60 CLR 336.

56. There are several matters that enable me to find to the requisite standard that Mr Yim did not apply the wheel lock brakes. Despite the somewhat grainy quality of the footage, there is no indication that Mr Yim applied the brakes in the nominated 3 second time period or at all. Counsel assisting submitted that, because of where Ms Steele was standing next to the wheelchair, the footage would have had to show Mr Yim reaching around near her in order to apply the left hand side wheel brake. This submission is persuasive. In questioning at inquest, Mr Yim accepted that it was not clear on the footage that he undertook this action. Further, the wheel lock brakes require relatively firm manual downward pressure of the brake mechanism to bring down the metal plate onto the wheel. Whilst this action is not time-consuming, the application of both brakes requiring him to be at different sides of the wheelchair is unlikely to be achieved in just a few seconds. Additionally, in accordance with the expert evidence, it is unlikely that the wheelchair would have moved at all if the wheel lock brakes had been applied. There is always a possibility of the wheels skidding down the hill rather than rotating, but the footage does not indicate a skid and the bitumen surface was not wet. Instead, the wheelchair appeared to roll, perhaps a distance of two or three metres, down the hill in an upright position before it toppled over and Mrs Stevens fell out of it.
57. Finally, it is to be noted that when Mrs Stevens was left in her wheelchair, she was not facing directly down the slope. Instead, she was placed at a distinct angle to the slope with the right-hand side wheel positioned higher on the slope. It would seem as a matter of common sense that the right hand side wheel was bearing less of the weight than the left-hand side wheel. This may partly explain the initial pivot of the wheelchair around the left hand side wheel. It may or may not be that a movement by Mrs Stevens triggered that initial pivot. It may also be that the ineffective right-hand side attendant brake contributed to the fall by allowing the right-hand side tyre to rotate more freely. Mr Cordwell did not conduct experiments in an attempt to recreate the fall, presumably due to the multiple variables involved. Regardless, the movement of the wheelchair is consistent with the attendant brakes being applied but subsequently being unable to hold the wheelchair on the slope.

Seatbelt

58. At the time of the fall, Mrs Stevens was not wearing the wheelchair seatbelt.
59. Mrs Stevens resisted attempts to secure her wheelchair seatbelt at Barossa Park Lodge as she became agitated when staff attempted to fasten it. From that time onwards the seatbelt was not secured by Ms Steele in order to spare her mother further agitation. Counsel did not submit that Mrs Stevens' fall and fatal injuries might have been reduced or prevented had she been wearing her seatbelt.
60. Mr Cordwell identified the purpose of the seatbelt as keeping the person centralised in the wheelchair. Counsel assisting submitted that had Mrs Stevens been centralised in the wheelchair by the use of the seatbelt, her weight would likely distribute generally to the lower, left-hand side. As she was not wearing a seatbelt, her weight may have distributed even further to the left, or she may have counter-balanced to the right.
61. Further, given the movements of Mrs Stevens and the wheelchair before her fall, if she had been attached to the wheelchair by a seatbelt, her downhill travel may have been at a more rapid speed and for a further distance. The fall was, on any scenario, inevitable. I cannot therefore make a finding that the failure to wear a seatbelt was a significant contributor to her fall and injuries.

Causation for death

62. The circumstances contributing to Mrs Stevens' fall are multifactorial. The significant contributing causes were the fact that the wheel lock brakes were not applied to Mrs Stevens' wheelchair whilst she was left unattended on a slope. She was unable, by virtue of her frailty and immobility, to protect herself from falling. Other circumstances which created this unfortunate situation included the lack of space in the drop-off zone, the undesirably steep disability car park and surrounds, the fact that Mrs Stevens was not moved to a flatter space, and the fact that the fare was not paid whilst she was still in the taxi.
63. I do not consider that Mr Yim, in giving evidence, was deliberately giving incorrect evidence regarding application of the wheel brakes. It seems that the most likely explanation for his evidence is that he was not able to countenance not having correctly undertaken his duty. His evidence in other respects was credible.

HES car park

General comments

64. Dr Paul McCartney gave evidence at inquest regarding the HES car park. He acknowledged that patients had previously made comments to HES employees about the steep gradient and said that such concerns had been instrumental in HES entering into discussions with the council to change the street front parking into a five-minute drop-off zone. He also said that there had been no injuries sustained in the car park since the commencement of the business in 2007, with the exception of the incident regarding Mrs Stevens. Although Ms Steele and Ms Devereux had received information that there had been several similar incidents, the evidence in the investigation indicates that this is not the case.
65. Dr McCartney gave evidence that 1000 patients attend HES every week, with a large portion of those patients being elderly. He said that one patient per day requiring a wheelchair would visit HES. It goes without saying that the accessibility and safety of the car park is especially important for elderly and disabled patients. Dr McCartney provided evidence that HES leased the property adjoining the existing car park in 2019 following the incident involving Mrs Stevens. That property now contains additional parking spaces for HES which are on substantially flat land. However, this additional car park does not contain a designated disability car space and is further from the entrance to HES.
66. Dr McCartney annexed to his affidavit a set of preliminary plans commissioned by HES following the incident involving Mrs Stevens. The design brief specified on the plans involves, *inter alia*, a redesign of the access to the front entry of HES to improve vehicle movements and pedestrian access. A new disability parking space has been included on the plans for the existing car park and is depicted on a flat surface close to the street front. He said that any new disability car parking space for HES would comply with current regulations and standards. The plans also have provision for a dedicated passenger drop-off bay and relocated parking bays on the flatter and lower portion of the car park.
67. Dr McCartney gave evidence that the owner of the HES property, Professor Nitin Verma, is supportive of proceeding with the plans. He stated, however, that HES intended to await any findings and recommendations in this inquest before implementing the plans.

Carpark signage

68. A sign on the fence at the location where Mrs Stevens was left near the disability car parking space stated “*Carers should seek assistance at reception*”. The words on the sign were accompanied by pictures of a wheelchair and walking frame. Mr Yim said that he saw the sign on the fence near the disability space, and thought the image of the wheelchair meant it was appropriate for people with a disability to remain at that spot. I do agree, having visited the car park, that the sign may tend to indicate that persons with mobility issues or who require a wheelchair could appropriately remain at that point before calling reception for assistance. Dr McCartney said that the sign on the fence was intended as notice for all carers using any part of the car park, not just the disability car space, to call reception for assistance. He accepted that the sign did not include a phone number for this purpose. He also accepted that more than one sign could have been placed in the car park to make this message clearer. I comment, however, that signage in this circumstance cannot by itself guarantee safety and the prime responsibility lies with those responsible for the care of vulnerable or immobile persons.
69. There was a further sign near the reception entrance to the building, just down the hill from where Mrs Stevens was positioned, which at the time of the incident read “*No drop off here. All drop offs at Lower Entrance in 5 min Parking Zone. Lift available. No standing anytime.*” Next to that sign was a sign “*Ambulance drop off only*” with an arrow pointing to the side of the building.
70. I understood Dr McCartney’s evidence to be that the “*no drop-off*” sign was intended to prevent drop-offs in the whole car park, not just the area immediately in front of the sign. The intention was that all drop-offs would occur in the safer and flat 5 minute zone on Argyle Street.
71. Despite the intentions of both signs, I thought they contained some ambiguity and lack of clarity. It was not specified on the signage how carers could contact reception, when to do so, or what assistance would be provided. Additionally, the “*no drop off*” sign could have been reasonably interpreted to relate only to the immediate area in front of it, rather than the general car park. The presence of the adjacent ambulance drop off sign tends at first glance to also reinforce that interpretation. It would be simply speculative to consider that, if clearer signage was observed by Ms Steele and Mr Yim prohibiting the taxi drop-off in the car park, then the course of events that followed may have been altered.

72. I received evidence from Dr McCartney that a much larger no drop-off sign has now replaced the previous sign. It is situated at the same location near reception, contains similar wording and states that patient drop-off and pick-up is to be on Argyle Street *only*.
73. During this investigation and inquest, HES, its senior staff and Dr McCartney have been most helpful in providing requested information and evidence. I also accept HES and property owner intend to improve the safety of the car park in the manner outlined or similar manner. Given the safety issue involved, is nevertheless appropriate to make a formal recommendation to this effect.

Findings required by s 28(1) of the Coroners Act 1995

- a) The identity of the deceased is Cynthia Stevens;
- b) Ms Stevens died in the circumstances set out in this finding;
- c) The cause of death was multiple rib and pelvic fractures due to a fall from a wheelchair on sloping land; and
- d) Ms Stevens died on 1 December 2019 at Hobart in Tasmania.

Recommendations

74. I **recommend** that HES and/or the owner of the HES premises at 182 Argyle Street finalise plans to redesign and improve the safety of the HES carpark for all users, including the safety of disability car parking spaces and passenger drop-off areas; and proceed without delay to implement such plans.
75. I **recommend** that HES conduct a review of the adequacy and efficacy of the current signage in the car park so far as it concerns safety of all users of the car park; and, if appropriate, implement different or additional signage in order to enhance safety.

Acknowledgements

76. I am grateful for the assistance provided by counsel assisting, Ms Belonogoff, as well as the competent representation provided to their respective clients by Ms Cuthbertson SC and Ms Morgan.
77. I also acknowledge the work of the associates within the Coroner's Office and that of the investigating officer, Constable Brett Suttor.
78. Finally, I convey my condolences to the family and loved ones of Mrs Stevens.

Dated: 22 November 2022 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner