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 Irene Ganley

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

a) The identity of the deceased is Irene Ganley;

b) Mrs Ganley died as a result of an injury she sustained when she was hit by a motor vehicle while walking across the intersection of Harrington and Victoria Streets in Hobart;

c) Mrs Ganley's cause of death was a traumatic closed head injury; and

d) Mrs Ganley died on 2 May 2019 at Hobart, Tasmania.

This investigation concerns an accident which occurred at approximately 2:50pm on Tuesday, 30 April 2019. At that time a grey 2013 Nissan Pathfinder station wagon Tasmanian registered number D70ZU (the vehicle) was being driven by Paul Sciberras north on Harrington Street in Hobart. At the same time Mrs Ganley was walking westbound on Victoria Street towards its intersection with Harrington Street. Her intention was to cross Victoria Street and continue walking south on Harrington Street. As Mrs Ganley was crossing Victoria Street the vehicle made a right-hand turn from Harrington Street striking Mrs Ganley with the front right hand panel. Mrs Ganley was knocked over onto the roadway and sustained significant injuries. She passed away from those injuries on 2 May 2019.

At the time of the accident the weather was fine, the road was dry and it was light. Sergeant Walker describes the weather as being fine and although it was slightly overcast he says it was quite bright. Harrington Street, in the vicinity of the accident, is predominantly flat and consists of three lanes which run from south-east to north-west. Traffic in the right-hand lane can turn right into Victoria Street. There are parking bays on either side of Harrington Street, with the last parking bay on the right-hand side ending 8.3 m prior to its intersection with Victoria Street. Victoria Street is a single lane street with no lane markings. Parking bays are present on the northern side of that roadway and commence 7 m past the intersection. The

intersection is uncontrolled for both vehicles and pedestrians. There is footpath on either side of Victoria Street with a pedestrian crossover apron present on each corner where it intersects with Harrington Street. The prevailing speed limit is 50 km/h.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Ambulance Tasmania (AT) electronic patient care report;
- Royal Hobart Hospital (RHH) death report to Coroner;
- Affidavit of the forensic pathologist Dr Donald Ritchey;
- Affidavit of the forensic scientist Mr Neil McLachlan-Troup of Forensic Science Service Tasmania;
- Medical records obtained from the RHH;
- *Road Safety (Alcohol and Drugs) Act* 1970 paperwork with respect to alcohol and drug testing of a blood sample taken from Paul Sciberras;
- Collision analysis Report of Senior Constable Richard Keygan;
- Affidavit of Senior Constable Richard Keygan;
- Statement of Paul Sciberras;
- Affidavit of Michael Ganley;
- Affidavit of Constable Jesse Barnard;
- Affidavit of Constable Megan Hopper;
- Affidavit of Sergeant Gavin White;
- Affidavit of Sergeant Luke Walker;
- Affidavit of Senior Constable Paul Hyland;
- Affidavit of Constable Ian Bellette;
- Affidavit of Andrew Brodribb Tasmania police (rank not stated);
- Affidavit of Paul Wells;
- Affidavit of Senior Constable Jimi Morris;
- Affidavit of Constable Jared Gowen;
- Scene diagram, notes and seen survey map;
- Prosecution documents with respect to complaint no. 8918/2019 and
- photographs, body worn camera footage, CCTV footage, phone records and forensic evidence.

A Coroner's jurisdiction and functions

In Tasmania, the coroner's functions are set out in s28(1) of the *Coroners Act* 1995 (the Act). By this section, the coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By s28(2), a coroner may make comment on any matter connected with the death, and by s28(3), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

Coroners complete their written findings pursuant to s28(1) into a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in his or her investigatory function and subsequently, in the making of findings. Many of the public inquests held by coroners in Tasmania are made mandatory by the Act.[1] The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular circumstances of the investigation.[2] I did not consider it desirable to hold an inquest in this matter because I can perform my statutory functions without proceeding to an inquest.

When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial; whereas in criminal or civil proceedings the proceedings are adversarial; that is one party against another.[3] In these proceedings I am required to thoroughly investigate the death and answer the questions (if possible) that s28 of the Act asks. Those questions in s28(1) include who the deceased was, how they died (that is the circumstances surrounding their death), what was the cause of the death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[4] A coroner is required to make findings of fact from which others may draw conclusions.

A coroner does not have the power to charge anyone with a crime or an offence nor does she or he have the power to award compensation. A coroner also does not have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates. In this case, Mr Sciberras was charged on complaint 8918/2019 with causing the death of another person, namely Mrs Ganley, by negligent driving contrary to s32(2A) of the *Traffic Act* 1925 and driving without due care and attention in breach of rule 367 (1) of the *Road Rules* 2019. He pleaded not guilty to those charges and the matter

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[1] S24(1) of the Act.
[2] S24(2).
[3] Attorney-General v Copper Mines of Tasmania Pty Ltd [2019] TASFC 4 at [21].
[4] *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at [7].

proceeded to hearing on 12 and 13 November 2020 and on 15 December 2020. The presiding magistrate was not satisfied the prosecution had proved those charges beyond reasonable doubt and they were therefore dismissed on 21 July 2021. It is important to bear in mind that s28(4) of the Act prohibits me from including *"in a finding or comment any statement that a person is or may be guilty of an offence."*

As noted, one matter that the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by s28(1)(b) upon the coroner.[5]

A coroner may comment on any matter connected with the death into which she or he is enquiring. The power to make comment *"arises as a consequence of the [Coroner's] obligation to make findings … It is not free ranging. It must be comment 'on any matter connected with the death' … It arises as a consequence of the exercise of the coroner's prime function, that is, to make 'findings'"*.[6]

The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[7]

Background

Mrs Ganley was 81 years of age (date of birth 30 April 1938), married and retired at the date of her death. Mrs Ganley met her husband, Michael, in 1964 in the Shetland Islands. They were married on 12 September 1967. Mrs Ganley was originally from the Shetland Islands and Mr Ganley was from England. They lived in the Shetland Islands for about a year after they were married before they moved to Inverness. The couple had two daughters while they resided in Inverness the first in 1968 and the second in 1970.

The family emigrated to Australia in 1973 at which time Mr Ganley took up a five-year government contract as an architect. Mr and Mrs Ganley settled in Tasmania and have resided here ever since. In about 1980 Mrs Ganley commenced working as a teachers' aid at

[5] See *Atkinson v Morrow & Anor* [2005] QCA 353.
[6] See *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[7] (1938) 60 CLR 336 per Latham CJ at 347 and Dixon J at 362 and 368-9.

Blackmans Bay Primary School. She worked in that employment for approximately 23 years until she retired. She loved that work.

Mr Ganley says his wife was generally fit and well. She did have high blood pressure and was prescribed medication to treat that condition. She also had an unsteady heartbeat/murmur and was prescribed medication to control that condition. Despite this Mr Ganley says she was always steady on her feet and she never fainted and nor did she have problems with walking or with her balance. She had good eyesight and only wore glasses to read. Her hearing was normal.

Circumstances Leading to Death

On the day of this accident, it was Mrs Ganley's 81st birthday. She had made a hair appointment at 12:15pm that day at Red Salon which was above Dome Café at the Collins Street end of the Elizabeth Street Mall in central Hobart. Mr Ganley dropped Mrs Ganley off near the post office in Macquarie Street. He says she was in good spirits and was her usual self at this time.

Mr Ganley says he was due to meet his wife at 3:00pm in Harrington Street. It had been arranged for him to stop in the layby on the left-hand side of the road outside the Australian Government Centre just before the intersection of Harrington Street with Collins Street. He waited for five or 10 minutes but she did not turn up. He then drove around the block and went back to the layby and then he tried to contact her by telephone but there was no answer. He could not remain parked where he was so he drove to South Hobart and parked and then rang her again but she did not answer. He then telephoned the hairdresser and was advised she had arrived at her appointment and had since left.

The evidence discloses that Mrs Ganley paid for her hair appointment by means of a bankcard at 2:26pm. Following the appointment, she made her way to Victoria Street by an unknown route however it is likely she has attended a shop or shops along the way because a chocolate bar and some over-the-counter reading glasses were located at the scene of the accident.

Mrs Ganley is observed on CCTV footage, walking uphill on the footpath on the northern side of Victoria Street at 2:49pm. She is carrying a paper shopping bag and a handbag and is walking steadily and at a good pace immediately prior to the accident. Mrs Ganley reaches the corner of Victoria Street where it intersects with Harrington Street at 2:49pm and 41 seconds. She steps off the footpath at 2:49pm and 42 seconds and commences to walk in a southerly direction across Victoria Street. At 2:49pm and 45 seconds the vehicle comes into view as Mrs Ganley is approaching the halfway mark across the road. She is approximately

three quarters of the way across the road when she is hit by the vehicle at 2:49pm and 47 seconds. The vehicle, when the collision occurred, is in the process of turning right from Harrington Street into Victoria Street. As a result of the collision Mrs Ganley falls backwards onto the road with significant force. Mr Sciberras is observed to get out of the vehicle at 2:49pm and 51 seconds and he goes to Mrs Ganley's aid.

Officers from AT then attended the scene at which time Mrs Ganley was conscious. Treatment was provided before she was transported to the RHH. After his phone call to the hair salon, Mr Ganley rang his wife again and this time a nurse at the RHH answered and told him that Mrs Ganley had been hit by a car and was at the hospital. He arrived at the RHH at 3:45 pm at which time he spoke with her and noted she was quite lucid.

Upon her arrival at the RHH, Mrs Ganley was seen by doctors at the Emergency Department before being sent for imaging which was conducted at 4:19pm. A CT scan of the brain was reported as showing Mrs Ganley had suffered a subdural haematoma, multiple left-sided rib fractures and a left scapula fracture. Treating doctors noted that subsequently, Mrs Ganley was exhibiting confusion, she was highly agitated, nauseous, hypotensive and she vomited. Mrs Ganley underwent a repeat CT scan at 6:53pm which showed a large intraparenchymal haemorrhage. She was on anticoagulants, so she was given a reversal agent. In subsequent discussions between neurosurgery, intensive care unit doctors and anaesthetics the family decided on palliative care rather than interventional management. Mr Ganley says he was advised it was likely his wife would not survive and that if she did she would have brain damage. Mrs Ganley was transferred to the Whittle Ward on 1 May 2019 and she passed away on the evening of 2 May 2019. Death was certified at 11:40pm.

Investigation

AT records indicate a call was received to attend this accident at 2:57pm and paramedics were at the scene eight minutes later. It was noted Mrs Ganley was conscious but she could not recall details of the accident. In addition to pain in the left shoulder, she complained of pain in the midline of the thoracic spine, the cervical spine and left ankle. Bleeding was noted on the parietal[8] skull on the left which was controlled with direct pressure from towels. Further treatment was provided and Mrs Ganley was taken to the RHH where she arrived at 3:45pm.

The records of the RHH confirm what is set out in the second full paragraph on this page.

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[8] The parietal bone is a paired, irregular, quadrilateral skull bone that forms the sides and roof of the cranium.

On 30 April 2019, Senior Constable Keygan from Crash Investigation Services (CIS) of Tasmania Police was tasked to attend this accident. He arrived on the scene at approximately 3:55pm. There he spoke to Constables Barnard and Hopper and he made a number of observations of the scene. As a result of those observations, he conducted some measurements and drew a map. He observed the sun was very bright and there was very little to no cloud cover. While standing on Harrington Street and looking in the direction of traffic flow, that is in a north westerly direction, the sun shone down on his face. He observed the vehicle parked in the second parking bay down from the intersection in Victoria Street and with Mr Sciberras' permission, Senior Constable Keygan photographed the exterior and interior of the vehicle.

On the following day, Senior Constable Keygan re-attended the crash scene with Senior Constable Hyland at which time they conducted various examinations and they produced a scene survey. On 3 May 2019, Senior Constable Keygan re-attended the scene with Constable Bellette and Senior Constable Brodribb. Constable Bellette took scene photographs at around 2:50pm showing the location of the sun and its visibility to drivers on Harrington Street, while Senior Constable Brodribb assisted Senior Constable Keygan in videoing drive-throughs of the crash scene in a police four-wheel drive vehicle. On 7 May 2019, Senior Constable Keygan re-attended the accident scene with Sergeant Walker and Senior Constable Keygan used a four-wheel drive police vehicle to calculate the minimum site distance for a vehicle travelling in the right-hand lane of Harrington Street, to be able to see a pedestrian stepping off the footpath on the northern corner of the intersection. In calculating that distance, they worked on the possibility a vehicle, parked in the last parking space on Harrington Street, prior to Victoria Street, completely blocked the view of a motorist until they passed the outer extremity of that parking space. Starting at 2:50pm, Sergeant Walker and Senior Constable Keygan then used the vehicle to conduct a number of drive-throughs of the crash scene. By inspecting the scene and the CCTV footage, Senior Constable Keygan was able to pinpoint where on the roadway the vehicle collided with Mrs Ganley. From that, he was able to measure some distances and calculate travel times and from those details the speed of the vehicle from the point it first appears in the CCTV footage until the collision, which was calculated to be 12 km/h. The stopping distance of the vehicle at that speed was then calculated but this of course assumes a driver sees an obstacle in front of him or her and reacts in order to bring the vehicle to a stop. In this case Mr Sciberras says he did not see Mrs Ganley prior to the accident.[9]

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[9] He says he did not see Mrs Ganley in the call he made to AT, in what he told Constable Barnard (which is on body worn camera footage), in what was recorded on Sergeant White's body worn camera footage and in his statement.

The forensic pathologist, Dr Donald Ritchey conducted a post-mortem examination on 3 May 2019. After conducting that examination and after considering the results of histology and toxicology, Dr Ritchey says the cause of death was a traumatic closed head injury which was sustained when Mrs Ganley was hit at low speed by a motor vehicle. Significant contributing factors include pharmacologic anticoagulation which was prescribed for atrial fibrillation in the setting of atherosclerotic and hypertensive cardiovascular disease. Dr Ritchey noted a 2cm scalp laceration of the posterior left side of the scalp and a large volume subgaleal haematoma.[10] There was a linear skull fracture of the left side of the occipital bone that extended into the posterior cranial cavity. Dr Ritchey goes on to say there *"was marked contusion of the ventral surfaces of the bilateral frontal poles and the anterior tip of the right temporal lobe. These cortical injuries on the anterior surfaces of the brain caused bleeding into the brain parenchyma with a large haematoma that perforated onto the ventral surfaces of the brain resulting in secondary brain injury leading to death."* Although there were multiple rib fractures on the left side, there was no traumatic lung injury present. I accept Dr Ritchey's opinion.

Mr McLachlan-Troup advised only prescribed medication at therapeutic or sub therapeutic levels were detected in Mrs Ganley's blood. No alcohol or illicit drugs were detected in the blood sample provided by Mr Sciberras.

Mr Wells inspected the vehicle on 3 May 2019 at the Hobart police garage. Mr Wells is employed as a transport inspector who says in the course of his employment, he has inspected a number of vehicles involved in serious and fatal crashes. He is a qualified diesel mechanic with over 22 years' experience in the motor trade. As a result of his inspection, he determined the vehicle was in a roadworthy condition prior to the accident. I accept Mr Wells' opinion.

The prosecution of the charges mentioned on page 3 proceeded on the basis that police investigations determined there were no obstructions to Mr Sciberras' view of Mrs Ganley prior to the crash and that he had ample opportunity to see her. The particulars of the negligent driving and the driving without due care and attention charges were the same in that it was alleged Mr Sciberras :

- failed to maintain a proper lookout;
- failed to observe Mrs Ganley crossing in front of him;
- failed to manoeuvre his vehicle to avoid a collision ; and he
- collided with Mrs Ganley and caused her death.

[10] That is clotting of blood between the skin on the scalp and the skull.

While Mr Sciberras did not himself give any evidence[11] he did adduce evidence which was provided by the retired, and very experienced, former police crash investigator Mr Rodney Carrick. After hearing all the evidence, the magistrate indicated in his decision that he preferred the evidence of Mr Carrick to that of the police officers where there was a difference of opinion. The magistrate indicated that he preferred Mr Carrick's evidence because of his 40 years' experience as a police accident investigator during which time he was in charge of crash investigations in the south of Tasmania for 15 years and then head of that service throughout the state since 2014. By contrast the police investigators were inexperienced and Mr Carrick made some valid criticisms[12] of the police investigation. In addition, Mr Carrick's evidence was not challenged in cross examination. The magistrate found Mr Sciberras was unable to see Mrs Ganley as she crossed Victoria Street due to one or more of the following factors:

- the sun shining directly into his eyes or affecting his eyesight,
- the adverse effect of sunglasses on his sight;
- the tinting of the windows of the vehicle;
- the shadowing in Victoria Street;
- the fact Mrs Ganley was wearing clothing which what may have obscured her because of the colour of the building behind her;
- the blind spot created by the A pillar which travelled across his view of Mrs Ganley as she and the vehicle moved.

The magistrate noted that in order to establish negligence it was the duty of the prosecution to establish Mr Sciberras did not exercise the degree of care that would be exercised by a reasonable and prudent driver in the circumstances. In other words, the prosecution needed to establish an ordinary prudent driver would or should have seen Mrs Ganley, in all the circumstances existing, so as to prevent a collision. The defendant was not obliged to establish anything. The mere occurrence of an accident does not, without more, give rise to a

[11] He is of course not obliged to say anything in his defence. It is for the prosecution to prove his guilt beyond reasonable doubt.

[12] Some of these criticisms included the fact that the police drive-throughs were conducted in different weather conditions than those that existed at the time of the accident. That shadowing and its effects, the effect of glare, the tint of the vehicle's windows and the effect of wearing sunglasses on visibility were not taken into account. Mr Carrick also noted police made no enquiries and/or did not investigate whether the A pillar on the driver side of the vehicle created blind spots for the driver immediately prior to or at the time of turning the vehicle and that this would continue as the vehicle was in motion and it was likely that Mrs Ganley, while crossing the road, had been in the driver's blind spot created by that pillar. In addition Mr Carrick noted there were no measurements or notes as to where vehicles were located on the eastern side of Harrington Street as that would have been helpful in determining the visibility of the defendant when he was about to turn into Victoria Street. For example there could have been a vehicle illegally parked on the yellow lines of Harrington Street and that possibility had not been excluded. Such a vehicle would have reduced visibility from what police had allowed for. A number of the police's calculations and the speed of the vehicle were also disputed by Mr Carrick. There were other criticisms.

presumption of negligent driving. Given the factors mentioned above and the speed at which Mr Sciberras was driving, which was well below the speed limit, the magistrate was not satisfied that Mr Sciberras did not exercise the degree of care that would be exercised by a reasonable and prudent driver in the circumstances. He therefore found the charges not proved and he dismissed them.

Subsequent to this decision I arranged for further investigations to be conducted by Senior Constable Keygan. He was assisted by Senior Constable Morris and Constable Gowen. Unfortunately, due to staff shortages at CIS, these further investigations were not completed until approximately 21 months after my request. Further enquiries were made of the manufacturer of the vehicle with respect to blind spots however that company indicated it did not hold any data relevant to blind spots in this model of vehicle. In addition further visibility testing was conducted on 14 May 2023 utilising the vehicle involved in the accident; not a police vehicle. Police advised this date was selected as it was close to the original crash date and the weather conditions were similar. Blind spot testing and further scene reconstructions were done. Walk-throughs of the crash scene from the pedestrian's point of view were also conducted. There was some re-measurement of the scene. A further witness was followed up but attempts to contact him failed. Further enquiries of an attending police officer who was possibly obtaining details from bystanders shortly after the accident have not identified any further witnesses.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Richard Keygan for his investigation and reports.

The circumstances of Mrs Ganley's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995 apart from the following. Having considered the further material my view is that these further investigations should have been conducted shortly after the accident and prior to the prosecution of Mr Sciberras.

I convey my sincere condolences to the family and loved ones of Mrs Ganley.

Dated: 4 October 2024 at Hobart, in the State of Tasmania.

Magistrate Robert Webster
Coroner