



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 Mary Kathleen Stuart

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

- a) The identity of the deceased is Mary Kathleen Stuart;
- b) Ms Stuart died as a result of injuries sustained in a single motor vehicle collision;
- c) Ms Stuart's cause of death was head, neck, chest and leg injuries; and
- d) Ms Stuart died on 23 May 2022 at Hobart, Tasmania.

Introduction

This investigation concerns a fatal single motor vehicle crash that occurred on Good Shepherd Circle, Sandy Bay at approximately 10:30am on Monday, 23 May 2022. The crash occurred within the grounds of St Canice Lifestyle Village which is operated by Southern Cross Care (Tasmania) Inc. and which is situated off St Canice Avenue in Sandy Bay. At the time of the crash the weather was fine, bright and sunny and the road was dry. The road surface at the scene of the crash was constructed of a bitumen mix that was in good condition with no visible surface defects. An inspection of the scene located nothing on the roadway surface that would cause the crash.

The crash involved a white Holden Cruze hatchback Tasmanian registered number EU4010 (the vehicle) which was being driven by Ms Stuart. Ms Stuart was the only occupant of the vehicle at the time of the crash. The vehicle was registered to her and its registration was current on the date of the crash. Ms Stuart had a current driver licence to drive a car.

In making the above findings I have had regard to the evidence gained in the investigation into Ms Stuart's death which includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;

- Affidavit of the forensic pathologist Dr Christopher Lawrence;
- Affidavit of the Forensic Scientist Neil McLachlan-Troup of Forensic Science Service Tasmania;
- Medical records obtained from Ms Stuart's general practitioner;
- Medical records obtained from the Royal Hobart Hospital (RHH);
- Affidavit of Jill McNiece;
- Affidavit of Janice Murphy;
- Affidavit of Kevin Herweynen;
- Affidavit of Chidi Njoku;
- Affidavit of Puneet Verma;
- Affidavit of Sergeant Scott Kregor;
- Affidavit of Constable Jared Gowen and his collision analysis report;
- Affidavit of Benjamin Hunt;
- Affidavit of Constable Anne Stewart;
- Affidavit of Constable Matthew Reardon;
- Affidavit of Constable D'arne Triffett; and
- Photographs, body worn camera footage and forensic evidence.

Background

Ms Stuart was 83 years of age (date of birth 11 May 1939), single and she was retired at the date of her death. She is the daughter of Thelma and Arthur Stuart. Ms Stuart was born in Hobart and she has three siblings one of whom is the senior next of kin Jill McNiece.

Ms Stuart attended primary school at Huonville and then at St Luke's which was situated in South Hobart. She attended years 7 to 11 at St Joseph's College¹ in Hobart. She first lived in Huonville with her family before they moved to South Hobart where Ms Stuart lived with her parents and siblings for most of her childhood.

Following her successful completion of year 11 Ms Stuart began working at the Attorney General's Department in Hobart as a stenographer. She worked in this role for approximately five years. She then worked in a similar position for the Tourist Bureau in Hobart before she travelled to London in 1964 where she worked in London and travelled to Europe. When Ms Stuart returned to Hobart she continued to reside with her parents in South Hobart.

¹ St Joseph's College amalgamated with Mount Carmel Primary School in 1957 to form Mount Carmel College.

Thereafter Ms Stuart travelled to Perth for approximately six months before returning to Hobart after which she undertook a variety of jobs in either a part-time or full time capacity. This included working at the Theatre Royal, Wrest Point Casino, the RHH, Parliament House, *The Mercury* and at the Electrolytic Zinc Works. She was known to work a number of jobs in order to fund her annual overseas holidays.

Ms Stuart moved into St Canice Lifestyle Village, Sandy Bay in 2011. Her driver licence was due to expire on 15 September 2024. She has no prior crash, sanction or demerit point history. Her driving record is exemplary. In 2014 she had a medical to assess her fitness to drive which she passed. Since that time it has not been compulsory to have a medical to determine a person's fitness to drive and therefore Ms Stuart was able to drive at the time of her death.

As to her health Ms Stuart was first diagnosed with osteoporosis in 2004. This affected her vertebrae and her hips. In 2019 she sustained a fractured radius as a result of a fall. There is no other falls history recorded in her medical records. Ms Stuart underwent two hip replacement surgeries, one in November 2017 and one in December 2019 which resulted in her having reduced mobility. She also experienced back pain and more recently she had been undergoing physiotherapy to treat her symptoms. Ms Stuart was diagnosed with a serious eye condition and in 1979 she underwent surgery for a detached retina. In 1996 she had further surgery to improve the quality of her vision due to a similar problem. In 2001 Ms Stuart was diagnosed with a hearing impairment and she was prescribed hearing aids to assist her. Ms Stuart's very good friend Ms Murphy says Ms Stuart could hear her in a quiet setting however her hearing deteriorated when they were in a more public setting. Ms Stuart suffered from a number of allergies to foods and she also suffered adverse reactions to some medications. Her last attendance with her general practitioner was on 15 March 2022. She attended to obtain advice on vaccinations. This was her only attendance with her general practitioner in 2022. The records suggest she was generally, given her age, a well person.

Ms Murphy says during Ms Stuart's retirement she would volunteer to deliver books from the library to people who could not attend themselves. Ms Stuart enjoyed driving. Ms Murphy says she was a caring person who put everybody else before herself. Each day she would run errands in her vehicle whether it was to go to a medical appointment or get the Sunday paper. Ms Murphy describes Ms Stuart as a careful driver and she was confident travelling as a passenger in Ms Stuart's vehicle. They met almost every Saturday for a catch up. Their last meeting was two days before the crash at which time Ms Murphy says Ms Stuart was her normal self and she was in good spirits. Ms Murphy had actually travelled as a passenger in Ms Stuart's vehicle on this day and she says she had no concerns about Ms Stuart or her driving behaviour.

Circumstances Leading to Death

At approximately 10:30am on Monday, 23 May 2022 Ms Stuart left her unit which is located at the rear of the St Canice Lifestyle Village in the vehicle. It is not known where she was intending to travel to. She drove her vehicle towards the main entrance to the village which is located on Good Shepherd Circle as that roadway connects with St Canice Avenue. As she was travelling on a downhill section of the road Ms Stuart lost control of her vehicle. It is not known why. Her vehicle has then collided with the rear of a parked and unoccupied vehicle located on the right-hand side of the roadway. She has then swerved to the left-hand side of the road and the wheels of her vehicle have rubbed against the curb after which she has accelerated towards a garden bed and collided with a gutter which caused her vehicle to become airborne. Ms Stuart's vehicle then travelled over the garden bed, disturbing the vegetation and it collided with an external wall of a unit within the Guilford Young Grove Aged Care Facility. At the time of the collision Ms Stuart was not wearing her seatbelt and as a result she was propelled forward and upwards with her head striking the roof near the A-pillar of the vehicle and her leg striking the underside of the steering wheel which caused it to buckle. Following the crash into the wall the vehicle has rotated 180° clockwise and has landed on its wheels facing back towards where she had driven from.

Ms Stuart was located unconscious and suffering from a severe head injury. Her upper body was resting horizontally across the centre console and front passenger seat with her head resting on the passenger window. Her feet were positioned under the steering wheel. Ms Stuart was extracted from the vehicle by witnesses who provided first-aid until officers from Ambulance Tasmania arrived. She was treated by those officers at the scene and she was subsequently transported to the RHH where she received further treatment. Despite the treatment Ms Stuart received she succumbed to her injuries and was declared deceased at approximately 2:07pm.

Investigation

Police officers from Hobart police station (Constables Stewart, Reardon and Triffett) attended the crash. On arrival they observed the vehicle had collided with a unit which was positioned below the intersection of St Canice Avenue and Good Shepherd Circle. The vehicle was facing this intersection with a severely damaged front end and windscreen, with all airbags deployed. Further damage to the garden bed and the unit wall was observed. Police officers from Crash Investigation Services (Constable Gowen) and Forensic Services (Sergeant Kregor) were tasked to attend the crash.

As a result of his enquiries Constable Gowen determined the St Canice Lifestyle Village is comprised of apartments to the south of Good Shepherd Circle whereas the Guilford Young

Grove Aged Care Facility is comprised of apartments to the north of Good Shepherd Circle. In the centre of the Circle is an area of lawn, shrubs and trees and there are marked areas for the parking of motor vehicles around the Circle. At the north-west corner of the Circle, the road becomes a T-junction, which permits road users to turn left towards St Canice Avenue or right to continue on the Circle. Dowling Street is the main access street around to the rear of the main building of St Canice Lifestyle Village. It connects with Good Shepherd Circle on its north-east and south-west corners. On the westernmost side of the Circle there is a downhill gradient and five parking spaces four of which were occupied at the time of the crash. The southernmost vehicle was not involved in the crash whereas the remaining three parked vehicles from south to north were a Nissan X Trail registered number C96JG, a Hyundai Accent registered number K92KH and a Toyota Hiace registered number D81HB which all displayed damage when inspected by Constable Gowen. There was a free parking space between the southernmost vehicle, which was not involved crash, and the Nissan X Trail.

The first evidence related to the crash was observed on the Nissan, which had sustained a broken left taillight. Red plastic debris was scattered on the nearby road surface. This damage was caused by the driver's side wing mirror of the vehicle as Ms Stuart failed to negotiate her way around the Nissan. There was red plastic material transfer located on the right wing mirror of the vehicle.

There was a minor scrape to the left rear wheel arch of the Hyundai and scraping and denting to the rear left wheel arch panel of the Toyota. The owners of these vehicles advised police that damage was not previously there however due to the path of travel of the vehicle Constable Gowen is of the opinion that damage to those vehicles was unrelated to this crash and therefore not caused by the vehicle. Having considered the evidence carefully I agree.

About 17.2 m north of the Nissan, on the opposite road edge, an area of raised gutter displayed signs of a recent abrasion. Light scratching was present on the gutter and the marks continued along the gutter's face for 3.3 m before they ceased. The abrasions and scuffing were caused by the left wheels of the vehicle as it rubbed against the curb before entering the garden bed. Next Constable Gowen observed a 2 m wide section of gutter on the north-west corner of the road and a cleared section of garden which contained no tyre prints which indicated to Constable Gowen the vehicle was airborne over the width of the garden. The northernmost edge of the garden is supported by a brick retaining wall which drops approximately 62 cm in height to a concrete footpath. There was no damage noted to the retaining wall which suggests the vehicle did not make any contact with it. Approximately 3.7 m north of the retaining wall, a brick, split-level villa displayed signs of a heavy impact.

The brickwork was misaligned and pushed inward, and an external drainpipe was dented. To the left of the villa the vehicle was at rest, facing south; that is it was facing in the opposite direction to the direction it was travelling in prior to impacting with the villa. The vehicle displayed severe damage to the front end which had been forced rearward during the collision. It was resting over a small garden bed next to a walkway which leads to the front door of the villa. The right rear of the Holden was elevated and supported by a metal fence above the sloped walkway which leads to the villas below.

Mr Hunt inspected the vehicle on 31 May 2022 at the police garage in Hobart. The vehicle had been seized by police and taken to that location after the crash. Mr Hunt is a transport safety and investigation officer and a qualified automotive mechanic with in excess of 16 years' experience in the automotive industry. As a result of his inspection he determined the vehicle was non-compliant as tinted film had been applied to the windscreen and protruded into the swept arc of the windscreen wipers. That said he indicated this defect did not cause or contribute to the crash. He found both front seat belts in the locked and retracted position which indicated the pre-tensioners had fired while the seatbelts were retracted. This indicates Ms Stuart was not wearing a seatbelt at the time the airbags deployed. The driver side sun visor had been dislodged and the fabric roofline in the vicinity of the A-pillar showed signs of skin transfer and blood, along with strands of grey hair lodged in the driver side upper door seal. This is consistent with Ms Stuart's head striking the roof in the vicinity of the A-pillar due to not being restrained by a seatbelt. I accept Mr Hunt's opinion.

Constable Gowen noted many vehicles are fitted with what is known as an event data recorder 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 and performance. This data is often stored within the airbag control module. The primary function of that module is to control the deployment of supplementary restraint devices fitted to the vehicle. This normally includes seatbelt pre-tensioners and front, side, knee, curtain and rollover airbags. The recording of data within the module is a secondary function. Although the vehicle was fitted with an event data recorder and although Constable Gowen was able to extract the airbag control module he says that module was not supported by the current technology required to download the data, and as such, no pre-crash data was available.

Drone technology was used to map the crash scene. That data was then uploaded to a mapping software program and a map of the scene was created.

As a result of his investigation Constable Gowen is of the opinion that prior to the crash Ms Stuart was travelling north on Good Shepherd Circle and has failed to negotiate her way

around the parked Nissan and has clipped the taillight of that vehicle with her right wing mirror. The vehicle has then deviated to the left side of the road where the left hand or passenger side wheels rubbed against the curb of the roadway before the vehicle accelerated² towards the garden bed. The vehicle then collided with the northern gutter at a speed sufficient to cause significant denting to all wheel rims and this has resulted in the vehicle becoming airborne. It has then travelled over the garden bed, disturbing vegetation as it did so, over the retaining wall and lower footpath, before colliding with a brick villa. At this point, Ms Stuart was propelled forward and upwards, with her head striking the internal roof near the A pillar and her leg striking the underside of the steering wheel which caused it to buckle. Following the collision with the villa the vehicle has rotated 180° clockwise and landed over the small garden outside the villa. Constable Gowen says due to the nature of the collision and the landing position of the vehicle he was unable to determine the vehicle's speed prior to the impact with the villa. Its speed was however high enough that when it collided with the raised gutter it became airborne. Although the entire front end of the vehicle was damaged, the rotation of the vehicle after impact indicates that impact was slightly offset to the front left of the vehicle (as one looks at the vehicle), forcing it to rotate clockwise before it came to rest. I accept Constable Gowen's opinion.

Dr Lawrence performed a post-mortem examination on 24 May 2022. As result of that examination and after considering the results of histology, toxicology, microbiology and a CT scan he determined Ms Stuart died of head, neck, chest and leg injuries which were caused by this crash. The autopsy did not reveal any evidence of a cardiac event which may have led to Ms Stuart losing control of the vehicle. No other medical cause for the loss of control was identified. Toxicology was negative for alcohol and illicit drugs. The only medications found in Ms Stuart's blood were those used by paramedics and medical staff at the RHH. Accordingly, their presence did not cause or contribute to the crash.

Comments and Recommendations

In this case I am satisfied no other vehicle caused or contributed to the crash. There were no defects in the road surface that may have caused the crash. There were no defects with the vehicle that caused or contributed to this crash. I am satisfied this crash occurred when Ms Stuart lost control of her vehicle which then led to the sequence of events described above. I am also satisfied Ms Stuart was very familiar with the layout of the road on which she was driving and she was a careful and experienced driver. She drove very frequently. In those circumstances it is difficult to conclude that the loss of control of the vehicle was due to inexperience, inattention or poor driving. While the investigation has not confirmed a

² This conclusion is corroborated by Mr Herweynen who says he heard a vehicle revving very loudly.

medical episode was the cause of the loss of control, and even though a cardiac event has been ruled out, I consider some other medical episode to be the more likely explanation.

Before finalising this finding there is a legitimate concern which has been raised by the senior next of kin Jill McNiece. She has written to my office outlining the fact that she phoned on at least four occasions in the previous two years and has questioned the delay in the provision of the finding in relation to her sister's death. She says in her correspondence that matters associated with her sister's estate cannot be finalised until a coroner's decision has been made. From her point of view there is no reason for the delay and she has been anxious about it and considers that her sister is not "*at peace*" until the matter is concluded.

There are three full-time coroners who are responsible for all reportable deaths in Tasmania. At the time I prepared this decision there were 964 pending cases which is in excess of 320 cases each. In the financial year ended 30 June 2017 reportable deaths numbered 579. In the subsequent six financial years ending on 30 June 2023 that number rose to 895 which is an increase of 54%. Despite that increase in the 2022/2023 financial year 943 matters were finalised. To be able to finalise that number of matters means each coroner is finalising in excess of one investigation each business day. This financial year reportable deaths increased to 1142 which is a 97% increase on the number of reportable deaths in the 2016/2017 financial year. I note in more recent times some additional investigative resources and a family liaison officer have been provided to the coronial office which are very welcome additions however the same number of coroners are ultimately responsible for what seems to be an ever increasing work load. In addition there has been a significant turnover of staff within the office, due to the nature and conditions of the work, and delays have been encountered in appointing and training new staff. These issues have inevitably led to delays in finalising matters. In addition, as Coroner Cooper pointed out in *Jari Elliott Ernest Wise* [2024] TASCDC 237, an amendment to the *Coroners Act 1995* is likely to significantly increase the number of public inquests and it is likely to require more extensive enquiries to be made by coronial staff. As he said at paragraph 87 of that decision "*[t]he effect of this upon an already strained coronial system will be to significantly delay all inquests, thereby increasing the grief and trauma of many families in our community.*" Not only will this reform delay all inquests it will delay the finalisation of matters such as this one. This situation and the difficulties which people like Mrs McNiece find themselves in can only be remedied by the provision of more resources.

I extend my appreciation to investigating officers Constables Stewart and Gowen for their investigation and reports.

The circumstances of Ms Stuart'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 convey my sincere condolences to the family and loved ones of Ms Stuart.

Dated: 31 July 2024 at Hobart, in the State of Tasmania.

Magistrate Robert Webster
Coroner