



## MAGISTRATES COURT of TASMANIA

### CORONIAL DIVISION



## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Wendy Anne Evans

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

- a) The identity of the deceased is Wendy Anne Evans;
- b) Ms Evans died as a result of injuries sustained when as a pedestrian she was struck by a passenger bus;
- c) The cause of Ms Evans' death was head and chest injuries; and
- d) Ms Evans died on 22 July 2016 at Campbell Street, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Evans's death. The evidence includes an opinion of the forensic pathologist who conducted the autopsy; toxicological analysis of samples taken from Ms Evans' body at autopsy and from the bus driver; relevant police and witness affidavits; a detailed police report; the complete prosecution brief; and forensic and photographic evidence.

At about 6.00pm on 22 July 2016 Ms Evans, who was holidaying in Hobart from her job with Queensland police, was at the intersection of Campbell and Macquarie Streets waiting to cross the road. Subsequent investigation showed that Ms Evans waited at the crossing for at least 30 seconds, facing a red light. She was dressed in black clothing and carrying a white plastic shopping bag in her left hand.

It was dark at the time, raining and the roadway was wet. The intersection was lit by street lighting although the streetlight on the south-eastern corner of Macquarie and Campbell Streets was not operating. I am satisfied however that the non-operation of that light had nothing to do with the tragedy that ensued.

At the same time a Metro Tasmania bus driven by Stephen Murray Hartstonge was stopped in Macquarie Street facing the same red light at the same intersection waiting to turn right to Campbell Street. The right-hand indicator of the bus was activated. The

lights changed to green for both the bus and Ms Evans. Ms Evans commenced to cross the intersection in a general west to east direction (in other words from the direction of the car park near the Tasmanian Museum and Art Gallery towards the Hotel Grand Chancellor).

At the same time as Ms Evans began to cross, Mr Hartstonge moved his bus forward and around the corner into Campbell Street. The maximum speed the bus attained was in the order of 5 km/h. As the bus was driven around the corner its front right external mirror struck Ms Evans and caused her to go under the front right hand wheel of the bus. Mr Hartstonge felt the impact and stopped the bus 1 or 2 seconds after he had struck Ms Evans.

Ms Evans suffered massive and unsurvivable head and chest injuries and died almost instantaneously. Members of the public, an off duty police officer and two other bus drivers rendered assistance at the scene. Ambulance paramedics and a number of police officers were quickly on the scene but it was apparent that nothing could be done for Ms Evans.

The scene was secured, forensically examined and photographed. The bus was removed from the scene and escorted by police to a compound in the northern suburbs of Hobart where it was secured for subsequent mechanical inspection. CCTV footage from the bus involved was obtained.

Mr Hartstonge was required to submit a sample of his blood analysis. That analysis was negative for the presence of alcohol and illicit drugs.

Ms Evans' body was removed from the scene and transported to the nearby mortuary at the Royal Hobart Hospital. At the Hospital an autopsy was carried out by the State Forensic Pathologist Dr Christopher Hamilton Lawrence. Dr Lawrence found that the cause of Ms Evans' death was massive head and chest injuries. I accept Dr Lawrence's opinion. Subsequent analysis of samples taken at autopsy were negative for the presence of alcohol and illicit drugs.

Ms Evans' body was formally identified by means of fingerprint comparison.

After initial examination on 22 July 2016 the bus was the subject of a further and more detailed examination on 25 July 2016 by a Transport Inspector employed by the Tasmanian Department of State Growth. The Inspector found that the bus was defective due to a non-compliant brake pedal the edge of which was worn and lacked rubber. The bus was otherwise in a well maintained state. I am satisfied that the defect

identified by the Inspector did not cause or contribute to the happening of the fatal crash.

Extensive additional investigations were carried out by officers of Tasmania Police Crash Investigation Services. Those investigations identified that the Metro bus had a substantial blind spot at its A pillar due to the thickness of that pillar in the location of the external right hand mirror. This was a matter however which in my view Mr Hartstonge ought to have been aware given his experience as a bus driver with Metro.

The investigation also revealed that Mr Hartstonge had an opportunity to have seen Ms Evans as she walked east along the footpath on the southern side of Macquarie Street before she (and he) reached the intersection.

On 7 September 2016 officers from Crash Investigation Services using the same bus involved carried out visibility testing. The testing was filmed. The Tasmania Fire Service assisted by hosing the road surface and providing a light shower water to the bus and the crash area as the re-enactment was being carried out. The bus was driven by Senior Constable Adam Hall. Crash Investigator Senior Constable Kelly Cordwell, dressed in similar clothing to Ms Evans, re-enacted her movements at the time of the crash. The evidence was that at the time of her death Ms Evans was 166 cm tall and weighed 56 kg. Senior Constable Cordwell is 168 cm tall and weighs 60 kg. Like Ms Evans Senior Constable Cordwell carried a light coloured shopping bag in her left hand during the test.

I have had regard to the results of that testing. I accept of course that the testing did not, and could not, replicate the exact circumstances in which Ms Evans died but it provided considerable assistance to better understand how the crash occurred. The testing illustrates quite clearly that Mr Hartstonge had ample opportunity to see Ms Evans as she walked towards the intersection.

Of note is the fact that Senior Constable Cordwell said that during the re-enactment she did not see the bus as she walked across Campbell Street until it suddenly appeared in her peripheral vision immediately before it would have struck her.

Mr Hartstonge was charged with, and convicted of, causing death by negligent driving contrary to section 32 of the *Traffic Act 1925*. He was sentenced to 3 months imprisonment wholly suspended for a period of 3 years on condition that he not commit another offence punishable by imprisonment during the period the order is in force and that he be of good behaviour. Although disqualified from driving for a period of 2 years he was granted a restricted license to enable him to continue to work as a bus driver.

I am satisfied that Ms Evans died in the circumstances set out in this finding. A factor that contributed to her death was the manner in which the lights at the intersection operate. Had those lights not operated in such a way that the traffic and the pedestrian lights both turned green at the same time, but rather the pedestrian crossing light turned green a period of time prior to the traffic light turning green, then it is likely in my view that Ms Evans would not have been killed.

#### **Comments and Recommendations**

I consider that the circumstances of Ms Evans' death are such as to require me, pursuant to Section 28 of the *Coroners Act 1995*, to **recommend** that the Department of State Growth urgently review the operation of the traffic and pedestrian crossing lights at the intersection of Macquarie and Campbell Streets, Hobart.

I extend my appreciation to investigating officer Senior Constable Kelly Cordwell for her investigation and report.

I convey my sincere condolences to Ms Evans' father Mr Thomas Evans, her brother and sister-in-law Peter and Katerina and her nieces Kaitlyn and Elizabeth on their loss.

**Dated** 3 May 2019 at Hobart, Tasmania.

**Simon Cooper**  
**Coroner**