



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Marion Olive Whittle

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

- a) The identity of the deceased is Marion Olive Whittle;
- b) Mrs Whittle died as a result of injuries sustained in a motor vehicle crash on 6 January 2014 on the Huon Highway, in Kingston in Tasmania;
- c) The cause of Mrs Whittle's death was cardiogenic shock and tricuspid regurgitation;
- d) Mrs Whittle died on 7 January 2014 at the Royal Hobart Hospital (RHH); and
- e) Mrs Whittle was born in Whangarei, New Zealand on 31 July 1926 and was aged 87 years.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Whittle's death. The evidence comprises of an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; and forensic evidence. I have also been greatly assisted by a detailed report compiled by crash investigator, Sergeant Rod Carrick, whose conclusions I accept.

I make the following further findings regarding the circumstances of Mrs Whittle's death.

Mrs Whittle was 87 years of age and was retired. She lived alone in her residence in Claremont. Her partner of 14 years, Christopher Athol Heath, visited her on a daily basis. Mr Heath was aged 69 years.

At approximately 12.00pm on Monday 6 January 2014, Mr Heath was the driver of a white Toyota Corolla sedan ("the Toyota"). Mr Heath had held his driver licence for 52 years and had an excellent driving record.

The Toyota was being driven south bound along a merging lane from the direction of the roundabout on the Huon Highway in Kingston, towards the Southern Outlet.

The passengers in the vehicle at the time were Mrs Whittle's son, Roger Hunter (front passenger seat), Mrs Whittle's daughter-in-law, Sally Patricia Hunter (rear seat driver's side),

and Mrs Whittle (rear seat passenger side). All persons in the vehicle were wearing seat belts. It was the intention of Mr Heath to travel to Huonville for lunch. The traffic at the time was light. The road was wet but it was not raining.

Based upon the analysis of the crash investigator, I find that the Mr Heath was travelling at a speed of no more than 60km/h whilst in the merging lane. This speed was appropriate for the conditions prevailing at the time.

The merging lane, from the roundabout to its conclusion, is approximately 300 metres in length. It is uphill and permits vehicles to merge into the dedicated south bound lane of the Southern Outlet. The merging lane is situated east of the dedicated south bound lane.

The merging lane and the dedicated south bound lane of the Southern Outlet are initially separated by an embankment followed by a raised traffic island, painted traffic island, continuous white line and then an intermittent white line. The intermittent white line permits merging into the dedicated south bound lane of the Southern Outlet.

The embankment between the south bound lane and the merging lane restricts the visibility of southbound traffic approaching the merging lane on the Southern Outlet. Unimpeded visibility of such traffic is not established until the vehicle on the merging lane negotiates the apex of the rise.

Shortly after entering onto the merging lane at the roundabout, Mr Hunter advised Mr Heath that he had taken the incorrect exit to travel to Huonville.

In the vicinity of the apex of the rise on the merging lane Mr Heath slowed, activated his right hand indicator and turned hard right across the dedicated south bound lane of the Southern Outlet. It was his intention to complete a U turn to travel north bound on the Outlet. He crossed over the continuous line when he was not permitted to do so.

At this time Mr Sam Oskar Woehler was driving a white Mitsubishi van ("the Mitsubishi") in a southerly direction along the Southern Outlet at a speed of about 75 to 80km/h. He was wearing his seat belt.

Mr Woehler was approaching the merging lane which was on his left hand side. He observed the Toyota turn hard right across the dedicated south bound lane in front of him.

Mr Woehler applied his brakes causing his vehicle to skid. The evidence established that he had insufficient perception and reaction time to avoid the crash. The front of the Mitsubishi van collided with the driver's side of the Toyota.

The crash occurred in the dedicated south bound lane, being the correct lane of travel for the Mitsubishi.

The Toyota came to rest on the western side of the north bound lane a short distance south of impact. The Mitsubishi van came to rest in the south bound lane a short distance south of impact.

Mrs Whittle was conveyed from the scene by ambulance and admitted to the Royal Hobart Hospital. She passed away on the evening of 7 January 2014 in the Intensive Care Unit of the hospital after consciously making the decision not to undergo surgery due to her poor prognosis.

The cause of death was determined by the forensic pathologist who conducted the autopsy as cardiogenic shock and tricuspid regurgitation secondary to traumatic papillary muscle laceration resulting from the motor vehicle crash. The forensic pathologist also noted that pre-existing heart conditions were significant contributing factors in the cause of death.

I am satisfied that alcohol, drugs, weather and road conditions were not factors in the crash. There were no defects to either vehicle that contributed to the crash.

On 4 December 2015 Mr Heath appeared in the Magistrates Court in Hobart before Magistrate Catherine Rheinberger and pleaded guilty to the charge of causing the death of Mrs Whittle by negligent driving. Her Honour imposed upon Mr Heath a sentence of 3 months imprisonment, wholly suspended for a period of 12 months and disqualified him from driving for a period of 12 months. She noted in sentencing the deep remorse and distress felt by Mr Heath as a result of his inadequate look out and performing a U-turn when not permitted to do so.

I find that, unfortunately, Mr Heath's error of judgement in driving across the southbound lane of the Southern Outlet caused the crash that, in turn, resulted in Mrs Whittle's death.

#### **Comments and Recommendations:**

I extend my appreciation to investigating officer Sergeant Rod Carrick for his high quality investigation and report.

The circumstances of Mrs Whittle'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 Mrs Whittle.

**Dated:** 27 March 2017 Hobart in the state of Tasmania.

**Olivia McTaggart**  
**Coroner**