MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Robert William East

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

a) The identity of the deceased is Robert William East, date of birth 13 December 1943.

b) Mr East was 78 years of age and lived in Radcliff Crescent in Rosetta. He was a fisherman throughout most of his working life and retired in 2000. Mr East had two children with his first wife and a further three children with his second wife, who passed away in 2018.

Throughout his life, Mr East suffered from a range of health complications. An avid footballer in his youth, Mr East had portions of his pancreas and spleen surgically removed following a football accident. This incident had long-term ramifications for Mr East's health, which declined following his retirement. In 2001, he was diagnosed with Type 1 diabetes and was prescribed medication to manage his symptoms. In 2005, Mr East had a minor heart attack, requiring surgery and ongoing medication.

As a result of his diabetes, Mr East suffered a deterioration in his circulation, and underwent a series of surgical procedures between 2004 and 2019. The surgical procedures included a femoral popliteal bypass procedure and the amputation of a number of his toes. Subsequently, he underwent amputation of both legs below the knee.

As a result of these procedures, Mr East became dependent upon an electric wheelchair for mobility. Despite his health conditions, Mr East lived independently with a limited amount of domestic assistance. He enjoyed socialising and he attended the Granada Tavern on a weekly basis.

At 4.00 pm on Wednesday 16 March 2022, Mr East attended the Granada Tavern, where he spent his time playing on the poker machines. While at the venue, Mr East consumed approximately five "schooners" (15 ounce glasses) of beer. At 8.00 pm, Mr East asked a staff member, Kaila Hanlon, to phone the taxi service, *13CABS,* to order a wheelchair-accessible taxi to drive him home. *13CABS* provided an estimated waiting time of one to one-and-a-half hours. Mr East agreed to wait that period of time, advising Ms Hanlon that this was a common waiting time for his taxi on a Wednesday night. Ms Hanlon attempted to contact another taxi service to find a shorter wait time, but was unsuccessful.

Approximately 45 minutes after ordering the taxi, Mr East requested Ms Hanlon to cancel the booking, stating that he would drive his electric wheelchair home instead. Ms Hanlon did not cancel the taxi in the hope it might arrive before Mr East's departure, and instead attempted to persuade him to wait. However, Mr East was adamant that he would ride home in his wheelchair and he proceeded to leave the Granada Tavern. Ms Hanlon stated in her affidavit for the investigation that she did not consider that Mr East was greatly affected by the alcohol he consumed. The distance from the Granada Tavern to his home was approximately two kilometres.

During the journey towards his home, Mr East entered Glenmore Creek Reserve and attempted to navigate the gravel path in the reserve connecting Parramore Street with Radcliff Crescent (the street where he lived). Approximately 20 metres along the gravel path from Parramore Street is a downhill right-hand bend. The evidence in the investigation indicates that Mr East lost control of his wheelchair at this point and veered off the path. He was unable to correct himself back onto the path, and his wheelchair instead turned left sharply, crossed a small grass area and travelled down an embankment.

The embankment was a "V" in shape, with a creek running through the lowest point, and two soil embankments of approximately 15 to 20 metres rising steeply from either side. When Mr East's wheelchair came to the lowest point of the embankment, it tipped him over and onto the other side, before landing directly on top of him. At such time, Mr East lost consciousness and suffered an injury to his nose. At some point, Mr East regained consciousness and was able to remove the wheelchair which was lying over him.

At approximately 10.00pm, Mr East was discovered by a nearby witness who heard him calling for help. At 10.14pm police officers arrived at the scene.

Assistance from Ambulance Tasmania and the Tasmanian Fire Service was requested, and personnel from those organisations arrived. Mr East was removed from the creek and then conveyed by paramedics to the Royal Hobart Hospital.

Mr East told attending paramedics that his wheelchair lost traction due to recent re-gravelling of the path. It is possible that this is the case but I cannot make a positive finding regarding why he lost control. It is also possible that the camber of the path, lack of lighting, mild intoxication and excessive speed might have been contributing factors. There is no evidence that his wheelchair was defective.

In hospital, a CT scan revealed that Mr East had suffered a severe head injury and his prognosis was assessed as poor. In consultation with his family, he was provided with palliative care and not actively treated. Mr East's condition continued to deteriorate until his death in the early hours of 18 March 2022.

c) The cause of death was subdural haematoma (head injury); and

d) Mr East died on 18 March 2022 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mr East's death. The evidence includes:

- The Police Report of Death for the Coroner;
- The Tasmanian Health Service Death Report to Coroner;
- Affidavits establishing identity and life extinct;
- Affidavit of Dr Christopher Lawrence, forensic pathologist;
- Toxicology report of Forensic Science Service Tasmania;
- Patient Care Record – Ambulance Tasmania;
- Hopkins Street Medical Clinic records for Mr East;
- Tasmanian Health Service records for Mr East;
- Affidavit of Lisa Rose East, daughter of Mr East;
- Affidavits of three attending and investigating officers, together with photographs and body worn camera footage;
- CCTV footage from the Granada Tavern;
- Report from the Department of State Growth; and
- Report from the Tasmanian Taxi Council.

Comments and Recommendations

An issue arising in this investigation was the lengthy period of time over which Mr East was required to wait for a wheelchair accessible taxi to transport him home from the Granada Tavern on the evening of 16 March 2022. He would not have died if a wheelchair accessible taxi had arrived to collect him within the 45 minute period in which he waited.

As part of this investigation, I sought information from the Department of State Growth ("the Department") and the Tasmanian Taxi Council ("TTC"). I have received helpful reports from both organisations in relation to the general availability of wheelchair-accessible taxis. Both the Department and TTC indicate that the taxi industry has experienced some unwillingness on the part of qualified wheelchair accessible drivers to undertake the work due to inadequate remuneration.

It would seem that there are currently limited incentives for qualified drivers to provide wheelchair-accessible taxi services.

The Department, in consultation with TTC, reports that it is currently working on a series of potential reforms to provide greater incentives to the taxi industry to increase the availability of wheelchair-accessible taxi services.

I comment that appropriate initiatives may go some way to increasing the availability of wheelchair-accessible taxis and thus preventing similar circumstances to those that led to Mr East embarking upon a risky journey in his own wheelchair.

I extend my appreciation to investigating officer Constable Emma Douglas for her investigation and report.

The circumstances of Mr Robert East's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr East.

Dated: 4 October 2023 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner