Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Ian George Palmer

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

a) The identity of the deceased is Ian George Palmer;
b) Mr Palmer died as a result of injuries received when, as a pedestrian, he was struck by a motor vehicle;
c) The cause of Mr Palmer’s death was traumatic injury to the left occipital region of the head; and
d) Mr Palmer died on 16 October 2017 at the Launceston General Hospital, Launceston, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Palmer’s death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; forensic, photographic and CCTV evidence; and the report of a Tasmania Police Crash Investigation specialist.

At about 9.10am on Monday 16 October 2017 Mr Palmer stepped from the footpath on the southern side of York Street, having just left Allgoods Store. A traffic light pedestrian crossing at the intersection of York and St John Streets was less than 20 metres away from where he began to cross the street.

Witnesses said, and CCTV showed, that Mr Palmer walked at a constant speed across the three lanes of York Street into the path of a silver Subaru Station Wagon being driven west on York Street in the northern (or right hand) lane. The Subaru struck Mr Palmer. He was lifted up onto the bonnet of the vehicle and then fell off the front driver’s side of the vehicle landing on his head on the road surface.
The driver of the Subaru, Mr Donald Nixon Stewart, stopped immediately to try to help Mr Palmer. Bystanders rushed to Mr Palmer’s aid. Police and emergency services were called and an ambulance was on the scene within 6 minutes. Mr Palmer was observed by attending paramedics to be in a critical condition. He received emergency treatment where he lay and was then taken to the nearby Launceston General Hospital where, sadly, he died a short time after admission.

An investigation into Mr Palmer’s death commenced. Tasmania Police Crash Investigation Specialist officers carried out a careful examination of the scene. Mr Stewart was the subject of normal post-crash testing but no alcohol or illicit drugs were found to have been present in his body at the time of the crash. Witnesses were interviewed and affidavits obtained. CCTV footage from 4 different locations (including a Metro bus) was obtained. Two different sets of CCTV footage actually show Mr Palmer being struck by the Subaru. Relevantly, the CCTV shows that the Subaru did not deviate from its lane, travelled at a constant speed and had its headlights on. The CCTV footage from the Metro bus, which was travelling down St John Street behind and in the same direction as the Subaru, shows that the brake lights of the Subaru were not activated until after Mr Palmer was struck.

The Subaru was inspected by a Transport Inspector. No mechanical deficiencies were identified which could have caused or contributed to the crash.

Using data collected at the scene, investigators were able to perform a speed analysis. It was determined by investigators that the Subaru was travelling at a speed of somewhere between 41 and 44 km/ph, well below the posted speed limit in the area of 50 km/ph. I accept that analysis as accurate.

On the evidence obtained I am satisfied that road and weather conditions did not cause or contribute to the happening of the fatal crash. The evidence was that the road surface was in good repair and that the weather was clear, fine and dry. In addition, I note the Subaru was travelling away from the sun.

Mr Palmer’s medical records were obtained and examined. Nothing in those records suggests any reason why he walked into the path of the Subaru.

The evidence is that in the immediate lead up to the crash Mr Palmer was alert and seemingly in good spirits. The autopsy conducted on his body by Tasmanian State Forensic Pathologist, Dr Christopher Lawrence, found nothing to explain Mr Palmer’s walking into the path of the Subaru. Although Dr Lawrence found that Mr Palmer was suffering from severe ischaemic heart disease he expressed the opinion, which I
accept, that condition did not appear to have contributed to his death. Dr Lawrence found that Mr Palmer had suffered numerous traumatic injuries, in particular a depressed skull fracture to his left occipital region, which appeared to have resulted from Mr Palmer’s head striking the road. I am satisfied that this injury was the principal cause of Mr Palmer’s death. I note also the toxicological evidence that Mr Palmer only had cardiac and blood pressure medication in his body at the time of his death.

Police Crash Investigators reconstructed the circumstances of the fatal crash. That reconstruction suggests, and I find, that there was nothing obstructing the view of the driver of the Subaru in the immediate lead up to the crash. When interviewed by Police, under caution, Mr Stewart said he simply did not see Mr Palmer before the crash. I accept that this is so.

I note Mr Stewart was subsequently charged with, and pleaded guilty to, causing Mr Palmer’s death by negligent driving.

I am satisfied on the evidence that neither speed, nor drugs and/or alcohol, nor road or weather conditions, nor vehicle mechanical deficiencies played any role in the happening of the crash which claimed Mr Palmer’s life.

Comments and Recommendations

I extend my appreciation to investigating officer First Class Constable Nigel Housego for his investigation and report.

The circumstances of Mr Palmer’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 Mr Palmer.

Dated 3 December 2018 at Hobart, Tasmania.

Simon Cooper
Coroner