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 Zena Kay Penney

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

a) The identity of the deceased is Zena Kay Penney, date of birth 1 March 1937.

b) Mrs Penney was 86 years of age, widowed and lived alone in Adventure Bay, Bruny Island. She has two adult sons. Mrs Penney had been in good physical and mental health for most of her life. However, in May 2021, she underwent a coronary artery bypass graft and aortic valve replacement due to heart disease. She recovered well from the surgery. Mrs Penney was capable and self-reliant in her activities of daily living, and received some limited domestic support. She was the holder of a driver's licence, although her fitness to drive was undergoing assessment by the Registrar of Motor Vehicles at the time of her death. This assessment was precipitated by Mrs Penney crashing her car into a vehicle in front of her on the Channel Highway in Margate on 22 February 2023. Mrs Penney attended her doctor on 24 March 2023 as part of her Medical Fitness to Drive Assessment. Her doctor advised her that she should, until the assessment was completed, limit her driving to Bruny Island only. The official notice from the Registrar of Motor Vehicles imposing this interim driving restriction was sent to Mrs Penney on 29 March 2023 and it is unlikely that she received it prior to her death.

On 30 March 2023 Mrs Penney drove her Holden Barina hatch from her home to Kingston to undertake errands. Nothing about her driving or use of the island ferry was untoward. The evidence indicates that Mrs Penney, when returning home from her trip, travelled south on the Main Road and drove over "The Neck" separating North and South Bruny. At 12.46pm, shortly after driving over The Neck, Mrs Penney's vehicle left the sealed roadway and travelled on to the left hand side road verge before crashing into a large tree. Her vehicle sustained extensive damage to the front. Although no one witnessed the crash, motorists

came upon the scene and provided assistance before the imminent arrival of the ambulance. The attending paramedics declared her deceased. Police officers attended the scene and commenced an investigation.

The evidence in the investigation, including specialist crash analysis, allows me to conclude that Mrs Penney was travelling at 85 km/h immediately before the crash, below the speed limit of 90 km/h. The evidence also indicates that she did not apply her brakes or accelerator before the crash. She was wearing her seatbelt and her vehicle was in roadworthy condition. The road and weather conditions played no part in the crash. No other vehicle or person was involved.

c) Following autopsy, the State Forensic Pathologist concluded that Mrs Penney died as a result of multiple injuries, including injuries to the chest, pelvis and right lower limb. In his affidavit, the State Forensic Pathologist stated that Mrs Penney may have suffered a cardiac arrhythmia (which may not have been life-threatening) causing her to drive off the road and crash her vehicle. However, he was not able to state positively that such a medical event occurred. Upon the evidence, it is also possible that fatigue or distraction may have caused the crash. I am not able to positively determine the reason why the crash occurred but I am satisfied that Mrs Penney died as a result of sustaining serious injuries as a result of it.

d) Mrs Penney died on 30 March 2023 at South Bruny, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits verifying identity;
- Affidavit of the State Forensic Pathologist who conducted the autopsy;
- Toxicology report of Forensic Science Service Tasmania;
- Tasmanian Ambulance Service records;
- Tasmanian Health Service records;
- Ochre Medical Centre general practitioner records for Mrs Penney;
- Affidavit Scott Penney, son of Mrs Penney;
- Affidavits of five witnesses who attend the scene of the crash;
- Affidavit of an employee of SeaLink Ferry Service and associated CCTV footage of Mrs Penney before the crash;
- Affidavits of four attending and investigating police officers, including crash investigation analysis and data, photographs and body worn camera footage of the scene;

- Affidavit of Transport Inspector, Noel Clark, regarding the condition of Mrs Penney's vehicle; and
- Documentation from Department of State Growth regarding Mrs Penney's driver's licence.

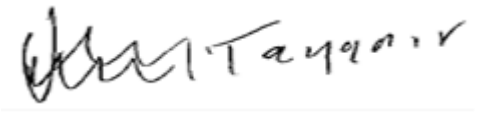
Comments and Recommendations

I extend my appreciation to investigating officers Senior Constable Leonie Ridge and Senior Constable Jimi Morris for their investigation and for their respective reports.

The circumstances of Mrs Penney'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 Penney.

Dated: 13 March 2024 at Hobart, in the State of Tasmania.



Olivia McTaggart

Coroner