



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 Ian Hewitt

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

- a) The identity of the deceased is Robert Ian Hewitt;
- b) Mr Hewitt died as a result of injuries sustained as a driver in a motor vehicle crash with another vehicle on the Channel Highway, Oyster Cove on 21 April 2016;
- c) Mr Hewitt died as a result of chest and abdominal injuries;
- d) Mr Hewitt died on 21 April 2016 at Channel Highway, Oyster Cove in Tasmania;
and
- e) Mr Hewitt was born in Yorkshire, England on 27 October 1944 and was aged 71 years.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Robert Ian Hewitt's death. The evidence comprises a detailed report of the crash investigator, the opinion of the forensic pathologist who conducted the autopsy, relevant police and witness affidavits, medical records and reports, and forensic evidence.

Based upon the evidence, I make the following further findings as to how Mr Hewitt's death occurred.

Mr Hewitt lived by himself at 48 Lighthouse Road, Lunawanna at Bruny Island. He was a retired school teacher and musician. He held a full drivers licence and had an excellent driving record.

At approximately 4.25pm on Thursday 21 April 2016 Mr Hewitt was the driver and sole occupant of a green 2003 Ford Fairmont sedan registered number FE 7232 ("the Ford"). He was driving in a southerly direction on the Channel Highway from the direction of Snug towards Kettering. He was wearing a properly fitted and adjusted seat belt. At the time the traffic flow on the highway was light. It had previously been raining and the bitumen road surface was damp. The driving visibility was good.

At a point approximately one kilometre south of the junction of Waldies Drive, Oyster Cove, Mr Hewitt approached the commencement of two sharp curves forming an 'S' shape section of road. The initial curve for Mr Hewitt travelling in a southerly direction was closed and to the right. There was a clearly visible 'curve speed advisory sign' indicating a speed of 55km/h facing southbound traffic prior to entry into the curve. This advisory sign applies to the right hand orientation of the curve and is specific to southbound traffic. At the apex of the right hand curve, on the eastern side, there are a number of "chevron" arrows erected. The arrows delineate the eastern road edge of the curve for southbound traffic. Double continuous white lines are present in this area. On both sides of the road there are fog lines, being painted road edges, and narrow bitumen shoulders. On the western side the shoulder is bounded by an Armco railing.

Mr Hewitt commenced to drive into the right hand curve at a speed above the curve advisory speed sign (55km/h) but under the applicable maximum speed limit of 90km/h.

At the same time Nicholas Joseph Tabor was driving a blue 2001 Subaru Impreza WRX registered number EM1606 ("the Subaru") in a northerly direction along the Channel Highway from the direction of Kettering towards Snug, being the opposite direction to that of Mr Hewitt.

Mr Tabor was the sole occupant of his motor vehicle. He had just negotiated the initial curve of the S shaped section of road from the south which, for him, was a closed right hand curve. He then approached the curve Mr Hewitt was exiting. Mr Hewitt at that point lost control of his vehicle and travelled onto the incorrect side of the road and into the path of Mr Tabor's vehicle.

Mr Tabor observed the Ford on its incorrect side of the road and in his line of travel, but had insufficient perception and response time to take any form of evasive action in order to avoid a collision. Mr Tabor only had a sight distance of approaching traffic of approximately 45 metres as he exited the right hand (northbound) curve.

The passenger side of the Ford between the A and C pillars impacted the front of the Subaru. The approximate point of impact was in the northbound lane, being the correct lane of travel for the Subaru.

Mr Hewitt's vehicle suffered extensive damage and Mr Hewitt sustained fatal chest and abdominal injuries.

Ambulance paramedics who attended shortly after the crash declared Mr Hewitt deceased at the scene.

Sergeant Rodney Carrick, crash investigator, attended the scene and conducted a full investigation. He determined that Mr Hewitt's speed on entry into the curve was at least 69km/h. On his exiting the curve (in the area of the eastern tangent) the passenger side wheel or wheels entered onto the eastern fog line, close to the gravel/grass verge on this side. Mr Hewitt attempted to correct the position of his motor vehicle by right hand steering input. This resulted in an oversteer and Mr Hewitt's vehicle commenced to rotate clockwise (passenger side first) across the double continuous white lines onto the incorrect side of the road.

Sergeant Carrick calculated that Mr Tabor was travelling at a speed of 75km/h at the time of impact, being below the speed limit.

I find that immediately prior to the collision Mr Tabor was driving his motor vehicle in a proper and appropriate manner and was not responsible for the crash. Further, the position of the Armco railing would have made it impossible for Mr Tabor to swerve left even if he had sufficient time.

There is no available evidence to suggest Mr Hewitt suffered any form of dissociative event or medical episode immediately prior to the crash. The position of the steering wheel and orientation of the front wheels (post-crash) is indicative of Mr Hewitt attempting a “counter steer” subsequent to the loss of steering control. A counter steer is a clear indicator of a conscious and deliberate act. I am satisfied that Mr Hewitt was conscious at the time of the loss of control of his vehicle.

The evidence indicates that neither alcohol nor drugs were factors in the crash. Mechanical fault and/or vehicle defects were also not factors in the crash.

On the day of the crash, an area of road south of the exit of the right hand curve, but north of the actual crash scene, was identified as an area which may have been slippery, causing Mr Hewitt to lose steering control. However, Sergeant Carrick determined that the area of identified road was no more or less slippery than any other section of road in that area. Further, the vehicle markings on the road demonstrated that the identified area had no relevance to the path or direction of Mr Hewitt’s vehicle prior to impact.

Unfortunately, I am unable to determine the reason why the passenger side wheel (or wheels) of Mr Hewitt’s vehicle crossed onto the eastern fog line when exiting the right hand curve north of the crash. I am satisfied, however, that it was due to driver error. Possible reasons for the error include inattention, distraction, fatigue and/or taking the incorrect driving line into and out of the curve.

Comments and Recommendations

I extend my appreciation to investigating officer, Sergeant Rodney Carrick, for his most comprehensive investigation and report.

The circumstances of Mr Hewitt’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 Hewitt.

Dated: 7 October 2016 at Hobart in the State of Tasmania.

Coroner
Olivia McTaggart