IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0272/2024

Police No: 24 109975

CORONERS' FINDINGS

ROAD DEATH 53 OF 2024

*Section 34 of the **Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of a **49 YEAR OLD CAUCASIAN FEMALE** and without holding an inquest, find that the deceased was born on **27 June 1975** and that her **death occurred on 2 November 2024, at Royal Darwin Hospital in the Northern Territory.**

Introduction:

60 people lost their lives on Northern Territory roads in 2024. The highest road toll per capita in over a decade and by far the highest in the country. These findings concern the tragic circumstances of road fatality number 53 of 2024.

This pedestrian death was the result of an uncommon accident. The deceased was attempting to walk across a footpath. Her view of the footpath was obscured by plants and she did not identify a young boy approaching on a bicycle. A boy was riding down the footpath. His view was also obstructed by plants and he had no advance notice that there was a pedestrian about to step into his path.

When the deceased stepped onto the footpath directly in front of the cyclist there was not enough time or distance for the cyclist to avoid the collision. The deceased was knocked to the ground and cracked her head. Her head injuries were catastrophic and despite medical interventions at hospital, she passed away and her family generously donated her organs in accordance with her wishes and her lifelong desire to serve others.

Both the pedestrian and the young cyclist were sober and neither were at fault.

Changes have been made to the footpath intersection to increase visibility.

The loss of this accomplished, selfless and devout female is a tragedy for her family and for the broader community.

Cause of death:

1(a) Disease or condition leading directly to death: **Blunt force head injury**

1(b) Morbid conditions giving rise to the above cause: **Reported pedestrian-pushbike collision**

Following an autopsy on 4 November 2024, Forensic Pathologist, Dr Salona Roopan, commented:

- The opinion as to the cause of death is based on the available police and medical information, and a post-mortem examination including ancillary investigations.
- CT scan of multiple regions with main findings on 30/10/2024 as documented in the CT scan reported: bilateral occipital bone fractures extending to the base of the skull and large subgaleal haematoma overlying the left occipital bone, contrecoup injury with right subdural haemorrhage. Petechial foci of haemorrhage of right frontal lobe (concerning for diffuse axonal injury), and intraventricular haemorrhage within the 4th ventricle and focal mass effect. No other injuries of the body were documented (neck/chest/abdomen/pelvis).
- Craniotomy was performed on the 30/10/2024 but the decedent progressed to brain death on the 02/11/2024. Organ recovery was performed on the 03/11/2024.
- I have no reason to believe with the information available and findings made during external examination of the body that the death was due to any other cause than the reported pedestrian-pushbike collision.

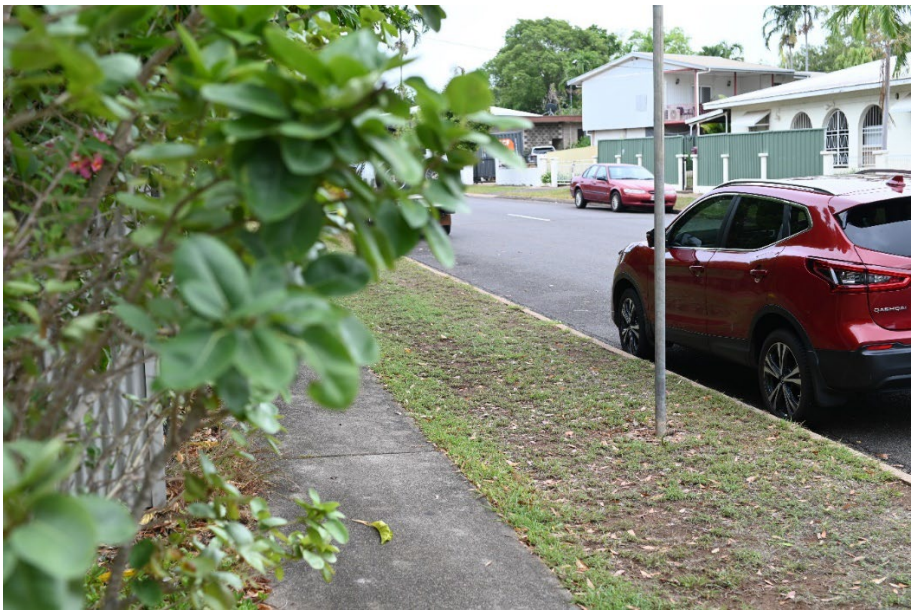
Circumstances:

On 30 October 2024 at approximately 3:15pm, the deceased exited a gate at the Nungalinya College property on Goodman Street, Nakara. The gate is set back from the main fence line. She stepped forward onto the footpath, heading towards the curb to cross Goodman Street. Her view of the footpath was obstructed by shrubbery located on the outside of the fence between the gate and footpath.

At the same time a 12 year old boy was riding his bicycle home from school on the footpath along Goodman Street.

Cyclist's direction of travel and view along the footpath (Goodman St) – leading to the gate (hidden from view) situated between the first two cars and to the right of the cross path to the street

Inside Nungalinya College – the gate the deceased exited



The deceased's view exiting the gate – looking towards the direction of the bike

The cyclist saw the deceased step into his path and tried to brake, however, there was insufficient time for him to stop or avoid the collision. His bike struck her, knocking her to the ground, and he came off the bike over the handlebars.

A passing motorist saw a young boy waving his hands yelling for help and stopped. When she checked, the deceased was lying on her back with her eyes open, breathing but unconscious and there was blood coming from the back of her head. On the ground lying near her was a book, eyeglasses and an ear pod. The motorist called 000 and used a scarf to try and stem the bleeding. The principal of Nungalinya College attended the scene with a first

aid kit. Paramedics from St John Ambulance arrived at the scene at 3:30pm and took over her treatment and she was conveyed to Royal Darwin Hospital.

At Royal Darwin Hospital a CT scan identified she had significant head injuries. In ICU her condition continued to deteriorate throughout the evening and, although a craniectomy was performed, her conditioned worsened and there were no further neurosurgical interventions available.

On 2 November 2024, she was declared clinically brain dead, but following her own and her families wishes, she was kept on life support until an operation was performed to remove her organs for organ donation on 3 November 2024. She was known to be an avid supporter of organ donation.

The coronial investigation by Police established that the cause of the collision was a failure by both parties to identify each other. The deceased's view was obstructed and she failed to identify the approaching bicycle and attempted to cross the footpath. The cyclist's view was also obstructed and he failed to identify the deceased entering his path. When the deceased stepped into the path of the cyclist he did not have enough time or distance to avoid the collision.

Based on the evidence, Police formed the view that the young cyclist had not intended the collision, could not have foreseen the collision and, in all the circumstances, could not avoid the collision.

Action taken after incident

The week following the collision, Nungalinya College relocated the gate to an area in the fence line with less vegetation and clearer sight lines to prevent a similar crash occurring.

New exit gate

New exit gate

Decision not to hold an inquest:

Pursuant to section 16(1) of the *Coroners Act 1993* I decided not to hold an inquest because the investigations into the death disclosed the time, place and cause of death and the relevant circumstances concerning the death. I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date. The circumstances do not require a mandatory inquest because:

- The deceased was not, immediately before death, a person held in care or custody; and
- The death was not caused or contributed to by injuries sustained while the deceased was held in custody; and
- The identity of the deceased is known.