IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000903

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Noraishah Binti Ismail
Date of birth:	21 April 1966
Date of death:	16 February 2022
Cause of death:	1(a) Unascertained
Place of death:	Fifth Street & Paschaendale Avenue, Merbein, Victoria, 3505

INTRODUCTION

1. On 16 February 2022, Noraishah Binti Ismail was 55 years old when she died in a motor vehicle accident. At the time of her death, Ms Ismail lived at Mildura, Victoria.

2. Ms Ismail was a Malaysian national and had been residing in Australia for about six years prior to her passing. She was the holder of a Malaysian driver's licence, but never obtained a Victorian licence. She had incurred two minor speed-related offences, but no other criminal or traffic history.

THE CORONIAL INVESTIGATION

3. Ms Ismail's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Ismail's death. The Coroner's Investigator conducted inquiries on the Coroner's behalf and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Noraishah Binti Ismail including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

8. On 16 February 2022, Ms Ismail drove her 2000 red Toyota RAV4 (**the car**) from her home to the home of her friend, Nurul Salleh, in Mildura. Ms Ismail picked her friend up at about 6.30am, with the intention of taking Ms Salleh to her workplace.

9. At about 6.45am, Ms Ismail pulled her car over to the side of the road as she had taken a wrong turn and needed to use the GPS map application "*Google maps*" on her phone to find a new route to Ms Salleh's workplace. Once Ms Ismail obtained a new route, she placed her phone on the centre console, just below the radio. Ms Salleh noted that Ms Ismail intermittently looked down at the phone to ensure she was following the correct route.

10. At about 7.00am, Ms Ismail was travelling westbound on Fifth Street. She looked down at her phone and realised there was an upcoming left-hand turn. She then looked back up at the road and belatedly noticed that she was approaching a stop sign and intersection, with another car to her right also about to enter the intersection. Ms Salleh stated that Ms Ismail "*was unable to stop so she decided to accelerate in order to get through the intersection and stop sign without hitting the car that was coming on her right*".

11. At the same time, Garry Russell was driving his white 2007 Nissan Navara utility (**the utility**) when he approached the intersection of Paschendale Avenue and Fifth Street. As he approached the intersection, he saw Ms Ismail's car to his left, also approaching the intersection. Mr Russell was familiar with the intersection as he drove there almost daily. He immediately knew that Ms Ismail faced a stop sign, however he immediately estimated that she was travelling too fast to be able to stop in time.

12. Ms Ismail made no attempt to stop. She accelerated and drove into the intersection at speed, in contravention of the stop sign. Mr Russell had no time to stop to avoid the collision. His utility impacted the driver's side of Ms Ismail's car, which came to rest in the northside lane

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

of Paschendale Avenue. There was extensive driver side impact damage. Mr Russel's utility came to rest facing east of the shoulder of the north bound lane of Paschendale Avenue. It had extensive front-end damage.

13. Mr Russell removed his seat belt, and he was able to get out of the utility. He went over to Ms Ismail's car and spoke to Ms Salleh, who was conscious with minimal injuries, but Ms Ismail was unresponsive. Ms Salleh noted her friend was breathing heavily but appeared unconscious.

14. Another motorist, Rohan Brown, was travelling east on Fifth Street and witnessed the accident occur from about 150 metres away. He stopped to assist and spoke to Mr Russell, who he assessed as "*dazed but was not injured"*. He called 000, before approaching Ms Ismail's car. Another passing motorist stopped and attempted to help Mr Brown extract Ms Ismail from the car, but they were unsuccessful.

15. Andrew Nemstas was also driving in the area and whilst he did not witness the accident, he observed a large dust cloud in the air. He realised that an accident had likely occurred, so he drove about 800 metres away to his farm, where his partner was located. Mr Nemstas informed his partner, Evelyn Saunders, about what had occurred and requested she accompany him to the crash site as she was a registered nurse.

16. Ms Saunders and Mr Nemstas arrived back at the scene within minutes. Ms Saunders first attended to Mr Russell and thought that he might be in shock, but otherwise appeared to be uninjured. Mr Brown called out for help so Ms Saunders and Mr Nemstas rushed over to Ms Ismail's car.

17. When Ms Saunders approached Ms Ismail, she observed that Ms Ismail was "*slumped forwards*" and unresponsive. Mr Nemstas leaned into the car through the rear right-hand passenger window to help support Ms Ismail's head and neck. Ms Saunders observed Ms Ismail's breathing was shallow and her pulse was not normal.

18. The first Ambulance Victoria (**AV**) unit arrived at 7.19am and immediately began to assess Ms Ismail and Ms Salleh. On arrival, paramedics determined that Ms Ismail was in cardiac arrest, had no pulse and was not breathing. Paramedics initially treated Ms Ismail in situ, while they waited for Country Fire Authority (**CFA**) and the State Emergency Service (**SES**) to attend and extricate Ms Ismail.

19. CFA and SES members extricated Ms Ismail at about 7.33am. Once Ms Ismail was removed from her car, paramedics were able to properly assess and treat her in the ambulance. Despite the best efforts of all emergency services personnel involved, Ms Ismail was unable to be resuscitated and was declared deceased at 7.56am.

20. Victoria Police attended the scene and investigated the cause of the collision. A report was prepared by Detective Senior Constable (**DSC**) Yuxing Zhao of the Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**), Victoria Police. DSC Zhao noted there was no evidence to suggest that either vehicle attempted to brake or avoid each other, so the impact occurred at or near 90 degrees. DSC Zhao calculated that Ms Ismail was travelling at about 94 km/h and Mr Russell was travelling at about 83 km/h at the time of the collision. Both lengths of road into the intersection have a posted speed limit of 100 km/h.

21. Both vehicles were also inspected by Victoria Police, and neither was found to have any mechanical faults or failures which could have caused or contributed to the collision. Ms Ismail's car was noted to be in roadworthy condition prior to the collision and was last serviced in July 2020.

22. At the time of the collision the weather was clear, the roads were dry, visibility was good and there was light traffic.

23. Mr Russell was breath tested and was required to undergo a blood test following the collision. No alcohol or drugs were detected.

24. In the approach to the intersection with Paschendale Avenue, there is an advisory sign on Fifth Street, notifying road users of the upcoming intersection. There is also a stop sign and solid white line on Fifth Street, at the location of the intersection. The road surface was noted to be in a good condition.

25. I note that in her statement, Ms Sallah reflected upon the cause of the accident and stated, "*I think if Noraishah was more focussed she could have avoided the collision*."

Identity of the deceased

26. On 16 February 2022, Noraishah Binti Ismail, born 21 April 1966, was visually identified by her friend, Muhamad Saiful Deen Bin Azizan.

27. Identity is not in dispute and requires no further investigation.

Medical cause of death

28. Forensic Pathology Registrar Dr Joanne Ho, supervised by Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 21 February 2022 and provided a written report of her findings dated 28 February 2022.

29. The post-mortem examination revealed subarachnoid haemorrhage, no intracranial haemorrhage or skull fracture and the cervical spine and vertebral column were intact. Dr Ho also noted a right pneumothorax, right needle thoracostomy, increased lung markings, multiple bilateral superior and inferior pubic rami fractures. Dr Ho explained that while the pelvic fractures were significant, it was not clear that they were sufficient to be the cause of death.

30. Dr Ho noted that an autopsy was recommended to clarify the nature of the subarachnoid haemorrhage as being primary natural disease (and therefore a possible cause of the motor vehicle incident) or if it was secondary to trauma. However, Ms Ismail's family objected to an autopsy, so only an external examination was performed.

31. Toxicological analysis of post-mortem samples did not identify the presence of alcohol or any other commonly encountered drugs or poisons.

32. As part of my investigation, I provided Ms Salleh's witness statement to Dr Ho, to determine whether it altered her opinion of Ms Ismail's cause of death. In Dr Ho's opinion, the cause of death did not change.

33. Dr Ho provided an opinion that the medical cause of death was "*1(a) Unascertained*".

34. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

35. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Noraishah Binti Ismail, born 21 April 1966;

    b) the death occurred on 16 February 2022 at Fifth Street and Paschaendale Avenue, Merbein, Victoria, 3505, from unascertained causes; and

    c) the death occurred in the circumstances described above.

36. Based on the available evidence, I am satisfied that the collision was primarily caused by Ms Ismail being distracted due to looking at her phone for directions, and her decision to accelerate into the intersection to try and avoid the impending collision.

37. However, I also note the comments made by the Coronial Investigator as follows:

Complacency is the main safety issue at this intersection due to the lead up distance. Once travelling on Fifth street from the last controlled intersection (A79) west bound traffic on Fifth Street have an approximate 3.8 kilometre lead up to the advisory and stop sign located at the intersection of Paschendale Avenue.

The 100kph speed limit is not appropriate for this cross intersection as there is minimal view of approaching traffic from all directions. Issues would also arise when the sun is low (Sunrise/Sunset) due to the east/west orientation of Fifth Street creating visibility issues.

The continuing road is Paschendale Avenue, a tow lane road in good condition.

The intersection has various obstructions ranging from corner positioned houses to flora and fauna.

This section of road is the responsibility of the Mildura Rural City Council.

38. I provided the comments to Mildura Rural City Council (MRCC) and received a response as follows:

a) MRCC is the designated authority with responsibility for the intersection of Paschendale Avenue and Fifth Street and is responsible for the care and management of the intersection.

b) A review of the intersection has occurred and as a result, advanced warning signs and additional stop signs have been installed.

c) Although the speed limit was temporarily reduced to 80 km/h as a result of the Murray River floods, the speed limit has since returned to 100 km/h.

d) The intersection was considered for Black Spot funding; however, the crash data has not been uploaded into the Road Crash Information System database, MRCC is unable to apply for funding.

e) Council has previously considered an area wide speed reduction plan, prior to the COVID-19 pandemic. The plan reduced the maximum speed limit in the irrigated area

to 80km/h, however "*At that point in time there was little support for this in the Council chamber*".

f) MRCC "*recently adopted the Road Safety Strategy 2023-2030 which advocates for the reduction of speed limits across the municipality*".

39. MRCC did not elaborate as to whether adoption of the 'Road Safety Strategy 2023-2030' will result in a reduction in the speed limit at this intersection. I note that prior consideration of reduction of the speed limit at this intersection was in the context of an "*area wide speed reduction plan*" and that this was ultimately not supported by Council, although the reasons why are not articulated. In any event, the concern about the inappropriate speed limit raised by Victoria Police is in relation to this one intersection. Whilst MRCC have advised that additional signage has been put in place, it is unclear how that will address the specific issue raised by Victoria Police.

40. Whilst the primary cause of the death of Ms Ismail was distraction caused by using her phone, it is the experience of this Court that many vehicle fatalities occur through human error such as inattention and distraction. It is also uncontroversial that reducing the speed at which a vehicle is travelling increases the likelihood of surviving a crash or avoiding injury. I am satisfied that it is at least possible that Ms Ismail's chances of survival would have been increased if the collision occurred at a lower speed.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That MRCC reduce the speed limit at the intersection of Paschendale Avenue and Fifth Street, having regard to the concern raised by Victoria Police that the speed limit is inappropriate.

I convey my sincere condolences to Ms Ismail's family for their loss.

I direct that a copy of this finding be provided to the following:

Salmah Ismail, Senior Next of Kin

Mildura Rural City Council

First Constable Graeme Birnie, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 08 July 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.