Coroners Act, 1996

[Section 26(1)]

Western  *Australia*

RECORD OF INVESTIGATION OF DEATH

Ref No: 36/13

I, Dominic Hugh Mulligan, Coroner, having investigated the death of ***Anh Thuy TRINH****, with an inquest held at Perth Coroner's Court on 10 September 2013, find the identity of the deceased was* ***Anh Thuy TRINH*** *and that death occurred on* ***12 May 2010,*** *at* ***Royal Perth Hospital, Wellington Street, Perth,*** *as a result of* ***Traumatic Brain Injury,*** *in the following circumstances:*

1. The deceased was a widow who lived at 200 Walter Road, Bassendean.

2. She worked as a seamstress in a factory located in Welshpool.

3. The deceased normally travelled to work by bus. She would take one bus from her home to Morley and then take another bus to her place of work.

4. At about 7:30am on Monday 12 May 2010 the deceased went to work on the number 98 bus operated by Transperth. That day was like any other except it was the deceased's 55th birthday.

5. The bus travelled in a south-westerly direction along Oats Street in Carlisle.

6. Oats Street is a typical suburban street which is orientated along a north-east/south-west axis. It has one lane for traffic travelling in each direction. The two lanes of traffic are separated by a well-marked median strip which is approximately 1.41 meters in width.

7. The speed limit along Oats Street is 50 km/h.

8. Shortly after the bus passed the Harris Street intersection it stopped at a bus stop. The deceased got off the bus, turned right and walked to the front of the bus. She then stepped onto Oats Street and walked in front of the stationary bus towards the northern side of the road. She paused briefly as she was adjacent to the right corner of the bus.

Figure 1 - Aerial photograph of Oats Street, Carlisle[1]

9. As Ms Trinh was crossing Oats Street Mr Bret Henderson was driving his Nissan Navarra utility towards the deceased's location.

10. Mr Henderson, who was accompanied by his partner's 15-year-old daughter, drove the utility in a south-easterly direction along Harris Street.

[1] Exhibit 1, Volume 1, Tab 27

11. He then turned right on to Oats Street and drove towards the number 98 bus which was located in the same lane in which he was travelling. Mr Henderson saw the bus driver indicate his intention to stop, and watched as the bus pulled into the bus stop at which the deceased alighted.

12. The manner of Mr Henderson's driving was unremarkable.

13. As Mr Henderson approached the stationary bus he decided to overtake it. To this end he indicated and then drove partially over the median strip. He was travelling below the speed limit as he overtook the bus. Mr Henderson believed he was driving at about 20 km/h. A witness, Mr Andrew Oliver believed Mr Henderson's vehicle was travelling at about 30 to 40 km/h.

14. As Mr Henderson was passing the bus he saw Ms Trinh emerge into view around the front of the bus. She looked to her left and then carried on walking directly into the path of Mr Henderson's vehicle, which was coming towards her from her right.

15. Mr Henderson did what he could to avoid a collision. He applied his brakes and turned the vehicle to his right. His vehicle skidded for a short distance and then hit the deceased.

16. The deceased suffered a severe brain injury as a consequence of the collision.

17. Mr Henderson immediately stopped his vehicle and went to the deceased's aid. Another person called '*000*' and sought the assistance of the emergency services. Meanwhile Mr Henderson, along with other passers-by, did what they could to help Ms Trinh whilst they awaited the arrival of an ambulance.

18. An ambulance arrived at the Ms Trinh's location at about 7:40am. At that time Ms Trinh was conscious but in pain. She had an obvious injury to her left temple, which was swollen. She had blood coming from her mouth and nose and a pool of blood was visible in the area where she lay.

19. After assessing the deceased the ambulance paramedic officers and transported her to Royal Perth Hospital.

20. The deceased underwent a CT scan at Royal Perth Hospital, which showed she had suffered catastrophic brain injuries. She underwent emergency lifesaving surgery

during which it was discovered the deceased's injuries were such that her condition was beyond recovery.

21. The deceased's condition declined and she died during the afternoon of 12 May 2010. She was certified to be life extinct by two of her treating physicians.

22. On 14 May 2010, a post mortem examination was performed on the deceased by a forensic pathologist who, after receiving the results of further investigations on 10 December 2010, determined the cause of death to be '*traumatic brain injury'.*

23. On 20 May 2010, a neuropathologist, Dr Vicky Fabian, examined the deceased's brain. She found evidence of neurosurgical intervention, widespread subdural haemorrhages, recent lacerations and contusions to both the deceased's frontal and temporal lobes and cerebral swelling.

24. A toxicological analysis of samples of the deceased's blood detected hydroxychloroquine at a level of approximately 0.2 mg/L, which falls within the high therapeutic – toxic level. The analysis also detected the presence of metoclopramide and propofol. The use of these medications was consistent with the deceased's proper hospital care.

25. Police officers commenced an investigation into the death. The police interviewed witnesses to the accident and they also arranged for Mr Henderson's Nissan Navarra utility to be examined by police vehicle examiners.

26. On 3 June 2010, Mr Henderson's vehicle was examined by Senior Constable Rogers and Senior Constable Harston, who were both attached to the Vehicle Investigation Unit. The vehicle examination report written by Senior Constable Rogers recorded a number of defects, which in his view would not have caused or contributed to the collision.

27. Senior Constable Rogers identified that both of the front tyres were unserviceable, as the tread depth had warned below 1.5 mm on the inner shoulders. Senior Constable Rogers also identified a number of other defects including; a cracked windscreen, no rear mudflaps, the inside trim on the driver's door was missing, lowering blocks had been fitted to the rear suspension.

28. The police issued Mr Henderson with a notice requiring the defects be remedied.

29. At the conclusion of their investigations the police did not identify any suspicious circumstances or evidence of the unlawful involvement of any other person in the death of the deceased.

30. In particular the police concluded that notwithstanding the defects to his vehicle the nature of Mr Henderson's driving was reasonable and he had no opportunity to avoid the collision with Ms Trinh.

31. On the evidence available to me I am satisfied that on 10 May 2013, Ms Trinh attempted to cross from one side of Oats Street, Carlisle, to the other. As she did so she looked in the direction of traffic travelling away from her position, but did not look in the direction for vehicles travelling towards her. She then stepped in front of a vehicle driven by Mr Henderson, who had no realistic opportunity to avoid colliding with her.

32. Ms Trinh suffered severe brain injuries as a consequence of the accident, which resulted in her death on 12 May 2010.

33. I find death arose by way of Accident.

DH Mulligan
Coroner
26 September 2013

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