Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Kirsten Dawn McDougall

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

a) The identity of the deceased is Kristen Dawn McDougall;

b) Ms McDougall died as a result of a single motor vehicle crash in the circumstances described further in this finding;

c) The cause of Ms McDougall’s death was aspiration pneumonia due to traumatic brain injury;

d) Ms McDougall died on 20 July 2015 at the Royal Hobart Hospital, in Tasmania; and

e) Ms McDougall was born in New South Wales on 21 October 1980 and was aged 34 years; she was single at the date of her death.

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

On 7 February 2014, Ms McDougall and her de facto partner, Damien Aron James, were travelling from Hobart to Launceston in a Mazda sedan on the Midland Highway. They intended to stay with a relative and purchase a new vehicle the following day. Ms McDougall, who was then the holder of a learner driver licence, started the drive from Hobart. Mr James was the front seat passenger. At a point south of Campbell Town, Mr James answered Ms McDougall’s mobile phone and spoke to her sister. Subsequently, Mr James commenced to drive the vehicle with Ms McDougall as the front seat passenger.
At a point approximately 4.5km south of Powranna Road the vehicle veered from the left lane across the centre white line onto the grass verge on the right side of the road. It then ran over a metal guide post and continued for approximately 50 metres in a straight line down a slight embankment before crashing into a gum tree. The crash was sufficiently forceful to cause the rear of the vehicle to leave the ground and veer to the left. There were no eyewitness to the loss of control of the vehicle and its crash. However, subsequently several persons stopped to assist. Upon arrival, paramedics determined that Mr James was deceased as a result of his injuries.

Ms McDougall was transported to the Royal Hobart Hospital where she had a prolonged hospitalisation due to severe traumatic brain injuries. She was eventually transferred to St John’s Hospital before being transferred to the Bishop Davies Court home for full-time high level care. Sadly, she remained in a clinically persistent vegetative state.

On Monday 20 July 2015, Ms McDougall was taken to the Royal Hobart Hospital for an elective CT scan of the brain. Medical notes indicate that whilst in Radiology she vomited after which she became haemodynamically unstable and hypoxemic. She was admitted to the hospital for palliative care and her condition deteriorated rapidly. She died in the evening of 20 July 2015, several hours after the aspiration event and one year and five months after the motor vehicle crash.

A detailed crash investigation was conducted by First Class Constable Nigel Housego, an experienced crash investigator. He formed the opinion that the crash occurred because Mr James fell asleep whilst driving. He formed this view for a number of reasons:

a) There was no evidence of braking on or along the edges of the highway other than the rolling tyre marks leading to the tree.
b) There were no other vehicles in the area at the time.
c) The weather was fine, the road dry, and visibility good.
d) The vehicle was roadworthy and free of any defects that may have caused the crash.
e) The vehicle was travelling at 104.5km/h, as determined by speed analysis calculations, being below the posted speed limit of 110km/h.
f) There was nothing on or about the roadway that would cause the vehicle to crash.
g) The road was straight and in good condition.
h) Mr James appears to have had a propensity on occasions to fall asleep during the afternoon.
i) Mr James was not using his mobile telephone at the time of the crash.

Constable Housego formed the opinion that, given the continuous path of the vehicle onto the other side of the road, Ms McDougall was also likely to have been asleep.
Even if both had woken as the vehicle crossed the audible line or gravel, the crash could not have been avoided at that point.

**Comments and Recommendations:**

I make the following comments and recommendations pursuant to s28 of the *Coroners Act 1995*. They are identical to those made in the finding into Mr James’ death that is published simultaneously with this finding.

In the 10 year time period from 2005 until the present, a total of 116 serious crashes and 40 fatal crashes have occurred within Tasmania, as a result of driver fatigue or sleep.

A large proportion of these crashes occurred on the Bass and Midland Highways.

I note the significant efforts over a lengthy period made by the State government in the Road Safety Awareness Program to reduce the consequences of driver fatigue.

Constable Housego observed in his report to me that the topics of fatigue and sleep are not adequately addressed in the driver licence testing process. There are two forms of testing: a knowledge test and two practical tests. Presently, there is only one question dealing with fatigue in the knowledge test. As questions appear randomly, an applicant taking the test may not encounter this question.

After consultation between Constable Housego and the Manager of Driver Training and Assessment Services, Department of State Growth, there will shortly be an increase in the questions appearing in the knowledge test concerning the “fatal five” causes of serious crashes - speed, fatigue, alcohol and drugs, inattention and failure to wear seatbelts. The addition of these questions is a positive development in reinforcing crucial road safety issues.

The practical tests in the driver licence testing process are the Novice L2 driving test and the Novice P1 driving test. There is no knowledge testing during these tests.

There may be scope to incorporate further education and reinforcement of the causes of serious crashes into the driver licence testing process.

I therefore **recommend** that the Department of State Growth consider the feasibility and merits of implementing further strategies into the driver licence testing system with the aim of educating new drivers as to the major causes of fatalities and serious crashes, and their prevention.

I extend my appreciation to investigating officer, First Class Constable Nigel Housego, for his thorough investigation and report.

I convey my sincere condolences to Ms McDougall’s family and loved ones.
Dated: 29 June 2016 Hobart in the state of Tasmania.

Olivia McTaggart
Coroner