Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Rod Chandler, Coroner, having investigated the death of Nebras Elias

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

a) The identity of the deceased is Nebras Elias;
b) Dr Elias was born in Erbil City in Iraq on 26 November 1973 and was aged 43 years;
c) Dr Elias died on 8 November 2017 at Lebrina in Tasmania; and
d) The cause of Dr Elias' death was multiple blunt traumatic injuries sustained in a motor vehicle crash.

Background
Dr Elias was a medical practitioner who trained and qualified in Iraq. He emigrated to Australia under its skilled migrant programme and in 2015 commenced work at the Launceston General Hospital as a resident medical officer. Previously, he had been employed for around four years at the Swan Hill Hospital in Victoria. It was his professional aim to be able to practice in Tasmania as a general practitioner and to this end he commenced, on 16 October 2017, a three month placement at the Scottsdale Doctors Surgery in Scottsdale. Dr Elias was unmarried. He enjoyed good health.

Circumstances Surrounding the Death
Dr Elias was the owner of a Holden Commodore sedan (Victorian registration no. UDX-313). At around 6.00pm on Wednesday 8 November 2017, he was driving the Commodore south towards Launceston on Golconda Road at Lebrina when it came into collision with a Hino light truck (registration no. D88MD) being driven in the opposite direction by Mr Ricky Warren. Dr Elias died at the scene of the collision.

Post-Mortem Examination
An autopsy was carried out by pathologist, Dr Ruchira Fernando. She made this observation: “There was a subarachnoid haemorrhage involving cerebellum and around brain stem. Histologically this area showed features suggestive of an anterio-venous malformation with recent haemorrhage.” Dr Fernando then opined that: “This subarachnoid haemorrhage due to anterio-venous malformation appears the primary event causing loss of consciousness leading to lose (sic) control of the vehicle.” She
then stated that in her opinion the cause of Dr Elias’ death was a subarachnoid haemorrhage due to rupture of an anterio-venous malformation of the brain stem and involvement in a motor vehicle accident.

Dr Fernando’s findings at autopsy and her opinion upon the cause of death were reviewed by pathologist, Dr Terence Brain. This review was sought after Senior Constable Michael Rybka of Tasmania Police’s Northern Crash Investigation Services advised of his opinion that the loss of control of the Commodore was not due to a medical event but rather was attributable to a momentary loss of attention by Dr Elias which led the vehicle to move onto the gravel verge and has been followed by Dr Elias then steering the vehicle harshly to the right which has caused his loss of control.

Dr Brain provided his report in which he expressed the view that the cause of Dr Elias’s death was multiple trauma with a likely contributing factor being a small subarachnoid bleed within a vascular malformation. Dr Brain includes this comment: “Given the strong evidence from the road crash investigation, some control was affected to correct the gravel verge off-road incident indicating some consciousness during the correction. This does not to my mind dismiss a likely small subarachnoid bleed.”

The role (if any) played by a subarachnoid haemorrhage in bringing about Dr Elias’ crash caused me to seek the opinion of forensic pathologist, Dr Donald Ritchey. To facilitate his opinion Dr Ritchey was provided with all relevant material including the Northern Crash Investigation’s report, all relevant photographs both of the crash and the autopsy and the histologic sections. Dr Ritchey has reported to me that in his opinion: “Mr Elias has died as a direct result of multiple blunt traumatic injuries sustained in a motor vehicle crash. The finding of myelolipomas of the adrenal glands (benign tumours of the adrenals) and an arteriovenous malformation in the brain appear to reflect incidental pathology and not to have directly impacted Mr Elias’ death.”

Dr Fernando has since considered the report of Dr Ritchey and has reviewed her own opinion. She advises me that she now accepts the opinion of Dr Ritchey upon the cause of Dr Elias’ death.

Investigation

The circumstances of the collision have been the subject of a comprehensive investigation overseen by Senior Constable Rybka. It indicates the following:

- That Dr Elias had been working that day at the Scottsdale practice. He left the practice at around 5.45pm intending to travel to Launceston to meet his girlfriend. He planned en route to visit Kmart in Launceston.
- That, just prior to the crash, Mr Warren was driving the Hino uphill on Golconda Road intending to travel to his home at Lebrina. His vehicle was in the northbound lane travelling at 45 to 50 km/h.
• The crash occurred when the Commodore travelling downhill on Golconda Road was entering a right hand curve. At this point the Commodore has tracked onto the left hand gravel verge. Dr Elias has responded by steering harshly to the right to steer the vehicle out of the gravel. In the result the Commodore has commenced to yaw clockwise and then side-slip out of control across double continuous centre lines onto the incorrect side of the roadway. The collision with the Hino then ensued with the Commodore being two metres on the incorrect side of the roadway at this moment.
• At the time of the crash the weather was fine and the road surface dry.
• A speed analysis suggests that the Commodore was travelling at 93 km/h at the time of the crash. The area of the crash is subject to a 100 km/h speed limit.
• Both Dr Elias and Mr Warren were wearing seat belts.
• Blood testing of both Dr Elias and Mr Warren shows that neither had ingested alcohol or an illicit drug.
• Both the Commodore and the Hino were inspected by a transport inspector attached to the Department of State Growth. The inspections did not reveal any mechanical faults or failures which may have caused or contributed to the crash.
• Police found a white iPhone in Dr Elias’ vehicle sitting on the centre console. It was plugged into a white charger cable and still actively functioning as a GPS.
• Dr Elias had not made a call on his iPhone after 5.18pm when he spoke to his girlfriend. However, whilst in Scottsdale he had enabled the phone’s GPS and set the destination to Kmart’s address in Launceston.
• Police officers arrived on the scene shortly after the crash occurred. It was evident to them that Dr Elias was deceased.

Findings, Comments and Recommendations

The first observation to make is that the investigation undertaken by the crash investigator clearly establishes that in the moments before the crash the Commodore was driven onto the gravel verge before being firmly steered to the right, a movement which caused it to yaw and to then move out of control into the incorrect lane. This course taken by the Commodore, when considered with the other evidence, satisfies me of this scenario. First, because of a moment’s inattention Dr Elias has unintentionally allowed his vehicle to drift onto the gravel verge. The cause of that inattention is not known. It may be that he was distracted by the GPS which he had employed. Alternatively, there may have been a moment of drowsiness. Whatever the cause Dr Elias has realised the need to return the Commodore to the sealed surface and in doing so has firmly steered to the right. This is clearly, in my opinion, the action of a driver who, is fully conscious and not one overtaken by an intervening medical event. It is this corrective manoeuvre on Dr Elias’ part which has led to his loss of control and the vehicle moving onto the incorrect lane and into the immediate path of Mr Warren’s Hino.

The scenario which I have set out is consistent with Dr Ritchey’s opinion that the brain pathology found at autopsy was incidental and did not impact upon Dr Elias’ death. I accept Dr Ritchey’s opinion on this issue in preference to the opinions expressed by Drs
Fernando and Brain. I also accept Dr Ritchey’s opinion upon the cause of death, specifically that Dr Elias died from multiple blunt traumatic injuries sustained in the crash.

I need to observe that the evidence clearly shows that at all times Mr Warren was driving in a safe and proper manner and that his actions did not in any way cause or contribute to the crash.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the Births, Deaths and Marriages Registration Act 1999. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Dr Elias’ family and loved ones.

Dated: 4th of January at Hobart in the State of Tasmania.

Rod Chandler
Coroner