IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: A0043/2024

Police No: 24 83749

CORONERS FINDINGS

ROAD DEATH 45 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 51 YEAR OLD ABORIGINAL MALE** and without holding an inquest, find that he was born on **29 January 1973** and that his **death occurred on 1 September 2024, at Alice Springs Hospital in the Northern Territory.**

Introduction:

These findings concern road death 45 of 2024.

This is the death of a 51 year old man who had documented medical conditions. He suffered a spontaneous intracerebral haemorrhage while riding his motorcycle. This medical event caused him to crash and caused his death.

He had a blood alcohol reading of 0.14%, was not wearing a helmet, and suffered some injuries in the crash, but these factors do not appear to have contributed to the crash or his death.

Cause of death:

1(a)	Disease or condition leading directly to death:	**Spontaneous intracerebral haemorrhage**
1(b)	Morbid conditions giving rise to the above cause:	**Motorcycle crash (rider)**
2	Other significant conditions contributing to death but not related to the condition causing death:	**Alcohol intoxication**

Other conditions present but not regarded (or provable) as contributing to death was: Severe focal coronary artery atherosclerosis

Following an autopsy on 3 September 2024, Forensic Pathologist, Dr John Rutherford commented:

The decedent was a 51-year-old male who had been involved in a motorcycle incident in the vicinity of Mount Peachy outstation circa 08:00 hours on Sunday 25/08/2024 on Hugh River stock route at Mount Peachy. He was suspected to have suffered a "medical incident" that had resulted in his crashing the motorbike. He was conveyed to Alice Springs Hospital and stayed in the Intensive Care Unit on life-support until he spontaneously died, life being pronounced extinct at 17:54 hours on 01/ 09/ 202 4. The provisional cause of death was given as "heart failure". His antemortem blood alcohol reading was 0.14%.

Summary of main pathological findings

- Spontaneous right intracerebral haemorrhage.
- Midline and downward shift of the brain from intracerebral haemorrhagic space-occupying lesion (haemorrhage) and oedema.
- Secondary left temporal lobe haemorrhage.
- Secondary pontine haemorrhage.
- Dilatation of all four cardiac chambers.
- Severe focal stenosis of the anterior descending branch of the left coronary artery.
- Grazing and contusion to the left side of the forehead, the right side of the nose, the left shoulder, left arm, left side of the front of the torso (patchy) and left flank

Comments

- The type of intracerebral haemorrhage was not typical of that seen in classical head injuries.
- The type of intracerebral haemorrhage was that characteristically seen with spontaneous intracerebral haemorrhage from the penetrating lenticulostriate branches of the middle cerebral arteries.
- This appears to have resulted in secondary left temporal lobe and pontine haemorrhage.
- The pulmonary oedema may have been neurogenic in origin.
- There was severe focal coronary artery stenosis and some local intramyocardial periarteriolar fibrosis. Given the fatal spontaneous natural cerebral haemorrhage, it is unlikely that the cardiac condition made any significant contribution to death; had he survived, it may well have become a problem later on in the ensuing months or years.

Opinion as to medical cause of death

- I am satisfied that death was from spontaneous intracerebral haemorrhage.
- There were injuries as a consequence of the crash but these did not contribute to or cause the death.

Police investigation:

A coronial investigation by police found no suspicious circumstances surrounding this death.

Background:

The 51 year old rider was born in Alice Springs and was an experienced Stockman and a self-taught man of many trades. He spoke four languages. He loved culture and hunting and never

experienced a boring day. He had been riding motorbikes all his life. He was a hardworking, much-loved family member and friend to many, and is greatly missed by all who knew him.

Circumstances:

On the morning of Sunday 25 August 2024, the rider visited his sister and father at an Outstation. After a cup of tea and a cigarette he left on his Yamaha YZ450. He was not wearing a helmet.

On his ride home he crashed his motorbike approximately 100 meters from the turn off to the Hugh Stock Route.

When he failed to arrive home his family went to look for him and found him unconscious. Tracks on the road were observed and it appeared to family that he had "missed the corner", had tried to get back on the road, hit two little trees, and come off his motorbike. His bike was 6-7 meters from where he was lying. They rang the ambulance at 8.21am and put him in the recovery position and cleared the blood and dirt from his nose so that he could breathe.

Titjikala Clinic staff were the first medical team to arrive and observed him to have dry blood clotted around his nose, a slightly swollen right wrist and dried blood on the side of his head. St John Ambulance (SJA) attended the location at 9.25am and provided medical treatment. There was a small amount of blood in his airway that required suctioning.

Whilst SJA were transporting him to Alice Springs they requested additional assistance due to his airway. A Medical Retrieval and Consultation Centre (MRaCC) Doctor was dispatched from Alice Springs with a Patient Travel St Johns crew. He had an episode of agonal respirations on route lasting approximately 1 minute. The Doctor travelled in the back of the Ambulance with him and continued to assist with respirations until arrival at the Alice Springs Hospital where he was taken to resuscitation.

He was placed on life support in the Intensive Care Unit where he remained for the next week. Multiple scans and assessments took place and it was found that he had a bleed on his brain. Consultation between the Surgical team in Alice Springs and the Neurological team from Royal Adelaide Hospital took place with the decision that there was no further treatment available.

He passed away surrounded by family and loved ones at 5.54pm on Sunday 1 September 2024 in the Intensive Care Unit.

Decision not to hold an inquest:

Pursuant to s 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.