MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

I, Simon Cooper, Coroner, having investigated the death of Alice Mwarabu

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

a) The identity of the deceased is Alice Mwarabu;
b) Mrs Mwarabu died as a result of injuries sustained in a motor vehicle crash;
c) The cause of Mrs Mwarabu's death was multiple blunt injuries; and
d) Mrs Mwarabu died on 11 October 2017 at the Royal Hobart Hospital, Hobart, Tasmania.

**Introduction**

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Mwarabu's death. The evidence includes an opinion of the forensic pathologist who conducted the autopsy; the results of toxicological analysis of samples taken at autopsy and from the other driver involved in the crash; a comprehensive crash investigation report; relevant police and witness affidavits; medical records; and forensic and photographic evidence.
2. Mrs Mwarabu, mother of Benedict and wife of Mr Mbaz Kanyok, was born in the Congo on 15 August 1984. After a period of time living in Rwanda, Mrs Mwarabu moved to Australia in 2010.
3. In 2014 she married Mr Kanyok and 2 years later became an Australian citizen. The same year she obtained her Tasmanian drivers licence having previously driven in Rwanda and the Congo. Her husband describes her as a good driver, someone who "wouldn't drive fast and always [kept] her eye on the road".
4. Approximately a month before she died Mrs Mwarabu obtained employment as a carer at the Southern Cross Homes Fairway Rise Residential Aged Care Facility at Bellerive on Hobart's eastern shore.

**The Events Leading up to her Death**

5. The evidence is that in the week leading up to the fatal crash (4 October to 10 October 2017) Mrs Mwarabu worked dayshift (7.00am to 3.00pm) on 4 October, afternoon shift on 5 October (5.00pm to 9.00pm). On 6 and 7 October her roster duty was from 7.00am to 3.00pm but on both occasions she worked a double shift from 7.00am through until 11.00pm. Employment records show that Mrs Mwarabu did not work on 8 or 9 October. She recommenced duty on 10 October at 11.00pm and concluded at 7.00am on 11 October, the morning of the crash.
6. During her shift that night she was mentored by an experienced carer.
7. Her supervisor on the night said in a statement given to investigators that Mrs Mwarabu took an allocated rest break between 1.00am and 1.30am.
8. The evidence is that a double shift is only worked with the consent of the employee and must be authorised by the Nurse in Charge. Mrs Mwarabu worked 52 hours, had two days off and then recommenced work the night before her crash. There is no evidence to suggest that she was forced to work any of the additional overtime hours. Nor is there any evidence to suggest that she was exhibiting any signs of fatigue (due to work or any other reason) in the week leading up to the evening prior to the crash.
9. I set out her work hours in some detail because of an email sent by the Australian Nursing and Midwifery Federation (Tasmanian Branch) to the Coroner's Office after Mrs Mwarabu's death. The email raised a number of issues with respect to Mrs Mwarabu's hours of work. The allegations included first, that the night before her crash Mrs Mwarabu worked a double shift. Employment records indicate that she did not. Her husband corroborates the fact that Mrs Mwarabu commenced work at 11.00pm. Second, the union alleged that in the fortnight leading up to her crash Mrs Mwarabu worked 115 hours. The employment records kept by Mrs Mwarabu's employer do not support this allegation. I observe that no documentation or proof of any sort was provided by the union in respect of the allegations raised by it. I am affirmatively satisfied that the matters raised are without foundation in fact.
10. Returning to the circumstances of Mrs Mwarabu's death, she worked, as has been noted above, an 8 hour shift from 11.00pm on 10 October until 7.00am on 11 October. There is no evidence that during the course of her shift she displayed any overt signs of fatigue. None of her co-workers reported her as

appearing tired. None of her co-workers indicated that she complained to them of feeling unwell or fatigued. Mrs Mwarabu concluded her duties at 7.00am and commenced the journey to her home in Moonah. She was driving the family blue 2008 Toyota Camry. Mrs Mwarabu was alone in the vehicle and the evidence was that she was wearing a seatbelt.

11. At approximately 7.10am, Mrs Mwarabu was driving her car west on the Domain Highway from the direction of the Tasman Bridge towards the Brooker Highway. The posted speed limit in the area is 70 km/h. Subsequent crash investigation indicates that Mrs Mwarabu was travelling at somewhere between 10 and 12 km/h in excess of the speed limit. She failed to negotiate the arc of a sweeping left hand curve in the road and drifted to the right over the continuous double centre line into the opposing lane of travel. Subsequent investigation by crash investigators showed that Mrs Mwarabu did not attempt to brake or correct the position of her car on the road.
12. At the same time, a white Scania refrigerated truck being driven by Mr Brendan Bennett was travelling in the opposite direction on the Domain Highway. Mr Bennett was in the correct lane. He saw Mrs Mwarabu's Toyota move into his path. He braked heavily and swerved left in an effort to avoid impact. However, Mr Bennett had both insufficient time to respond and insufficient distance to take any meaningful evasive action. The front driver's side of the Toyota impacted the front driver side of the Scania truck. Subsequent investigation demonstrated that the crash occurred entirely in the eastbound lane. The eastbound lane of the Domain Highway was the correct lane of travel for the Scania truck and the incorrect lane of travel for Mrs Mwarabu's vehicle.
13. Mrs Mwarabu suffered terrible injuries and was trapped in the driver's compartment of her car. Members of the public, including a registered nurse, Mr Jordan Morris, stopped and tried to provide her with assistance. Mr Morris detected a faint radial pulse. He noted Mrs Mwarabu's respiration was erratic. Ambulance Tasmania paramedics were on the scene at 7.21am. CPR was commenced and maintained while Mrs Mwarabu was extracted from her vehicle by Tasmania Fire Service personnel. She was rushed to the nearby Royal Hobart Hospital but unfortunately died shortly after her arrival there.

**Investigation**

14. After formal identification by her husband, an autopsy was performed on Mrs Mwarabu's body by experienced forensic pathologist, Dr Donald Ritchey. Dr Ritchey found that Mrs Mwarabu had suffered numerous injuries including blunt trauma to her head, thorax, abdomen and pelvis, arms and legs. I accept Dr Ritchey's opinion that the cause of her death was multiple blunt injuries. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. Nothing other than caffeine was detected as being present in those samples.
15. Mr Bennett underwent standard post-crash testing. Blood was taken from him and subsequently analysed. The analysis was negative for alcohol and or illicit drugs.
16. The subsequent crash investigation indicates that Mr Bennett was driving his truck at a speed under the permissible maximum of 70 km/h at the time of, and in the lead up to, the happening of the crash. Witnesses confirm that his driving was appropriate as does GPS tracking data downloaded from the truck.
17. I am satisfied on the evidence that neither drugs nor alcohol caused or contributed to the happening of the crash.
18. Similarly, I am satisfied that neither road conditions nor weather caused or contributed to the happening of the crash. The weather was fine and clear and the road itself, a busy one with approximately 25,000 vehicle movements per day, has nothing about its construction, layout or surface which rationally could have caused or contributed to the happening of the crash.
19. Both vehicles were extensively damaged in the crash. Both were impounded by police and both subsequently examined by a motor vehicle inspector employed by the Department of State Growth. Both were found to have been in a road worthy condition and have no defects which either caused or contributed to the happening of the crash.
20. The investigation satisfies me that neither driver involved was using a mobile phone at the time of the crash.
21. I am also satisfied that no other person caused or contributed to the happening of the crash.
22. The extensive investigation in relation to Mrs Mwarabu's death showed that excessive speed (on her part) was a contributing factor to the happening of the

crash. The other significant factor, when the evidence is viewed as a whole, was driver inattention (again on Mrs Mwarabu's part).

23. The evidence satisfies me that Mr Bennett was in no way responsible for the happening of the fatal crash. Although he braked heavily and swerved to the left he had insufficient time and space to respond so as to avoid the collision.

**Comments and Recommendations**

24. The circumstances of Mrs Mwarabu's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.
25. I convey my sincere condolences to the family and loved ones of Mrs Mwarabu on their loss.

**Dated** 10 September 2019 at Hobart in the State of Tasmania.

**Simon Cooper**
**Coroner**