IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0173/2024
Police No: 24 66337

CORONERS FINDINGS

ROAD DEATH 32 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of a **78-YEAR-OLD ABORIGINAL FEMALE** without holding an inquest, find that she was born on **1 July 1946** and that her **death occurred on 10 July 2024, at Royal Darwin Hospital in the Northern Territory.**

Introduction:

60 People lost their lives on Territory roads in 2024. The highest road toll per capita in over a decade and by far the highest in the country. These findings concern road death 31.

In the Northern Territory 73% of fatal crashes occur on rural and remote roads. Of these, 47% are run-off/roll-over crashes. Aboriginal people are over-represented in the road death toll. The 'Fatal 5' factors which are considered to give rise to the greatest risk of road crash deaths or serious injury are:

- Drink/drug driving
- Failure to wear a seatbelt
- Excessive speed
- Distraction (e.g. mobile phone use)
- Fatigue

This Aboriginal lady died in hospital from injuries sustained (in combination with existing health co-morbidities) as a passenger in a single vehicle, run-off crash, on a remote road. She was wearing a seatbelt. There was no evidence of drink/drug driving or excessive speed. The scene evidence indicates it was a low-speed crash. It is possible the driver was distracted or fatigued but there was insufficient evidence to prove either of these alternative possible contributions and the driver was not charged.

Cause of death:

1(a)	Disease or condition leading directly to death:	**Blunt force chest injuries**
1(b)	Morbid conditions giving rise to the above cause:	**Reported motor vehicle crash (passenger)**

2	Other significant conditions contributing to death but not related to the condition causing death:	**Chronic Obstructive Pulmonary Disease/ Asthma, malnutrition, frailty**

In the absence of a post-mortem examination the Forensic Pathologist recommended:

- **Review of the decedent's medical records in the Northern Territory electronic records Royal Darwin Hospital patient folder revealed medical history of:**
    - Background medical history: Chronic Obstructive Pulmonary Disease/ Asthma with recent admission for pneumonia, hypertension
    - Previous neck of femur fracture
    - Malnutrition: cachexia
    - Regular medications: omeprazole 20mg/daily, thiamine 100mg daily, multivitamins daily, colecalciferol 50mcg daily, Ferro-F tablet daily, Trelegy 1 puff daily, salbutamol when needed.
    - Clinically considered to have high risk of mortality because of severe chest trauma and was admitted for comfort care in hospice.

- This was the in-hospital death of a 78 year old adult female following hospitalisation for motor vehicle collision. The deterioration and death of the decedent, although related to her traumatic chest injuries, were compounded by her underlying known medical conditions including malnutrition and respiratory disease which further complicated her clinical course.

- In light of the information provided, I am of the opinion that a reasonable cause of death in the absence of an autopsy is:
  1a. Blunt force chest injuries
  1b. Reported motor vehicle collision as a passenger
  II. Chronic Obstructive Pulmonary Disease/ Asthma, malnutrition, frailty

Background:

The deceased grew up in Nauiyu. She had a large family, a marriage over 50 years, children and grandchildren. She loved camping and hunting. She had worked in a health centre and women's shelter. She is remembered as a good woman who loved her kids and grandkids. She is sorely missed and mourned by her family and community.

Circumstances:

On the afternoon of Sunday 7 July 2024, the deceased and her 72-year-old husband went for a drive in their registered white Toyota Hilux 4 door utility. The husband was driving (the driver), and the deceased was in the front passenger seat (the passenger). She was wearing her seatbelt.

Some time prior to 7.04 pm, the couple were travelling south on Daly River Road approximately 18 km from Nauiyu. For unknown reasons, scene evidence shows that the vehicle crossed on to the wrong side of the road and left the sealed road surface. The vehicle travelled down a slight embankment. It struck a washout at the edge of the culvert which caused damage to the bulbar and to the left-hand front passenger wheel. The passenger side airbag fully deployed and the driver's side airbag partially deployed from the steering wheel. The vehicle continued through the scrub, sideswiping trees, before it came to a stop.

The crash occurred outside of mobile reception. The couple remained at the scene with the vehicle until they waved down a passing Toyota Prado. The passenger accepted a lift to the Nauiyu Community Health Centre; however, the driver chose to remain at the scene with his Hilux.

The health clinic was alerted to the crash and the arrival of the passenger. Health Clinic staff called 000 to report the crash.

At the clinic the passenger complained of pain to the sternum and ribs area of her chest and said that the car went off the road and a white bag (the vehicle's airbag) hit her. She was clinically stable and was provided pain relief and her vitals were monitored. She remained at the Health Centre until approximately 11.35 pm when she was transferred to Royal Darwin Hospital (RDH) by CareFlight with a family member as escort.

A clinic nurse took the ambulance to the crash scene to collect the driver. Other community members also travelled to the crash scene to assist the driver and recover the Hilux. When they arrived, the driver was still in the driver’s seat. The driver was taken to the clinic. He was breath tested which returned a negative reading for alcohol. He suffered only minor injuries and was later discharged.

Following her admission to the RDH Intensive Care Unit, scans confirmed that the passenger had suffered spinal, rib and sternum fractures. Due to her injuries, age and poor health, which included Chronic Obstructive Pulmonary Disease and Cachexia (malnutrition), she was clinically considered to have a high risk of mortality.

This sad news was discussed with her and her escort, and she was admitted to the Palliative Care unit for end-of-life care. She passed away at 4.25 am on 10 July 2024.

Further investigation:

The Major Crash Investigation Unit (MCIU) were notified of her death.

Photographs were taken of what remained of the crash scene.

They seized the Hilux and data was imaged from its crash data recorder (airbag control module), but information was limited due to the vehicle's age.

They obtained statements from family and community members who had attended the crash scene and/or who had spoken to the occupants of the Hilux about the crash. The driver was asked to participate in a record of interview, but he could not demonstrate his understanding of his right to silence, and later chose not to speak about the crash.

The crash occurred along Daly River Road some 18 km/s outside of Nauiyu Community and was reported to 000 at 7.04 pm.

At the scene of the crash, Daly River Road is a sealed bitumen roadway consisting of one northbound lane and one southbound lane. The lanes are separated by double solid white painted lines. The speed limit was 100 km/h.

The roadway is raised with slight embankments on either side of the road and a culvert running underneath the roadway. Dirt at the edge of the culvert had been eroded away creating a small washout.

On the day of the crash, the weather conditions were fine, and the road was dry.

The vehicle was a registered 2014 Toyota Hilux 4 door utility.

There was insufficient scene evidence and crash data recorder (CDR) data to be able to conduct a speed calculation. However, a visual inspection of the scene and the vehicle indicated a low speed crash.

Prosecution:

Based on reported accounts given by the passenger and driver to family and community members, the investigating police considered two plausible scenarios:

(1) The driver was distracted by an argument and took his eyes off the road. If that occurred, police considered it might amount to carelessness sufficient to support a charge.

(2) The driver fell asleep or "blacked out". If that occurred, police considered that there would need to be evidence that he was aware of the risk (that he knew he was tired or had a risky medical condition) and chose to drive anyway, to support a charge. The police found no such evidence.

The investigating police considered that neither scenario could be discounted and neither could be proved to the criminal standard. However, on 20 December 2024 an opinion file was appropriately submitted to the Director of Public Prosecutions (DPP) for the charge of Careless Driving - Resulting in Death: section 308 of the *Traffic Act* 1987. The DPP considered the available evidence and determined there was no reasonable prospects of conviction and no prosecution was commenced.

Decision not to hold an inquest:

Under section 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, and 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.