IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0282/2024

Police No: 24 113972

CORONERS FINDINGS
ROAD DEATH 57 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 47 year-old Caucasion male** and without holding an inquest, find that the deceased was born on **27 December 1976** and that his **death occurred on 11 November 2024, at Royal Darwin Hospital in the Northern Territory.**

Introduction:

2024 was a particularly deadly year on Northen Territory roads with 60 deaths recorded. These findings concern the death of a 47 year-old Caucasian male passenger, road death 57 of 2024.

The Fatal 5 factors which are considered to give rise to the greatest risk of road death include drink/drug driving. The driver had consumed methamphetamine and so had the passenger.

The driver was an employed truck driver carrying out the duties of his employment when he collided into the rear of another truck travelling in front of him.

Toxicological analysis determined that the driver had a blood methylamphetamine concentration of 0.9 mg/L, with Professor Jason White estimating the level at the time of the crash to have been approximately 1.3 mg/L. This concentration is described as well above that typically found in methylamphetamine users and above the range most commonly associated with driving impairment. Expert evidence concluded that such a level would cause marked impairment of concentration, attention, judgement and reaction time, together with an increased likelihood of risky or impulsive behaviour. The driver was experiencing a dangerous level of methamphetamine intoxication, sufficient to significantly compromise his ability to perceive and respond to hazards ahead. This intoxication directly contributed to his failure to detect and avoid the slower-moving vehicle, resulting in a high-speed rear-end collision.

Cause of death:

1(a)	Disease or condition leading directly to death:	**Multiple blunt force injuries to the neck, chest and lower limbs**

1(b) Morbid conditions giving rise to the above cause: **Reported multiple heavy vehicle motor vehicle crash (passenger)**

Other conditions present but not regarded (or provable) as contributing to death were: Methylamphetamine and Cannabis consumption.

Following an autopsy on 13 November 2024, Forensic Pathologist, Dr Donovan Loots commented:

- The opinion as to the cause of death is based on the available police and medical information, and a full post- mortem examination including ancillary investigations.
- The circumstances of death involved an adult male who was a passenger in a vehicle that collided head-on with the back of a triple cattle trailer road train. The decedent was airlifted to Royal Darwin Hospital but suffered a cardiac arrest enroute and could not be resuscitated.
- A post-mortem CT scan confirmed the presence of bilateral pneumothoraces, bilateral diffuse opacifications in the lungs (likely representing pulmonary contusions), a small volume haemorrhage around the spleen and a proximal left femur fracture with associated pelvic acetabular fracture.
- A full post-mortem examination was conducted. External examination revealed multiple and extensive blunt force injuries chiefly involving the left hip and lower limbs. There were superficial abrasions to the forehead and nasal bridge. The big toe of both feet showed severe crush injuries with fractures to the distal phalanges and avulsion of the overlying skin and toenails. There was evidence of extensive medical intervention and resuscitative efforts including intravascular and intraosseous cannulas and bilateral finger thoracostomies. Internal examination showed no skull fractures or intracranial haemorrhages. There was a transverse fracture of the anterior wall of the cervical vertebrae involving C5/6 with contusion of the subjacent spinal cord. The lungs showed widespread intrapulmonary haemorrhages and perivascular tears. There were multiple superficial capsular lacerations to the liver and the spleen was ruptured with an associated subcapsular haematoma.
- Histological examination of the tissues sampled confirmed the presence of the widespread intrapulmonary haemorrhage seen macroscopically. Serial sections examined from the cervical spinal cord showed epidural and subdural haemorrhages proximally around the spinal cord and further showed central cord haemorrhage with necrosis at the level of the cervical spinal column fracture. The liver and spleen showed disruption of the capsule with associated subcapsular haemorrhages.
- The pneumothoraces seen in the post-mortem CT scan are difficult to interpret in the setting of resuscitative efforts, specifically in the context of emergency finger thoracostomies to bilateral chest walls. The injuries seen in the lung parenchyma (pulmonary tears with associated haemorrhages) are in keeping with those caused by high-velocity blunt force chest trauma and may explain in part the presence of the air in the chest cavities. Small volume pneumothoraces may well have been caused by the blunt force trauma to the lungs. The size of the pneumothoraces were likely subsequently increased as a result of resuscitative efforts.

- The cervical spine injury (C5-6 fracture with associated cord contusion and haemorrhage) was not evident on the CT scan in this case but was apparent at autopsy. A study by Makino *et al,* reported a relatively high incidence of cervical spinal cord injuries in cases with normal post-mortem CT findings. These injuries typically occurred below the level of C1-C2 with radiographically occult intervertebral disk injuries and peri- vertebral haemorrhages.
- Toxicology analysis conducted on specimens obtained during the post-mortem examination confirmed a blood alcohol concentration of 0.013%. No alcohol was detected in the vitreous humour. The illicit stimulant drug methylamphetamine was detected at an elevated level of 0.11mg/L along with the metabolite of cannabis (delta-9-tetrahydrocannabinol). The anti-emetic agent ondansetron was detected in the blood but not quantified and the opioid drug morphine was detected in the blood and urine (likely due to medication administered during medical management and resuscitation). I am of the opinion that the toxicology did not cause the death.

Background:

The deceased passenger was born in New Zealand and moved to Australia when he was three years old. He was a skilled mechanic, an accomplished athlete, and a world champion bull rider. He was a beloved father, brother and son. The pain of his loss is immeasurable.

Circumstances:

On 10 November 2024 the driver was driving an Isuzu truck for Nighthawk Transport. The deceased passenger was a former Nighthawk Transport employee and requested a lift to Katherine. Although it was against policy, the driver agreed and picked him up. On the journey south, the driver crashed the truck causing the death of his passenger. The driver was charged with Dangerous Driving Causing the Death contrary to section 174F of the *Criminal Code Act* 1983. The driver was sentenced on 5 March 2026 to 3 years imprisonment with a non-parole period of 18 months. In the sentencing remarks, His Honour Justice Southwood set out the facts of the driving which caused the death.

> On 10 November 2024 the offender was employed by NightHawk Transport to drive a white Isuzu FMFVM pantechnicon truck. Such trucks are sizeable trucks although they are not in the league of Triple Dolly semitrailers.
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> Sometime in the evening, the offender travelled from Katherine to Darwin as part of his work duties. He picked up the victim while in Darwin and then started to return, driving the pantechnicon back to Katherine.
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> At 2:30 am on 11 November 2024, the offender was driving south on the Stuart Highway between Adelaide River and Emerald Springs. The offender crashed his pantechnicon into the rear trailer of an unregistered triple trailer road train which was travelling south on the Stuart Highway. That is, it was travelling in the same direction as the offender.
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> The road train was driven by PCB. The offender's vehicle approached behind PCB's vehicle. His lights were on high beam. Believing the vehicle was trying to overtake over double lines, PCB slowed the speed of his road train. The road train

was travelling steadily at around 50 kilometres an hour and the offender's vehicle went straight into the rear end of the road train.

I accept the submissions made on his behalf that he was not attempting to overtake the road train at the time this accident occurred. However, this does not reduce the seriousness of this offending. The front end of the offender's pantechnicon sustained extensive damage in the crash trapping the offender and the deceased victim in the cabin.

A motorist driving north on the Stuart Highway saw the aftermath and stopped to render assistance and contact the authorities. Emergency services attended and extracted both men from the pantechnicon.

As a result of the crash, the victim suffered serious life-threatening injuries. The offender also sustained serious leg injuries. The offender and the victim were both taken from the crash scene to the Royal Darwin Hospital by CareFlight. Tragically, the victim died as a result of the injuries he sustained in the motor vehicle crash.

At the Royal Darwin Hospital at 7:31 am, about five hours after the crash, blood samples were taken from the offender, and a toxicological analysis was conducted on the blood sample. The results of the analysis identified that the offender's blood contained a concentration of methamphetamine of 0.90 milligrams per litre of blood and a concentration of amphetamines of 0.09 milligrams per litre of blood.

On the basis of these toxicology results, Professor Jason White calculated a countback of the methamphetamine concentration in the offender's blood at the time of the crash. He concluded that the likely concentration of the drug at the time of the accident was 1.3 milligrams per litre.

Based on studies of samples of concentration from users of methamphetamine including those driving under the influence of that drug, Professor White concluded that the offender's methamphetamine concentration of 0.90 milligrams per litre at the time of testing was a relatively high concentration, well above that required to produce significant physiological and subjective effects and above the range typically found in methamphetamine users. Professor White stated that at this level the drug is associated with very significant increases in accident risks. Such a concentration adversely affects a person's capacity to drive and their mental state. As a result of the driver's intoxication he stated, "The offender could not maintain proper control of the vehicle and his dangerous driving as a result of intoxication caused the crash and the death of the deceased person."

The offender declined to speak to police when requested after receiving legal advice. Counsel for the offender told the Court that the offender admitted the truth and accuracy of the facts to which I have referred. I find the facts proven and I convict the offender of the count on the indictment. The impact of this offending has had an enormous impact on the relatives, children and partner of the deceased man. It has been a great tragedy in their lives.

Medical Assistance at Scene:

In addition to those facts, I note that at 2.35am Emergency Services were alerted to the crash via an automatic crash detection alert from the deceased passenger's iPhone as well as a call from a witness to 000. Daly River Police, Pine Creek Fire and Rescue, and clinic staff were dispatched to the scene.

Staff from Pine Creek Health Clinic, were the first medical responders to arrive at the crash scene at approximately 4:20am. They accessed both occupants within the cab and provided initial treatment. The passenger was conscious and responsive at the time of their arrival. Due to the damage and elevated position of the truck cab, access to the passenger was restricted until it was pried open by emergency responders. Clinical care was handed over to CareFlight personnel upon their arrival

The driver and passenger were both extricated from the vehicle and flown to Royal Darwin Hospital via CareFlight. The passenger was transferred under full resuscitation to Royal Darwin Hospital arriving at 7.17am.

The passenger was declared deceased at 7.27am in the Emergency Department.

The driver suffered extensive lower limb injuries and was conveyed to Royal Darwin Hospital for medical treatment.

The driver of the prime mover was uninjured.

Vehicle inspection:

The vehicles involved were a 2023 medium ridged Isuzu FM FVM Pantechnicon and a Ford Louisville prime mover; triple trailer road train combination

On 11 November 2024 both vehicles were inspected on-site by Northern Territory Motor Vehicle Registry, Heavy Vehicle Inspectors.

The 2023 Nighthawk Isuzu Pantechnicon truck was essentially new, with no information to suggest that it was defective in any way.

The Ford Prime Mover was inspected and found to have numerous defects that made it unroadworthy. These defects did not contribute to the crash. It was also unregistered.

Tests and/or Calculations Conducted:

On scene testing was conducted on the lights of the prime mover which showed that the lights were receiving power after the collision. This corroborates the CCTV and dashcam footage which showed that the lights were lit and working pre- and post-crash.

The Airbag Control Module (ACM), Safety Restraint System (SRS), and Electronic Braking System (EBS) modules were removed from the crashed Isuzu truck and forwarded to the manufacturer in Japan for data extraction. Although technicians were able to access the modules, they confirmed that no event data had been recorded. It was determined that a loss of power occurred before the system could complete the data write process, resulting in no retrievable crash data being available.

The driver's hospital admission bloods were secured through a warrant, his identity was confirmed through a NISK and toxicology tests were conducted. They returned a result for 0.9mg/L of Methylamphetamine and Amphetamine.

Road Features and Conditions:

This fatal crash occurred on a section of Stuart Highway between Hayes Creek and Emerald Springs, approximately 15km north of Emerald Springs Roadhouse. The roadway is a sealed bitumen road comprised of one northbound and southbound lane, each separated by double, solid white lines. The double solid white lines are to prohibit any overtaking in either direction due to the extended curve in the roadway impeding the visibility of oncoming vehicles. The highway is bordered by a wide gravel shoulder on both sides of the roadway. The roadway in the vicinity of the crash is in good condition and free of any apparent defects. The curve in the roadway is not of significant magnitude to warrant any curve advisory warning signage. This section is a sign posted 130km/h speed zone.

Weather and Lighting Conditions:

At the time of the incident, it was night and dark, with no streetlighting. Weather conditions were fine and dry, with clear visibility.

The Ford Louisville prime mover driver:

The road train driver did not stop at the crash scene or offer assistance. He drove a further 20 kms before stopping. He told police it was the only safe place to stop although he passed Emerald Springs on the way. He did not contact emergency services but did contact his employer. His employer drove from Kakadu to meet him and they both then returned to the crash scene arriving approximately two and a half hours after the crash. The driver identified himself to police and participated in a road side breath test which returned a negative result.

Police considered a charge of hit and run (s 174 FA(1) of the *Criminal Code Act*1993). However, they received advice that for that charge to be made out it would be necessary to prove that the driver knew or was reckless to two elements: (1) that the vehicle was involved in an incident; and (2) that the incident resulted in the death of or serious harm to a person. As there was no evidence to establish the second of those elements no charge was laid.

Nighthawk Transport:

Enquiries were made to determine what, if any, procedures were in place at Nighthawk Transport to ensure that its drivers were sober and not fatigued when performing work duties.

The driver was employed at Nighthawk from 16 October 2022 – 3 September 2023 and from end of May 2024 through to mid November 2024. According to his contract of employment he could be terminated without notice if he abused alcohol or drugs, on or before commencing work, which adversely affected his ability to carry out his duties.

At least from 1 May 2024, Nighthawk Transport had a drug and alcohol policy which provided that employees must not be under the influence of drugs or alcohol when performing work duties. The policy provided for random, causal or post-incident drug and alcohol testing. The policy was expanded upon in the Nighthawk Human Resources Employee Handbook which notes that "NH has a strict zero tolerance policy in place" and states that "random testing that ensures all employees and contractors will be tested on average, at least once in a 12 Month period."

Following this crash, Nighthawk entered liquidation. Enquiries were made of the liquidator and former owners in an effort to locate any records concerning the driver's drug and alcohol testing history. No records could be located.

The owner until 17 May 2024 said that only ‘reasonable cause testing’ took place during her period of extended ownership, and there was no truly random drug or alcohol testing conducted.

The Director of Nighthawk Transport from 1 May 2024 and through to the time of the collision advised that that the driver did not have any reportable incidents or fatigue issues during 2024 and the collision occurred on his first shift back after a weekend off. The driver was conducting a regular Australia Post delivery run. The driver had performed that run and those duties for the previous owner and had been trained and inducted in the duties. The Director was not aware of any fitness or drug use issues for the driver but said that random drug and alcohol testing had not yet commenced under the new ownership. Further, the Director was not aware of any near misses when the driver was driving, however, a traffic infringement notice was received after the collision for a failure to stop at a red light (which had issued before the collision).

Comcare advised that that while the incident arose out of the business or undertaking of the Australian Postal Corporation, no further action was required. NT WorkSafe advised that their investigation was finalised and no further action will be taken.

Opinion as to the Cause of Crash:

Based on the available evidence, it is the opinion of the investigating officer that the primary cause of the collision was the failure of the driver to identify the presence of the lead vehicle, which was travelling in the same direction along the Stuart Highway.

Toxicological analysis determined that the driver had a blood methylamphetamine concentration of 0.9 mg/L, with Professor Whites interpretation estimating the level at the time of the crash to have been approximately 1.3 mg/L. This concentration is described as well above that typically found in methylamphetamine users and above the range most commonly associated with driving impairment. Expert evidence concluded that such a level would cause marked impairment of concentration, attention, judgement and reaction time, together with an increased likelihood of risky or impulsive behaviour. Accordingly, the driver was experiencing a dangerous level of methamphetamine intoxication, sufficient to significantly compromise his ability to perceive and respond to hazards ahead. This intoxication directly contributed to his failure to detect and avoid the slower-moving vehicle, resulting in a high-speed rear-end collision.

During his sentencing proceedings the driver admitted that he occasionally used methamphetamine to remain awake during long work hours and acknowledged that his methamphetamine use directly contributed to the crash.