IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: A0026/2024

Police No: 24 61261

CORONERS' FINDINGS

ROAD DEATH 30 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 22-YEAR-OLD ABORIGINAL MALE** and without holding an inquest, find that he was born on **21 August 2001** and that his **death occurred on 22 June 2024, at Larapinta Drive, Hugh in the Northern Territory.**

Introduction:

60 people lost their lives on Territory roads in 2024. These findings concern road death number 30.

Considering the terrible and increasing loss of life on our roads and consistent with my function to ensure the coronial system in the Territory is administered and operates efficiently,[1] and my power to comment on public safety connected with a death,[2] it is intended to publish anonymized findings into all road deaths in 2024. It is hoped that by making findings about the circumstances of these deaths public, this will improve individual and agency awareness as to the causes of road fatalities, with the ultimate objective of saving lives and reducing the road death toll in the future.

The 'Fatal 5' factors which are considered to give rise to the greatest risk of road crash death and serious injury are:

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

In the Northern Territory[3]:

- 41% of fatal crashes involve alcohol, which is perhaps not surprising given that the Northern Territory has the highest per person alcohol consumption in Australia (in

[1] Section 4A of the *Coroners Act 1993*
[2] Section 34(2) of the *Coroners Act 1993*
[3] Northern Territory Government, Towards Zero Road Safety Action Plan 2024-2028

2016 it was 27% higher than the national average[4]), and 25% of adult NT residents consume alcohol at a level that puts them at risk of long term harm[5]

- 33% of fatal crashes include the failure to wear seat belts
- 30% are speed related
- 7% are fatigue related
- 73% of fatal crashes occur in rural and remote areas, and on these roads 'over-turned' and 'run-off' incidents account for 47% of crashes
- Although Aboriginal people make up approximately 30% of the population, they are overrepresented in road fatalities, accounting for 50% of fatalities and 30% of serious injuries

This was a single vehicle, roll-over crash, on a remote road. The 22-year-old Aboriginal driver (the driver) who passed away was speeding, highly intoxicated and not wearing a seatbelt when he lost control of the vehicle. He was a disqualified driver and should not have been on the road. He passed away from catastrophic injuries caused by the crash and was discovered by a passing motorist.

He was a proud Arrernte man, a family man and a good man. His death is a tragedy for his family and his community.

Cause of death:

1(a)	Disease or condition leading directly to death:	**Significant blunt force trauma, with traumatic bisection of the body**
1(b)	Morbid conditions giving rise to the above cause:	**Reported single motor vehicle rollover (driver)**
1(c)		**Acute alcohol intoxication**

A Post-mortem CT-scan was performed at Alice Springs Hospital on 25 June 2024. The Forensic Pathologist commented:

Essential clinical history

- Review of the Northern Territory electronic clinical case records showed a number of consultations related to alleged assaults (most recent admission to Alice Springs Hospital in May 2024). There were no records of any chronic underlying medical conditions.
- There were strong objections against autopsy by next of kin**.**

[4] Unnikrishnan R., Zhao Y., Chondur R., Burgess P., "Alcohol attributable death and burden of illness among Aboriginal and Non-Aboriginal populations in remote Australia, 2014-2018", Int J Environ Res Public Health, 2023 Nov; 20(22): 7066

[5] Alcoholpolicy.nt.gov.au accessed 4 October 2024

Pathological findings material to death

- No external or internal post-mortem examination was performed as per the coroner's instructions.
- A post-mortem CT scan was performed; it was reviewed by Dr Sarah Constantine, specialist radiologist. The main observations were:
  - Head and face:
    - Diffuse subarachnoid haemorrhage and mild pneumocephalus.
    - No skull fracture identified.
    - Depressed fracture of the right orbital floor with blood in the sinus.
  - Neck:
    - No cervical spine fractures, and normal cervical spine alignment.
  - Torso:
    - Large bilateral pneumothoraces.
    - Complete disruption to the lower thoracic spine with several centimetres of separation, with complete cord transection.
    - Multiple fragmented vertebra and a number of metallic density foreign bodies including 1 lodged in the body L1.
    - Herniation of the intra-abdominal contents through the defect into the flank region.
    - The liver appears grossly intact.
    - The spleen was partially herniated through the left flank and not clearly identifiable, with significant surrounding blood.
    - The right kidney was partially herniated, left kidney not clearly identifiable.
    - Multiple bowel loops herniated dorsally.
    - Pancreas and adrenal gland not identifiable.
    - Multiple lower rib fractures, more so on the left but involving both sides.
  - Pelvis and lower limbs:
    - Bilateral inferior and superior pubic rami fractures extending into the acetabulae on both sides.
    - Fractured right femoral neck.
    - Comminuted fracture of the mid-shaft of the right femur.
    - Fractured right tibial plateau and proximal right fibula.
  - Upper limbs:
    - No major upper limb injury.
- Blood samples were collected by the mortuary technician for post-mortem toxicological analysis.

Specimens were taken for toxicological analysis:

Results: Forensic Science Case Number: 2403141
Vitreous Humour Alcohol **0.21 %**
Vitreous Humour Gamma-hydroxybutyrate not detected

No other drugs listed in the Scope of Analysis were detected in the Vitreous Humour.

Background:

The driver was raised in Alice Springs. He was a happy person and enjoyed playing rugby league, riding motorbikes and fishing. He had a close group of friends and a close family. He was married and had a young child.

Circumstances:

On 5 March 2023 the driver was convicted of medium range drink driving. His licence was disqualified for 12 months. For a further 12 months he was not permitted to drive except if he had an alcohol interlock fitted to his car and obtained an interlock licence. He did not have an interlock fitted so he was a disqualified driver on 22 June 2024

On Friday the 21 June 2024, he socialised with friends at ten pin bowling in Alice Springs and he then went to a friend's home. Throughout, alcohol was consumed. Later at about 1:30am on Saturday morning 22 June 2024, a good friend rang him from town and asked for a lift. The driver picked him up and they returned to the friend's house and continued socializing and drinking.

At around 2:50am the driver drove his friend to Jay Creek Outstation on Larapinta Drive, close to Stanley Chasm. He was said to be driving normally and within the speed limit and they arrived at around 3 to 3:20am. They finished their alcoholic 'roadie' and then drank water.

The driver left Jay Creek Outstation at about 4am or 4:15am. He drove out of the property onto Larapinta drive travelling west towards Waterhouse Outstation. He drove for about 10km before he lost control of his vehicle and crashed.

The crash was approximately 47km west of Alice Springs on Larapinta Drive. It was discovered by a passing motorist at about 6.30am. She was driving from Hermannsburg to Alice Springs. The motorist stopped and determined that there was nothing that she could do to help, and she continued driving towards Alice Springs until she got phone coverage at Standley Chasm. She immediately called 000 at about 7.00am.

St John Ambulance attended the Crash location and confirmed the date and time of death as 22 August 2024 at 7.50am.

Police investigation:

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

The crash occurred on a remote section of road. The speed limit was 110kph. At the time of the crash, it was night-time and there was no street lighting. The weather was fine, clear.

The road surface was 2 coat sealed asphalt, with no signs of damage or decay. The road was divided by a broken white and solid centre lane line, so traffic heading inbound to Alice Springs could not overtake. It was a long straight section of road that was defined with solid unbroken outer fog lines inside a small shoulder. There was a further small, graded shoulder before a drop off to a large, grassed area with some scattered shrubs and grasses. The stretch of road is depicted in the below photo (courtesy of Major Crash).

A Major Crash Detective examined the scene.

Scene evidence revealed that the Hilux entered a slight right-hand bend outbound on Larapinta Drive, over a crest into a slight right downhill gradient. The driver failed to negotiate the bend causing the two left side tyres to contact the gravel shoulder next to the left lane fog line. The right two tyres remained on the asphalt. To regain control of the vehicle, the driver sharply turned the steering wheel to the right. This caused the rear wheels to move out of line with the front wheels causing the vehicle to drift into a right sidewards skid. The driver again tried to regain control of the vehicle and turned the steering wheel sharply to the left to re-enter the road. This caused the vehicle to commence a right-hand side skid or critical yaw, and it traveled sideways. As the Hilux moved sideways it tripped and rolled violently. It struck a concrete culvert and drain and then rolled sharply to the left. The vehicle rolled for approximately 150 meters before coming to rest on the correct side of the road.

At some point the driver was ejected from the vehicle. There was no evidence suggesting that his seatbelt was worn. It is not known how the driver became severed at the waist, but his upper body and lower body were located approximately 80 meters apart.

The Major Crash Detective calculated the speed of the Hilux from the tyre friction marks left at the scene. The speed of the Hilux at the point at which control was lost was estimated to be 130kmh and 150kmh.

The Hilux was inspected post-crash by MVR inspectors. No defects were identified that contributed to the crash.

Opinion as to the Cause of Crash:

It was the opinion of the Major Crash Detective that the following factors contributed to this crash:

- Intoxication - The driver's blood alcohol content was 0.210% which is more than 4 times the legal limit.
- Excessive and dangerous speed - At the point when the driver lost control of the Hilux, the calculated speed was between 130kmh and 150kmh in a 110kmh zone.
- Failure to wear a seatbelt.
- It is also possible that driver fatigue and inexperience contributed.

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.