ATTORNEY-GENERAL

Parliament House
State Square
Darwin NT 0800

GPO Box 3146
Darwin NT 0801

REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendations regarding Road Death 41 of 2024

Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendations of Local Court Judge Elisabeth Armitage, Territory Coroner, regarding Road Death 41 of 2024 (the Deceased) (Attachment A refers).

This Report includes the response to the recommendations of the Territory Coroner by Ms Gemma Lake, Acting Chief Executive Officer (CEO) of the Department of Logistics and Infrastructure (DLI).

On the evening of 8 August 2024, the Deceased, a 59 year old female, was struck by a road train along Stuart Highway. The cause of death was due to extensive crush injury. The Deceased's inability to notice the road train was notably due the Deceased being intoxicated, poor hearing and eyesight, and under the influence of drugs,.

Recommendations of the Coroner

The Coroner made the following two recommendations in regard to the Deceased:

'1. **I recommend to the Department of Logistics and Infrastructure** that that the Road Safety Task Force and Implementation Project Team investigate this death. For the purpose of investigating this death additional representation from Licencing NT should be requested. The investigation should identify what factors contributed to the death including any liquor licencing breach. The investigation should determine whether there are ways of improving road safety including for example, ways of improving compliance with licencing conditions to prevent road deaths, such as advocating for proactive reviews of CCTV by licence inspectors and/or recommending increased penalties for breaches.

2. **I recommend to the Department of Logistics and Infrastructure** that it amend the membership structure of the Road Safety Task Force to include representation from Licensing NT.'

Response to Coroner's recommendations

A copy of the Coronial Findings were provided to Ms Lake on 8 September 2025, in accordance with section 46A(1) of the Act.

A written response was received from Ms Lake dated 2 December 2025, as required by section 46B(1) of the Act. The response was as follows:

Recommendation 1

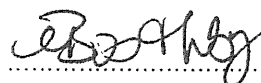
> 'The Department accepts this recommendation. The Department has progressed the Coroner's recommendations to the Road Safety Task Force and the recommendations were discussed at the Road Safety Task Force meeting on 1 December 2025.
>
> At the meeting it was agreed that the Pedestrian Safety Reference Group will be re-established. Licencing NT is an existing member of the Pedestrian Safety Reference Group. The Pedestrian Safety Reference Group's purpose is to investigate possible solutions to issues impacting the safety of at-risk pedestrians and the Group reports through the Road Safety Implementation Project Team to the Road Safety Task Force.
>
> The Coroner's recommendations will be referred to the Pedestrian Safety Reference Group with a direction to investigate this death, including reviewing previous Police and Licencing NT investigations into the death and considering whether any further actions could be considered. The Group will report back on their investigations to the first meeting of the Road Safety Task Force in 2026.'

Recommendation 2

> 'The Department supports this recommendation through membership of a sub group of the Road Safety Task Force. The Road Safety Task Force considered that Licencing NT's membership of the Pedestrian Safety Reference Group (which reports through the Road Safety Implementation Project Team to the Road Safety Task Force) as the most effective approach for investigating pedestrian road safety issues. The Road Safety Task Force will therefore not add Licencing NT to the Road Safety Task Force membership at this stage.
>
> The Department takes road safety and the loss of life on Territory roads seriously and remains committed to continuously improving safety outcomes for all road users including pedestrians.'

I am satisfied that the Acting CEO of DLI has considered the recommendations of the Territory Coroner and has responded to the recommendations.

DATE: 12 JAN 2026



MARIE-CLARE BOOTHBY

ATTACHMENT A

NORTHERN TERRITORY OF AUSTRALIA

Office of the Coroner

Our Ref: A0037/2024

The Honourable Marie-Clare Boothby
Attorney-General
GPO Box 3146
DARWIN NT 0801
Minister.Boothby@nt.gov.au

Dear Minister,

RE: RECOMMENDATIONS - CORONIAL FINDINGS – ROAD DEATH 41 OF 2024

Pursuant to Section 35(1) & (2) of the *Coroners Act* (NT), please find attached a copy of my Coronial Findings in which I make a recommendation in response to the death of road death 41 of 2024.

Should you have any queries, please do not hesitate to contact me on telephone 899 97770.

Yours faithfully

Elisabeth Armitage
TERRITORY CORONER

21 July 2025

cc Chief Executive Officer (CEO) Gemma.Lake@nt.gov.au

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IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

CORONER'S FINDINGS

ROAD DEATH 41 OF 2024

Section 34 of the Coroners Act 1993

I, Elisabeth Armitage, Coroner, having investigated the death of **a 59 year old female** and without holding an inquest, find that the deceased was born on **13 January 1965** and that her **death occurred on 8 August 2024, at Stuart Highway, Stuarts Well in the Northern Territory.**

Introduction:

This death is the 41st road death for 2024 compared with seven (7) road deaths at that same time in 2023.

This was a pedestrian death. The Northern Territory Towards Zero Road Safety Action Plan recognises that pedestrians are vulnerable road users. Most pedestrian deaths occur at night. Since 2019, 97% of pedestrian fatalities in the Territory were under the influence of alcohol and most were heavily intoxicated. Where pedestrians are under the influence of alcohol, predictability of movement and visibility at night is challenging for drivers. In response to these known factors, the Plan states that a Pedestrian Road Safety Working Group involving a range of key stakeholders has been formed to identify immediate solutions and work towards reducing pedestrian fatalities and injuries.[1]

This death was avoidable. The road train-pedestrian crash occurred because of the pedestrian's inattention to the traffic on the Stuart Highway and it was nighttime. Her intoxication (blood alcohol concentration of 0.15%), poor hearing, poor eyesight and the distraction of cigarettes, all likely contributed to her inattention when she stepped into the path of the road train.

Her intoxication was seemingly enabled, at least in part, by a failure of the licensee of Stuarts Well Roadhouse to comply with the special conditions of its licence.

One witness explained,

"...the lady didn't look. The mate in the semi-trailer, it's not his fault. He had no time to stop."

The 45-year-old sober and experienced road train driver was treated for shock and distress. He reported to the attending paramedics that he felt very shaky but declined further assistance. He has since given up long haul trucking.

The deceased is mourned by her family and community. Her death also traumatised the road train driver, witnesses, and first responders.

Cause of death:

1(a) Disease or condition leading directly to death: **Extensive crush injury**

[1] Northern Territory Government, Towards Zero Road Safety Action Plan 2024-2028, p16

1(b)	Morbid conditions giving rise to the above cause:	**Pedestrian run over by a heavy vehicle (road train)**
1(c)		**Acute alcohol intoxication**

Following an autopsy on 14 August 2024, Forensic Pathologist, Dr Marianne Tiemensma commented:

Summary of main pathological findings

- External examination showed:
    - The body of an overweight adult female.
    - Decapitation with complete traumatic disruption of the head and face.
    - Significant traumatic disruption of the body, with exposure of the intra-thoracic organs and structures, and palpable and visible fracture of the pelvis, upper and lower limbs.
    - Abrasions and gaping lacerations involving the upper limbs, lower limbs, and torso.
- A post-mortem CT scan showed:
    - Complete separation of the head from the remainder of the body, with crushing of the head and comminuted fractures of the face and skull.
    - Fractures involving C1, with the spinal cord severed at the junction of the cervical spine and skull base; significant disruption of the spine at the cervical thoracic junction and again at the L1-2 level where there are several centimetres of separation.
    - Extensive fractures and traumatic disruption of both scapulae, the sternum, and the ribs on both sides.
    - Crushed pelvis with fractures through all bones including the sacrum, widening of the right sacroiliac joint and disruption of the pubic symphysis.
    - Fractured left mid to distal shaft, comminuted fractures of the proximal tibia and fibula bilaterally and a fracture dislocation of the right ankle.
    - Fractured distal left tibia and fibula and multiple fractures of the feet.
    - Fractures of the distal right ulna and radius and some fractures of the right hand.
    - Fracture of the mid shaft of the left humerus, comminuted fractures around the elbow and mid shaft of the left radius and ulna.
    - Multiple fractures of the left hand.
- Toxicological analysis of a post-mortem chest cavity blood showed:
    - Blood alcohol concentration of 0.15%.
    - Gamma-hydroxybutyrate (32mg/L).
    - Presence of ondansetron.

Comments

- I have no reason to believe with the information available, findings made during external examination, and post-mortem CT scan of the body that the death was due to any other cause than the extensive unsurvivable crush injuries sustained when the decedent was run over by a heavy vehicle.

Post-mortem toxicology results the following:

- An elevated concentration of alcohol was measured in the chest cavity blood sample. It should be noted that a chest cavity sample is not an optimal sample, particularly given the state of the body of the decedent with extensive traumatic injuries, and the prolonged post- mortem interval. The possibility exists that some of the measured alcohol may have resulted from post-mortem ethanol synthesis.
- Gamma-hydroxybutyrate was measured in the preserved cavity blood sample at a level of 32 mg/L. The post-mortem interval of 6 days should be considered when interpreting the results, as gamma-hydroxybutyrate concentration in blood samples increases with the length of post-mortem interval, and possibly on storage in-vito. Therefore, the presence of gamma-hydroxybutyrate in the sample may be due to post-mortem production and should not be taken as evidence of its consumption without other supporting information.

Police investigation:

A coronial investigation by Major Crash Investigators found no criminal offending arising from this crash.

Circumstances:

At the time of the crash the deceased was living with her partner and extended family at an outstation south of Stuarts Well.

On 18 July 2024, the deceased was given a health check by Congress. It was discovered that she had both poor eyesight and hearing. Her results were:

Visual acuity right eye: 6/12 Visual acuity left eye: 6/15 Hearing assessment: Poor - referred for treatment.

She was referred to an optometrist and audiologist.

During the afternoon of Thursday 8 August 2024, the deceased and two family members drove from the outstation to Stuarts Well Roadhouse in a red Holden Commodore sedan. Her family members were in the front seats (the male was driving, and his female partner was in the front passenger seat) and the deceased was in the back. They arrived around 3.00pm. They wanted to purchase cigarettes, but they stayed and purchased alcohol and some tins of food.

Stuart Wells Roadhouse has a liquor licence, with conditions including that alcohol is only permitted to be served to people staying on-site (paid accommodation) or with a meal.

Between 3.10 - 7.17 pm, the group purchased 21 cans of VB and seven bottled drinks of alcohol, a total of 29 drinks.

The deceased did not make any purchases herself, but it is assumed she drank the alcohol as it was mostly her money they were using and in a later toxicology reading she had a blood alcohol concentration (BAC) of 0.15%, which meant she was highly intoxicated. The deceased was not on the Banned Drinkers Register.

As they were drinking in 'rounds' it is likely that her family members were also intoxicated.

At around 7.20 pm, the group left Stuarts Well to drive back to the outstation, travelling south along the Stuart Highway.

Quite separately, three other travelers also left Stuarts Well in their blue 2003 Subaru Outback (Queensland registration). This group stopped on the side of the highway around 1.5 km south of Stuarts Well Roadhouse. They parked perpendicular to the road around five metres off the eastern side of the highway. The boot was facing away from the road so they could let their dogs out for a run. This group had just fled Queensland to avoid arrest because of active warrants in their names. They had tried to find accommodation at Stuarts Well but were refused as they did not have enough money for a pre-payment, and they were considering sleeping on the side of the road.

As the deceased and her family members were driving south on the highway, they passed the Subaru parked perpendicular to the road. The male driver was concerned for their welfare and made a U-turn and parked parallel on the western side of the highway, opposite the Subaru. The driver got out and walked across the road and asked them if they were all right.

He spoke to the occupants of the Subaru for a few minutes. On being reassured that they were all right and did not need assistance he returned to the red Commodore and his partner was still in the front passenger seat.

Unnoticed by either the driver or his partner, the deceased had exited the red Commodore. She walked across the road towards the Subaru, possibly to ask for cigarettes, as one of the travelers was standing next to the Subaru and smoking.

At the same time, a Western Star triple road train was heading south on the Stuart Highway. Having just passed the reduced speed limit at Stuarts Well, the road train driver was increasing his speed to 100km/h which is the set maximum speed of the truck. The road train driver noticed the red Commodore on the western side of the highway and, as there was also oncoming traffic (travelling north), his headlights were appropriately on low beam.

Possibly because she was intoxicated, had poor hearing, poor eyesight, and was focused on obtaining a cigarette, it seems that the deceased did not notice the approaching road train as she stepped into the south bound lane. At the very last she yelled "*Oh no*". The road train struck her, causing catastrophic injuries and her immediate death.

The road train driver had not seen her on the road but immediately realised that he had struck something. He braked heavily after the impact and came to a stop 50 - 100m along the highway. He radioed other traffic and asked them to stop and check what he had hit.

Her family members, seemingly still not knowing that the deceased had left the red Commodore, conducted a U-turn and started travelling south. The female front seat passenger was trying to have a conversation with the deceased when she realized that she was no longer in the back seat. They conducted another U-turn, intending to return to the Subaru to find her.

When the red Commodore pulled up again, other vehicles had already stopped, and the deceased was found passed away on the road. Her family members were shocked and distraught and drove back to Stuarts Well Roadhouse to use the phone to report the matter to police and later provided statements.

The scene of the crash:

Selected image from Major Crash investigators drone footage.

The crash occurred on the Stuart Highway approximately 1.5 km south of the Stuarts Well roadhouse and was reported to emergency services by the truck driver at 7.31pm, Thursday 8 August 2024.

St John Paramedics were alerted at 7.32pm and arrived at 8.47pm, and her death was obvious. Police closed the highway and protected the scene for Major Crash Investigators who travelled from Alice Springs.

The Stuart Highway runs north-south from Darwin to Adelaide. At the crash location it is a single carriageway with a north and south lane separated by broken white lines and a fog line marking the edge of the road. The crash occurred on a long straight section of the highway. The road was sealed and dry. The speed limit at the crash site was 130 km/h. The road was in good condition and not considered a factor in the crash.

The road train inspection:

MVR daytime inspection. Vehicle in-situ.

The truck was a 2012 Western Star Constellation Triple Road Train XS84CP (National Heavy Vehicle).

On 9 August 2024, a MVR heavy vehicle inspector attended the crash scene and inspected the vehicle. He found it to be roadworthy and there were no faults that may have contributed to the crash.

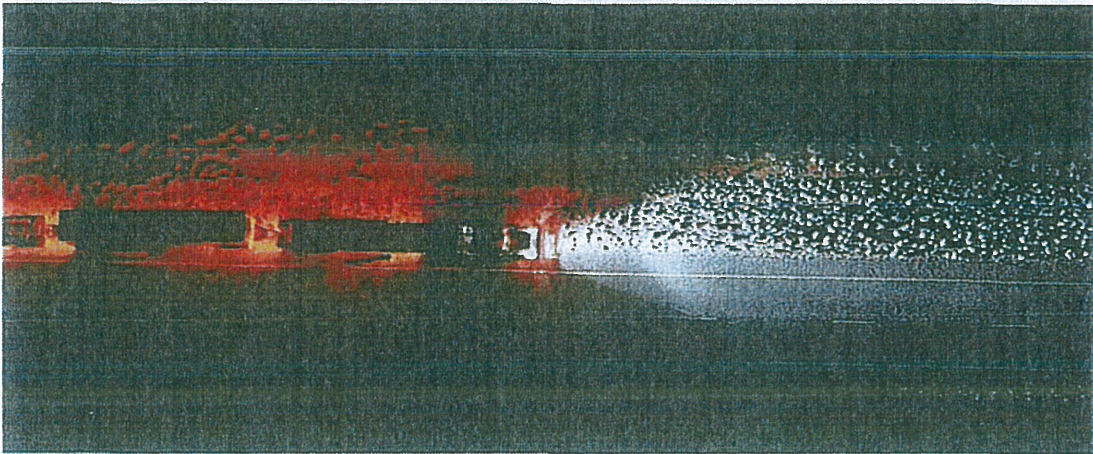
The crash investigation:

The crash scene was thoroughly investigated by a Detective Sergeant attached to the Major Crash Investigation Unit and a detailed brief of evidence was prepared.

At the time of the crash, it was nighttime and there was no street lighting. The deceased was wearing predominately darker clothing and so was harder to see than someone in light clothing. The road train's headlights were dipped appropriately due to on-coming traffic. The headlights illuminated 25.42m. This meant that the deceased would first have become visible to the road train driver when she was 25.42m away if he was looking directly ahead.

Most drivers take 2.8 seconds to perceive a hazard and respond. Travelling at or close to 100 km/h, this would mean the average driver would take 78 metres to perceive the hazard and respond (brake press time). It would then take further time and distance to stop.

As the road train driver only had 25 metres within which to observe the deceased, he was not able to respond or avoid striking her.



Real time drone image depicts the truck's head light beam.

It was the crash investigator's opinion that the primary cause of the crash was the deceased's inattention to the oncoming traffic. She stepped into the path of the road train and the crash was unavoidable.

Breach of the *Liquor Act 2019*

Liquor Inspectors reviewed CCTV footage from Stuarts Well Roadhouse from 8 August 2024. The footage showed that two members of the group purchased 21 VB cans and 7 Carlton Dry bottles over 9 transactions, with a majority served in unopened containers. It is not known whether the Liquor Inspectors viewed footage from any other days. A Special Condition of the liquor licence permits the sale of liquor to members of the public ancillary to the purchase of a substantial meal. The licensee made admissions that the group did not purchase a substantial meal.

A charge under the *Liquor Act* was laid alleging that the licensee had intentionally engaged in conduct that resulted in a contravention of a condition of the licence and the licensee was reckless as to that result. The breach was admitted by the licensee. Taking into account the admission and previous good compliance with the conditions of their licence, the licensee was issued an infringement notice of 5 penalty units ($925).

It seems that the deceased's intoxication was enabled, at least in part, by a failure of the licensee of Stuarts Well Roadhouse to comply with the special conditions of its licence which are specifically designed to ensure persons passing through the roadhouse (instead of staying at the roadhouse) have only limited access to alcohol.

The liquor licence breach was only identified after the death. It seems reasonable to conclude that proactive reviews of CCTV by Liquor Inspectors may improve compliance with liquor licence conditions and in that way reduce the risk of deaths in similar circumstances. In addition, it may be that the imposition of much more significant penalties for this type of breach may also reduce the risk of deaths in similar circumstances.

Pedestrian Safety Reference Group

When this death occurred there was in existence a Pedestrian Safety Reference Group. The terms of reference of the Pedestrian Safety Reference Group includes the following information as to its background and purpose.

> Pedestrian fatalities continue to represent around 19 percent of lives lost in the Territory, and sadly, nearly all recent pedestrian fatalities involve Aboriginal people. The majority of pedestrian fatalities and serious injury occurs in the urban areas of Darwin, Palmerston and Alice Springs. However, crashes involving pedestrians occur across the network and often in rural areas where there is no street lighting. Pedestrian fatalities are most prevalent at night, and often in places where pedestrians are not widely expected to be on or near the road. The safety of Aboriginal pedestrians is also further compounded by wider social concerns such as homelessness and excessive alcohol consumption, increasing their risk of being involved in a fatal or serious injury crash. Where pedestrians are under the influence of alcohol, predictability of movement and the visibility of pedestrians at night is a challenging issue for other road users.
>
> In response to this ongoing issue, the Pedestrian Safety Reference Group (Reference Group) has been formed. The Reference Group's aim is to act as an informal and accessible forum for organisations working with at risk pedestrians, and provide them an opportunity to discuss projects, share information and to seek assistance and feedback on topical matters and items of interest. The Reference Group may, when instructed by the IWG and RSEG, investigate possible solutions to issues impacting the immediate safety of at risk pedestrians.

I understood from information available that its Meetings are to be held quarterly or as required in line with an IWG (Implementation Working Group) meeting and a record of meetings and action items will be maintained and reviewed at each meeting. The Group met on 16 May 2024 and 22 August 2024. A meeting planned for 21 November 2024 apparently did not occur. No Action items were generated from the 22 August 2024 meeting and there are no formal minutes. It is unclear whether this pedestrian road death was discussed at the 22 August 2024 meeting or whether it is on the agenda for any future meeting. Given the apparent contribution of a liquor licencing breach to this deceased pedestrian's level of intoxication, I considered that it would be appropriate for this Group to investigate this death to determine whether additional action (including action by Licencing NT) was required to prevent similar road deaths in the future.

Response of Department of Logistics and Infrastructure

Draft findings with the following draft recommendation were provided to the Department of Logistics and Infrastructure for comment:

> "**I recommend to the Department of Logistics and Infrastructure** that the IWG (Implementation Working Group) and RSEG (Road Safety Executive Group) investigate or instruct the Pedestrian Safety Refence Group to investigate the liquor licencing breach and its contribution to this death with a view to identifying whether there are ways of improving

compliance with licencing conditions to prevent road deaths, including, for example, advocating for proactive reviews of CCTV by licence inspectors and/or recommending increased penalties for breaches."

The Chief Executive Officer responded and provided the following information:

- Road Safety Governance arrangements for the NT were reviewed early in 2025 and it is suggested that the references to a Road Safety Executive Group and Implementation Working Group be updated to the Road Safety Task Force and Implementation Project Team. The Task Force is Chaired by the Chief Executive Officer of the Department of Logistics and Infrastructure, and members include the Motor Accident Compensation Commissioner, and senior representatives of NT Police, Fire and Emergency Services and the Department of Education and Training. The Road Safety Task Force meets three times a year, providing strategic road safety advice to Government, oversight of the development and implementation of road safety action plans and coordination of whole-of-Government road safety related policies and activities. The Road Safety Task Force is supported by a Road Safety Implementation Project Team, with membership from across the Task Force agencies.
- With regard to the draft recommendation, although the Pedestrian Safety Reference Group can consider the circumstances relating to road death 42 and whether additional action is required to prevent similar road deaths in the future, it may also be appropriate for Licencing NT to investigate the potential liquor licencing breach and opportunities for improving compliance including increased penalties for breaches.
- The continuation of the Pedestrian Safety Reference Group will be discussed at the next Road Safety Task Force meeting.

The Road Safety Task Force (RSTF) terms of reference state:

1. That its objective is to provide leadership to achieve a reduction in death and serious injury on Northern Territory roads.
2. Its role is to:

    a. Provide strategic leadership and set direction in conjunction with relevant Ministers;
    b. Provide recommendations to the MAC Commissioner regarding MAC fund expenditure and resourcing for each financial year;
    c. Oversee the development and implementation of road safety action plans as endorsed by Government;
    d. Provide ongoing advice to Government on specific road safety policy and priorities; and
    e. Lead the co-ordination of whole-of-Government road safety related activity.

3. It has the following functions:

    a. Engage with and advise Ministers in relation to whole-of-government road safety policy and priorities;
    b. Promote the coordination and cooperation of all stakeholders to meet the National Road Safety 2030 targets of reducing the Territory's road fatalities and injuries; and
    c. Provide recommendations regarding operational road safety expenditure and programs.

4. Its membership consists of:

    a. The RSTF will be Chaired by the Chief Executive Officer of the Department of Logistics and Infrastructure, with representatives from the following organisations:

- NT Police (NTPF)
- NT Fire and Emergency Services (NTFES)
- Department of Education and Training (DET)
- Motor Accidents Compensation Commission (MACC)

b. Additional representation from other organisations may be requested as agreed by all RSTF members.

Given the significant contribution alcohol plays in pedestrian and other road deaths, either by way of intoxicated drivers or pedestrians, it is not readily understandable why Licencing NT is not a member of the Road Safety Task Force. I consider that Licencing NT has a significant role and contribution to make in any plans for the reduction of road deaths in the NT. Accordingly, I will recommend that it be included in the membership of the RSTF.

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, the relevant circumstances concerning the death, and 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.

Recommendations

1. **I recommend to the Department of Logistics and Infrastructure** that the Road Safety Task Force and Implementation Project Team investigate this death. For the purpose of investigating this death additional representation from Licencing NT should be requested. The investigation should identify what factors contributed to the death including any liquor licencing breach. The investigation should determine whether there are ways of improving road safety including for example, ways of improving compliance with licencing conditions to prevent road deaths, such as advocating for proactive reviews of CCTV by licence inspectors and/or recommending increased penalties for breaches.
2. **I recommend to the Department of Logistics and Infrastructure** that it amend the membership structure of the Road Safety Task Force to include representation from Licencing NT.