IN THE CORONERS COURT OF THE NORTHERN TERRITORY

Rel No: D0121/2024

Police No: 24 47173

CORONERS FINDINGS

ROAD DEATH 21 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 29 year old Aboriginal female** and without holding an inquest, find that she was born on **22 December 1994** and that her **death occurred on 12 May 2024, at Litchfield Park Road, Charlotte in the Northern Territory.**

Introduction

These findings concern the death of a 29 year old Aboriginal female. She was the passenger in a vehicle that was involved in a single vehicle roll over crash. She was not wearing a seat belt and suffered catastrophic head injures and passed away.

Her death was the 21st death on Territory roads in 2024. In total 60 persons died on Territory roads that year. These anonymised findings are being published, together with similar findings concerning every other road death in 2024, in the hope that a comprehensive set of findings will assist Government and Non-Government agencies in identifying strategies to reduce road deaths in the future.

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 seat belt
- Excessive speed
- Distraction (e.g. mobile phone use)
- Fatigue

This death involved 3 of the Fatal 5. The driver was intoxicated and driving faster than the posted speed limit. The passenger failed to wear a seatbelt, perhaps in part because she too was intoxicated.

Her death is a tragedy for her child and partner, her wider family, and community.

Cause of death

1(a) Disease or condition leading directly to death: **Multiple blunt force injuries**

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

Other conditions present but not regarded (or provable) as contributing to death was: Alcohol intoxication.

Following an autopsy on 14 May 2024, Forensic Pathologist, Dr Salona Roopan commented:

- The opinion as to the cause of death is based on the available police and medical information, and a post-mortem examination including ancillary investigations.
- Extensive severe crush-type injuries were present of the head and neck with radiological confirmation of chest and upper limb injuries. There was no evidence of seat-belt injury on the decedent.
- Toxicological analysis showed a blood alcohol level of 0.19% which may be associated with loss of co-ordination and balance (motor skills) but there may be person to person variability depending on various factors. No other drugs detected from the Scope of Analysis. The toxicology results are non-contributory to the cause of death in this case.
- I have no reason to believe with the information available and findings made during external examination of the body that the death was due to any other cause than the reported motor vehicle collision as a passenger.

Background

This 29 year old Aboriginal female grew up and lived in lived a community close to Adelaide River. She was a good student, and later a good worker, and was employed.

She was in a relationship and had one daughter.

She enjoyed fishing for turtles and black bream, hunting Kangaroos, and camping at the back of her community. Her love for the environment was evident in her connection to country.

She is remembered as outgoing and adventurous, someone whom everybody loved.

Circumstances

On Sunday, 12 May 2024, she was with extended family and friends at Bamboo Creek. Some young children were at the creek. Most of the adults consumed alcohol. It seemed like everyone was having a good time, swapping stories, and sharing a meal.

Just before 4.00pm, an argument occurred between the deceased and her partner. She was upset and walked down the entrance road to the creek.

Her brother, C, was told that his sister had walked away. C took the keys of his wife's Blue Mazda 3 and drove along the entrance road and found his sister sitting under a tree.

She got into the Mazda, she did not fasten her seatbelt, and said, '*Just drive!'.* C drove north along Litchfield Park Road. Approximately 3km north of the creek entrance road the vehicle left the road onto the western dirt shoulder. In an attempt to steer the vehicle back to the road C oversteered to the right. The Mazda entered an uncontrolled clockwise yaw, sliding across north and southbound lanes and went into the shallow culvert. It impacted with a tree and violently rotated 180 degrees. The vehicle tripped and began to roll horizontally.

The deceased passenger was not secured by a seatbelt, and she was partially ejected out of the passenger window. As the vehicle rolled, her head was caught between the roof of the car and the ground, crushing her skull and causing a catastrophic head injury. The vehicle completed its revolution and landed on all four tyres.

C, secured by his seatbelt, remained in the vehicle. Horrified by the event he hugged his sister and wept.

Around 4.30pm, British tourists came across the crash site on Litchfield Park Road, 45 kms south of Cox Peninsula Road and attempted to render assistance. One approached the car while her husband managed traffic. Other travelers stopped to render assistance. One group turned back to get mobile reception so they could contact the local Rangers.

The crash was reported to authorities at 4.43pm.

Location and conditions

Litchfield Park Road is a sealed sprayed bitumen road running north to south. It is a dual lane road linking Cox Peninsula Road at the northernmost entrance to the Rum Jungle Road at the southern entrance. The road surface was in good condition with no notable defects.

The road surface is marked with double white lines through the centre at the crash location. There are no marked fog lines; the lanes are delineated by dirt shoulders. The western shoulder slopes gradually from the roadway, while the eastern shoulder has a shallow culvert that raises into a hillside. Both shoulders have natural vegetation of medium density.

The posted speed limit was 80km/h.

The weather was clear and fine and the road surface was dry.

The vehicle

The vehicle was a Mazda 3 hatchback. It was unable to be mechanically inspected post-crash due to the damage. There is no indication that the vehicle had any mechanical faults pre-crash.

Tests and/or Calculations Conducted

Utilising the Laser Scanned scene, a 3D model of the crash scene was generated. With the measurements taken within the model, a speed calculation was conducted. The speed of the vehicle at the commencement of the yaw was between 97.2Km/hr and 115.49Km/hr.

C was conveyed to hospital by ambulance. A blood sample was collected and it contained not less than .174 grams of alcohol per 100 milliliters of blood.

Police investigation

Major Crash Detectives charged C with Drive motor vehicle causing death.

C had 4 previous drink driving offences on his criminal history and previous licence disqualifications.

C attended CAAPS residential rehabilitation centre and completed a 12 week alcohol and other drugs rehabilitation program on 21 July 2026.

C pleaded guilty to the charge and on 23 July 2026 he was sentenced to 2 years and 3 months imprisonment suspended after 9 months on supervision conditions including that he is not to purchase, possess or consume alcohol. His driver’s licence was disqualified for 3 years.

Opinion as to the cause of the death

The crash occurred due to the driver's excessive steering input to the right in response to the vehicle drifting from the road on the eastern side. The driver was driving over the posted speed limit. The driver likely failed to identify the right-hand bend due to intoxication, inattention, distraction or fatigue. The passenger was not wearing a seatbelt and this contributed to the catastrophic consequences and her death.

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