IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: A0033/2024

Police No: 24 70582

CORONERS' FINDINGS

ROAD DEATH 40 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 28 YEAR OLD CAUCASIAN MALE** and without holding an inquest, find that the identity of the deceased was born on **22 December 1995** and that his **death occurred on 19 July 2024, at Stuart Highway, Renner Springs in the Northern Territory.**

Introduction:

60 people lost their lives on Northern Territory roads in 2024. The Territory death rate on roads is the is by far the worst in the country and 2024 was the highest death toll of the past 10 years. The road death toll has been described as "disgraceful" and "outrageous" by Senior Police and former Ministers. Considering this terrible loss of life and consistent with my function to ensure the coronial system operates efficiently and my power to comment on public safety connected with a death, I have undertaken to publish anonymised findings concerning all the 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 deaths are:

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

In this fatal collision which claimed the driver's life, two of the Fatal 5 were present. 7% of fatal crashes involve fatigue and this was one of those crashes. Although the driver was not wearing a seatbelt, given the severity of the crash a seatbelt is not likely to have saved his life.

The cause of the collision was the driver drifting onto the wrong side of the road into the path of an approaching road train. The driver's parents very graciously contacted the truck driver

to thank him for the care shown to their son immediately following the crash and their hope that he would recover physically and emotionally from the trauma and ordeal of this crash.

This young man's death is a tragedy, and he is mourned.

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 collision (driver)**

Following an autopsy on 23 July 2024, Forensic Pathologist, Dr Salona Roopan commented:

Summary of main pathological findings

- Post-mortem CT scan showed:
  - Extensive intracranial haemorrhage including intraventricular haemorrhage.
  - Fractured left and right mandible.
  - Multiple paravertebral rib fractures and bilateral haemopneumothoraces.
  - Fracture of the thoracic and lumbar vertebras.
  - Large pneumoperitoneum in presence of decomposition.
  - Diastasis of the sacral iliac joint and pubic symphysis and fractured left inferior and superior pubic ramus.
  - Comminuted fracture of the right acetabulum and femoral neck.
  - Comminuted fracture of the right femur.
  - Fractured right patella
  - Fractured right humerus and fractured right radius and ulna.
- External examination showed:
  - The body of a fully clad adult male with multiple extensive abrasions to the body with relative sparing of the back.
  - Abrasions and lacerations of the head with exposure of the frontal skull and palpable maxilla and mandible fractures.
  - Multiple abrasions and lacerations to the right arm and forearm with compound fracture of the righthumerus.
  - Multiple abrasions and lacerations of the right leg with compound fracture of right femur with exposed lacerated muscle and blood vessels of the thigh anteriorly. Large embedded black plastic fragments and glass were also present.
  - Greenish discolouration of the abdomen.
  - Subconjunctival pallor.
- Toxicological analysis did not detect alcohol, or any other drugs listed on the

laboratory's Scope of Analysis.

Comments

- 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.
- The extensive and severe injuries observed at autopsy are consistent with a high impact collision.
- I have no reason to believe that the information available and the findings made during external examination of the body that the death was due to any other cause than that sustained during the alleged **motor vehicle collision as a driver.**

Background:

The 28 year old male driver was born in Queensland and grew up with his extended family on a cattle farm. Over his life he received numerous qualifications and held many jobs. He relocated to Darwin in January 2022 and lived with friends. He was employed in and then commenced his own business in the disability sector.

Circumstances:

On 18 July 2024 the driver got up in the morning and spent the day and evening socialising and drinking with friends.

He arrived home at about 11pm, ate a meal and continued to drink beer and socialise.

There was a serious incident at his unit, and a physical altercation with one of his friends, and he was asked to leave the unit and not return. He left the unit in his 4x4 utility at 2.50am on 19 July 2024. He then commenced to drive South along the Stuart Highway with a stated plan to return to Queensland.

At 4.34am his mobile phone connected to the Coomalie cellular tower indicating he had left Darwin and was travelling south on the Stuart Highway. At 7.10am his phone was logged in in Katherine.

After departing Katherine, he drove to Mataranka where he remained for about 1.5 hours. His phone pinged at Daly Waters at 1.07pm and he stayed there for about 2 hours. He travelled south and his mobile phone pinged at Dunmurra at 3.14pm.

The crash:

At 4.49pm the driver was 12.2km north of Renner Springs and estimated by the Major Crash Investigation Unit to be travelling at about the posted speed limit of 130kph.

A road train with three trailers was heading north at about 90-95kph. The driver’s 4x4 utility collided head on with the road train in the north bound lane.

Three calls were made to 000 reporting the crash. Due to poor mobile reception, one call maker activated her Emergency Position Indicating Radio Beacon.

Police from Tennant Creek and Elliot were first on scene. The driver of the road train was breath tested with nil result.

The driver was killed on impact. St John Ambulance confirmed his death upon arrival and provided medical assistance to the road train driver.

A crime scene was declared and inspected by Major Crash Investigators.

The Scene:

The roadway is a single carriageway, with north/south lanes separated by broken white lines, and both lanes marked with fog lines.

Southbound, the road curves to the left with a mild downhill gradient.

The road was sealed, dry, and in good condition.

The road and speed limit of 130kph at the crash location were not considered factors in the crash.

The contact damage visible at the front of the driver's 4 x 4 utility showed that approximately 1.2 metres of the utility made impact with the front of the road train. The point of impact was approximately in the middle of the northbound lane, so the driver was on the wrong side of the road at the point of collision.

Tyre marks left on the roadway indicate the truck driver moved left in an unsuccessful effort to avoid the crash when the driver encroached into his lane. The truck's right steer wheel exploded and the momentum of the heavy trailers caused the prime mover to roll. A fire started in the truck but the driver was able to escape.

The prime mover ended up 114.53 metres from point of impact and the 4x4 utility ended up 10.87 metres from point of impact.

An occupant in a vehicle that stops suddenly (on impact with the truck), automatically resists the standstill due to inertia. The body continues to travel forward until stopped by an external object, normally a seatbelt. The driver was not wearing his seatbelt and hit the steering wheel and dashboard. The severity of his injuries reflect the severity of the impact.

Weather and Lighting Conditions:

Bureau of Meteorology data for the Tennant Creek and Elliott areas indicate dry weather, approximately 23°C, with no cloud and light winds at the time of the crash.

Weather conditions were not a contributing factor.

The crash occurred at approximately 4.59pm during normal daylight hours, with sunset at 6.16pm. and last light at 6.39pm. Lighting conditions are not a factor. The sun was not a contributing factor to the crash.

Vehicles involved:

2022 Great Wall Motors 4x4 Dual Cab Utility bearing NT registration

2010 Kenworth C508 Prime Mover bearing NT registration coupled with three trailers.

Both drivers held current appropriate licenses.

Vehicle Inspection:

On 26 August 2024, MVR Transport inspected the utility at the Tennant Creek Police Compound, due to the damage, the effectiveness of the vehicle's mechanical components could not be tested, but no faults were identified that may have contributed to the crash.

The airbag control module (ACM) data was unable to be retrieved as the module manufactured by Great Wall Motors is not supported by the Bosch Crash Data Retrieval (CDR) tool.

The Great Wall Motors 4x4 dual cab utility was purchased new at Darwin GWM in Darwin. A check of their records showed regular servicing with no adverse history.

The Kenworth C508 Prime Mover was not inspected by the MVR Transport Inspector as it was completely destroyed by fire, including any fitted data modules.

Seatbelt:

The driver's seat belt was found clipped into its shackle, with the lap and shoulder sashes pulled tight. This indicates that the driver deliberately secured the seat belt behind him, rather than wearing it correctly.

A review of his traffic history revealed a single infringement issued in Queensland in 2019 for not wearing his seat belt but his family said he usually wore his seat belt. There is insufficient evidence to suggest the driver habitually neglected to wear his seat belt

Opinion as to the Cause of Crash:

There was no evidence of negligence or fault by the truck driver.

There were no traffic reports to indicate that the driver was driving in anything other than a normal manner prior to the crash.

The driver's friends told police that he had been awake since the morning of 18 July 2024. He departed the unit at 2.50am on 19 July. Phone records reveal he spent about 1 hour or so in Katherine, much of the time on the phone. He spent 1.5 hours in Mataranka and 2 hours in Daly Waters. It is not known what he was doing during these stops, or whether he was resting, but there is evidence of a phone call and text from Daly Waters. Inclusive of those stops he had been on the road for about 13 hours before the crash.

Based on the evidence and mobile phone data it is likely the driver had been awake for about 36 hours in the lead up to the crash, with minimal rest.

The Transport Accident Commission Victoria has published Monash University research on the impact of fatigue on driving. Compared to 8 hours sleep, the risk of crashing after 5 hours sleep was 4.4 times higher. Under 5 hours sleep the risk increased substantially.[1]

Based on the facts available at the time of this report, it was the investigating officer's opinion that:

> The driver was affected by fatigue, leading to a slow drift over the centreline and into the path of the oncoming road train. The primary cause of the crash is likely fatigue.
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> The statement of the road train driver further supports this conclusion.
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> • Coming round the bend, he observed the vehicle on the centreline and expected it to return to its lane.
> • No evasive actions, such as swerving, were observed.
> • The vehicle maintained a steady trajectory into the Road Train's path.
> • The driver was just sitting upright, could not see his face but he was very upright.

There is no conclusive evidence to suggest suicide as the cause of the collision. The available facts point to fatigue as the more likely cause of this crash.

Responsibility for the collision lies with the driver who was driving on the wrong side of the road and collided head-on with the road train.

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.

[1] https://www.tac.vic.gov.au/road-safety/staying-safe/tired-driving