IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0033/2024

Police No: 24 12226

CORONERS' FINDINGS

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

I, Elisabeth Armitage, Coroner, have investigated the death of **FOUR PERSONS** whose deaths occurred on 3 February 2024, at Roper Highway in the Northern Territory. **These are Territory road fatalities 5, 6, 7 and 8 of 2024**

Introduction:

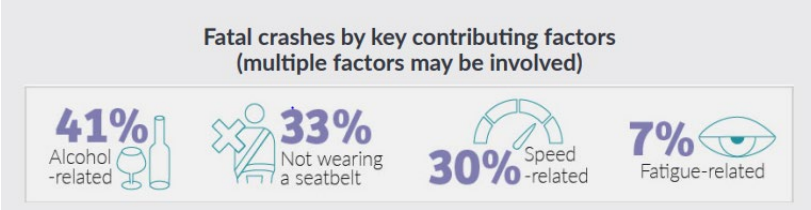
To date 50 persons have lost their lives on Northern Territory roads in 2024 compared to a total of 31 lives lost in 2023. Over the decade 2012-2021 on average 40 people lost their lives and 470 people suffered serious injuries on Territory roads each year. The average of 40 deaths per year was 3.2 times the national rate.[1] The Territory death rate on roads is by far the worst in the country and this year the death rate is trending to be the highest ever over the last 10 year period. The current road toll has been described as "disgraceful" and "outrageous" by Senior Territory Police members and the former Infrastructure Minister, Joel Bowden.[2]

In light of 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,[3] and my power to comment on public safety connected with a death,[4] 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 (eg. mobile phone)
- Fatigue

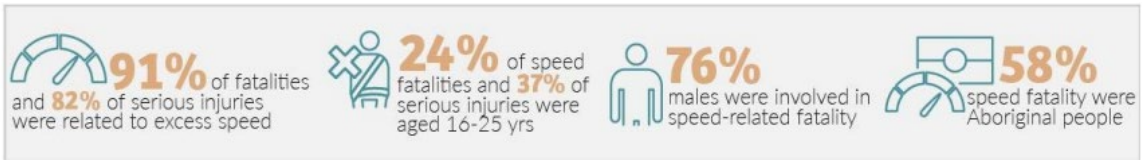
[1] Northern Territory Government, Towards Zero Road Safety Action Plan 2024-2028
[2] Fia Walsh, "'Disgraceful' road toll in crosshairs as NT road safety plan released", NT News, 25 July 2024
[3] Section 4A of the *Coroners Act 1993*
[4] Section 34(2) of the *Coroners Act 1993*



In the Northern Territory:[5]

- 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 2016 it was 27% higher than the national average[6]), and 25% of adult NT residents consume alcohol at a level that puts them at risk of long term harm[7]
- 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

It is known that inappropriate speed is often accompanied by other risky driving/riding behavior, such as non-seatbelt wearing and alcohol/drug involvement. The following diagram shows factors relating to speed fatalities for 2012-2021.[8]



On 3 February 2024, a 53 year old Aboriginal male driver of a Corolla was carrying 4 Aboriginal passengers. Passenger 1 was a 27 year old male, sitting in the front passenger seat. Passenger 2 was a 57 year old female and the driver's partner, sitting in the rear driver's side seat. Passenger 3 was a 57 year old female, sitting in the rear middle seat. Passenger 4 was a 63 year old female, sitting in the rear passenger side seat.

The Corolla was involved in a single vehicle roll-over crash and the driver and Passengers 2, 3 and 4 passed away at the scene from multiple blunt force injuries in combination with acute alcohol toxicity. Passenger 1 suffered serious but non-life threatening injuries.

[5] Northern Territory Government, Towards Zero Road Safety Action Plan 2024-2028
[6] 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
[7] Alcoholpolicy.nt.gov.au accessed 4 October 2024
[8] Northern Territory Government, Developing a new Towards Zero Road Safety Action Plan 2024 2028 Discussion Paper, pp19-20

The driver was the fifth death on Territory roads for 2024, Passenger 2 was the sixth death, Passenger 3 was the seventh death and Passenger 4 was the eighth death.

The deceased persons' blood alcohol readings were: driver - 0.28%, Passenger 2 - 0.2%, Passenger 3 - 0.16%, and Passenger 4 - 0.25%.

Neither the driver nor any of his passengers were wearing a seatbelt and all were ejected from the Corolla during the roll-over.

The speed of the vehicle (at the point of loss of control) was estimated to be 159 km/h on a single strip road with an unsignposted 110 km/h speed limit.

In this crash, which claimed 4 lives, at least three of the Fatal 5 were present: alcohol, speed and a failure to wear seatbelts.

Causes of death: Driver and passengers

1(a)	Disease or condition leading directly to death:	**Multiple blunt force injuries**
1(b)	Morbid conditions giving rise to the above cause:	**Reported single motor vehicle collision**
1(c)		**Acute alcohol intoxication of the driver**

Following autopsies on 8 February 2024, the Forensic Pathologists found:

- Concerning the driver, among other findings: lacerations and abrasions; fractures of the tibia, fibula, C7 vertebral, left scapula, ribs, left transverse processes of L1, L3 and L4, left acetabulum and superior pubic ramus, right tibial plateau and proximal fibula; blood around the spleen, suggesting possible splenic rupture; right haemothorax; left pneumothorax.
- Concerning Passenger 2, among other findings: blunt force injuries to the head; significant blunt force injuries to the chest and pelvis and blunt force injuries to the left arm involving the shoulder.
- Concerning Passenger 3, among other findings: lacerations and abrasions; subarachnoid haemorrhage; substantial soft tissue injury to the right side of the face, small fracture of the right alveolus in the maxilla; fractures of spinous process of C6, left laminar fracture of C7, transverse processes of T1 and T2 on the right, crush fractures of T6, T7, L1 vertebral bodies with multiple bone fragments in the vertebral canal with likely associated spinal cord damage; left transverse processes of T10 - L2; multiple bilateral rib fractures.
- Concerning Passenger 4, among other findings: significant blunt force injuries to the face and head, bilateral closed femur fractures and pelvic fracture.

- Concerning the driver the forensic pathologist concluded: I am satisfied that the cause of death was multiple blunt force injuries sustained during the incident. Post-mortem toxicological analysis showed a significantly elevated blood alcohol concentration of 0.28%, which is expected to correlate clinically with a strong degree of intoxication; some of the expected clinical effect include impaired muscle coordination, slow reflexes, blurry vision, unsteady gait, amnesia, and drowsiness.

- Concerning the passengers the forensic pathologists concluded: The deaths were due to the injuries sustained during the single motor vehicle collision.

Police investigation:

A coronial investigation by police found no suspicious circumstances surrounding these deaths.

Circumstances:

The driver lived with his partner, Passenger 2, in Jilkminggan.

Family members reported that he did not smoke very much but he did drink a lot of alcohol. The couple were known to travel to Mataranka on a regular basis to purchase alcohol. He had previously been on the Banned Drinkers Register (BDR) but his last active ban had expired in 2021. Although the driver did not hold a current drivers licence, he was known to drive a 2005 Blue Toyota Corolla.

On the morning of Saturday 3 February 2024, the driver and Passenger 2 were in Mataranka. CCTV footage records them re-fueling the Corolla and drawing cash from an ATM. While in Mataranka they acquired at least 1 carton of VB heavy beers, but when and where they acquired the alcohol is not known.

Witnesses said that the driver was already intoxicated by 2.30pm and driving around the "drinking area" with four passengers in the vehicle. A family member told him not drive back to Minyerri and suggested they catch the bus, but the driver ignored that advice and drove off with his passengers.

They travelled south from Mataranka and took the Roper Highway towards Jilkminggan and Minyerri. They continued past the Jilkminggan Community turn-off and stopped at the Strangways River crossing.

A family group were fishing at the crossing. The driver asked them for tobacco and they gave him some. Members from the fishing family said that the driver and all of the passengers were drunk and drinking from VB cans. Members from the fishing family offered to drive the car or suggested that Passenger 1 (who did not seem as drunk as the others) should drive. The driver disagreed and drove off with his passengers in the direction of Minyerri.

About an hour later the fishing family also drove off in the direction of Minyerri. The fishing family came across a crash site. They stopped their car well short of the crash as they did not want to expose their children to the crash scene. There were already two other vehicles stopped at the scene and occupants from those vehicles were checking on the driver and the passengers all of whom were lying on or near the road around the damaged Corolla. The fishing family recognised the driver and the other occupants. The driver, and Passengers 2 and 3 were deceased. But Passengers 1 and 4 were alive, although appeared seriously injured.

Two females (who were travelling in one of the original two cars which had stopped at the scene) left to call for help as there was no phone reception in the area. They drove approximately 20 kms to the

nearest station (Strangways Station). They used the station phone to report the crash to 000 at 7.12pm. They reported that a vehicle had rolled approximately 85 kms off the Stuart Highway (in the direction of Ngukurr) and that the station manager was travelling to the crash site with first aid kits.

Mataranka police members were called on duty to attend the crash scene. Mataranka clinic was notified and the clinic called in additional staff to attend the scene. The Mataranka Fire and Emergency Response Group (FERG) were notified to attend the scene. CareFlight was notified but advised they could only assist with a fixed wing aircraft from Tindall as they had no helicopters available to fly to, or land at, the crash site.

When the station manager arrived at the scene, Passengers 1 and 4 were still alive but, sadly, Passenger 4 passed away at about 8pm.

A clinic nurse and two ambulances (with drivers) were dispatched from Mataranka to attend the scene. When they arrived Passenger 1 was still alive but the driver and Passengers 2, 3, and 4 were declared deceased by the clinic nurse at about 8.45pm. Passenger 1 was transported by ambulance to Katherine District Hospital and then to Royal Adelaide Hospital for treatment. He was described as suffering from serious, but not life-threatening, pelvic, spinal and head injuries.

The FERG Captain arrived at the scene, followed closely by Police who arrived at 8.55pm. By that time it was raining heavily. Police observed the crashed Corolla on the road and four deceased persons all within 15 metres of the Corolla. A quantity of open and unopened VB cans were strewn throughout the scene.

Police spoke to the two females who had originally reported the incident. A crime scene was established and, as it was raining, the deceased persons were carefully placed in body bags and funeral directors were notified to collect the bodies for safe transport to the mortuary.

Members from the Major Crash Investigation Unit arrived at the crime scene at 10.40am on 4 February 2024. They were briefed by the initial attending Police members and examined the scene and the Corolla.

The crash site was on the Roper Highway next to Mole Hill, about 88 kms from the Stuart Highway (GPS 14 degrees53’35’”5 133degrees49’21”E). The road was a single lane with sealed asphalt and broad unsealed shoulders. The road surface was in good condition. The crash occurred on a right hand sweeping curve just after the road crested a hill. The station manager told police that she considered that the crash occurred at a “dodgy corner” and that the “whole road’s quite dangerous”.

At the time of the crash the weather was overcast but not raining and it was dusk.

The scene was photographed.

Selected photographs curtesy of Major Crash Investigators

Calculations were conducted on the yaw marks left on the road surface and a conservative speed of 159 km/h was considered likely at the point that control of the Corolla was lost.

The Corolla was inspected and was unroadworthy due to damage sustained in the crash. The Corolla was registered. The vehicle had passed a roadworthiness inspection on 21 August 2023, but witnesses reported that it was not in good repair by 3 February 2024. It was missing the rear window and the bumper bar was tied in place. These defects are not considered to have contributed to the crash.

The Crash Investigators concluded that the evidence at the scene indicated that a probable combination of speed, intoxication and possibly inattention caused the heavily loaded small vehicle to leave the sealed road surface as the road swept right on the crest of the hill. The driver attempted to make a correction to maneuver back onto the road surface but overcorrected. This caused the Corolla to enter a clockwise yaw which in turn caused the Corolla to slide across the road and down into a muddy and deep drain on the side of the road. The driver overcorrected again causing the Corolla to enter an anticlockwise spin and trip and roll as it met the soft mud. Due to the speed and taking into account the damage to the Corolla across all surfaces, it is estimated to have rolled three times before coming to rest on its wheels back on the road surface facing the direction that it had come from. The evidence indicates that none of the occupants had been wearing their seatbelts and all were ejected as a result of the violent rolling of the vehicle resulting in fatal, and serious, injuries being suffered.

The loss of four senior Aboriginal community members is a tragedy. They are mourned by their family and community.

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.