IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0211/2024

Police No: 24 83560

CORONERS FINDINGS

ROAD DEATH 44 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 54 YEAR OLD CAUCASIAN MALE** and without holding an inquest, find that he born on **29 December 1969** and that his **death occurred on 24 August 2024, at Arnhem Highway, Humpty Doo in the Northern Territory.**

Introduction:

60 people lost their lives on Territory roads in 2024. The highest road toll per capita in over a decade and by far the highest in the country. These findings concern road death 44.

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

There was no evidence of any of these factors in this crash on the Arnhem Highway.

The deceased was a licenced, sober driver, driving within the speed limit. Approaching him from the opposite direction was a warning vehicle which identified that it was being followed by an oversize vehicle.

Although the oversize vehicle was very wide, it complied with its permit and there was sufficient roadway left for most vehicles to pass without leaving the bitumen. However, as the deceased passed the road train his passenger side wheels left the sealed surface and entered the dirt verge. His vehicle then veered heavily right and collided with a road train that was following behind the oversize vehicle. Based on the available evidence it cannot be determined why the deceased veered sharply to the right.

His death is another tragedy on our roads. He is mourned by his family and friends, and his death comes at a cost to the broader 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 collision (driver)**

Following an autopsy on 26 August 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.
- At external and radiological examination, multiple blunt force injuries (head, neck, pelvis, and lower limbs) were present. Blunt force injuries were noted of the chest and left flank which may be in keeping with restraint-related/seatbelt injury. Toxicological analysis showed therapeutic concentrations and detection of reported prescribed medication (desvenlafaxine, metformin, irbesartan, hydrochlorothiazide and lercanidipine).
- Only prescribed medications were detected in his blood and nil alcohol.
- 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.

Police investigation:

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

Background:

The deceased had lived in the Northern Territory for about 16 years. He was a hard worker across a number of trades. He enjoyed working around the rural block where he lived, spending time on the tractor or lawnmower and building things. He loved going fishing and was a volunteer firefighter with Bushfires NT for about 8 years. He was described as a good bloke and a happy soul whose presence would lift a room.

Circumstances:

On the morning of Saturday 24 August 2024, the deceased travelled from his home to Coolalinga to do shopping in his blue 2017 Ford Ranger utility bearing Northern Territory registration plates. After leaving Coolalinga, he went to the OTR Service Station, and then the Humpty Doo Hotel bottle shop.

He departed the bottle shop at 10.19am and travelled east (outbound) from Humpty Doo on the Arnhem Highway past Edwin Road. A witness, EH, was in a vehicle immediately behind him as the speed limit increased from 80 km/h to 100 km/h. EH said that he wasn't speeding and appeared to be travelling at the speed limit of 100 km/h.

Approximately 1.5 km east of the Humpty Doo Hotel a white escort vehicle carrying a warning sign and warning lights approaching from the opposite direction. The vehicle was an escort for an Ostojic truck transporting a mining water truck from a quarry at Mount Bundy to Darwin as per the conditions of permit D85091.20 The water truck was loaded onto the flatbed trailer facing backwards with the left-hand side of water tanker extending past the width of the prime-mover and trailer.

Image of Ostojic truck on day of the crash

Another road user, AB, later described the truck and trailer as driving close to the edge of its side of the road with the water tanker extending past the centre line, however there was sufficient space for the oversize load to pass them without their vehicle having to leave the bitumen road surface. This was also the evidence of another road user, TG.

The section of road was straight and relatively flat with all witnesses describing being able to see the approaching oversize load clearly.

The oversize load was being followed by a Halkitis Brothers road-train being driven by UH from Mount Bundy to Pinelands. The road train was fitted with a vehicle tracking system which showed that the road train was travelling at approximately 73 km/h while behind the oversize load in the moments before the crash.

Shortly after 10.21 am, EH saw the deceased's vehicle passing the oversize load. EH described the deceased's Ford Ranger moving to the left to give space to the oversize vehicle but did not see any brake lights illuminate. EH saw the passenger side tyres of the Ford Ranger leave the bitumen road surface and they travelled into the dirt.

EH observed the Ford Ranger "lose control" and described that it "swerved straight into the oncoming road train".

The road train driver, UH, saw the deceased’s Ford Ranger with the passenger side tyres on the dirt just before it "skidded" across the road towards him.

The deceased’s Ford Ranger entered the westbound (inbound) lane and collided with the front, driver side of UH’s road train resulting in catastrophic damage to the Ford Ranger. The Ford Ranger was pushed back in to the eastbound lane, rotating 180°, and coming to rest approximately 24 metres from the point of impact. The road train veered off the road and came to rest in the cleared area on the southern side of the road.

EH, who saw the incident unfolding in front of her, slowed and pulled off the road. Other vehicles also pulled over and TG called emergency services. The phone was then handed to EH who had better local knowledge and she spoke to the call taker.

One of the vehicles that pulled over contained a nurse and she went to assist the deceased who was trapped in his driver's seat. At approximately 10.30am she examined him for signs of life but noted that his face had a cyanosed appearance, she could not feel a pulse, and she did not observe any signs of breathing.

St John Ambulance paramedics, Northern Territory Police and Northern Territory Fire and Rescue were dispatched to the crash. At 10.40am paramedics declared him deceased. He was left in-situ and the vehicle was covered with a tarpaulin.

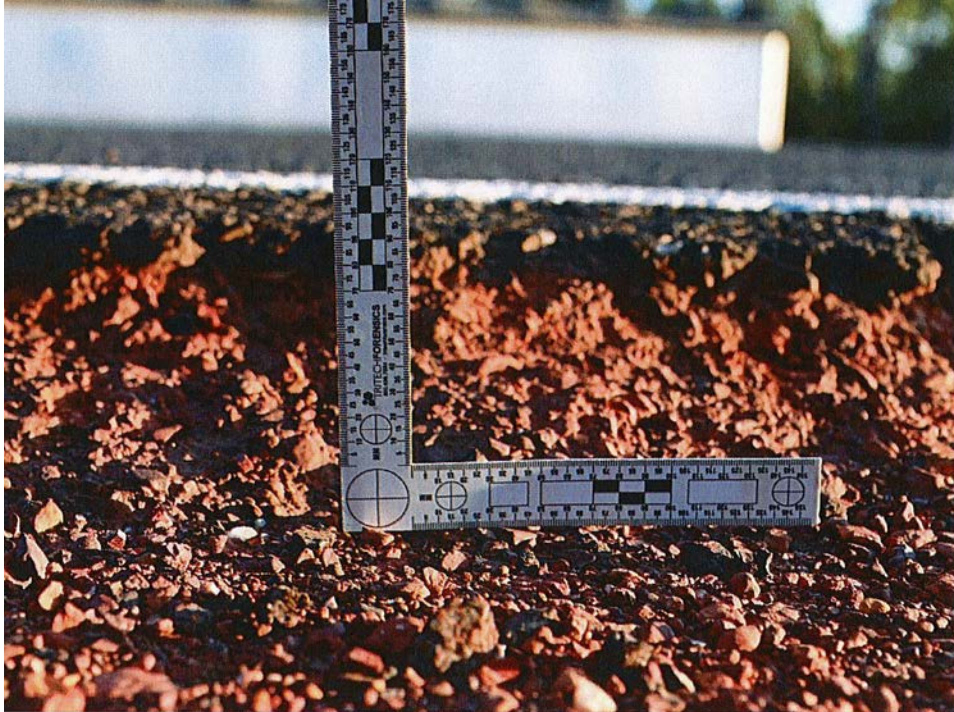
The road train driver, UH, was able to self-extricate through the passenger side door of his truck cabin and remained at the scene. He was examined by St Johns and cleared of any injuries. Attending police conducted a roadside breath test and preliminary drug test on UH which returned negative results.

Investigators from the Major Crash Investigation Unit (MCIU) attended the crash and commenced recording the scene through photography and a terrestrial survey. Arrangements were made with Northern Territory Fire and Rescue to reattend the scene to extricate the deceased from the vehicle.

A post-mortem examination was completed on 26 August 2024. It was the forensic pathologist’s opinion that the cause of death was multiple blunt force injuries from the reported motor vehicle collision. A sample of blood taken during the post-mortem was sent for toxicological analysis. The sample tested negative for alcohol and illicit substances with only prescribed medication detected.

An investigation into the cause of the crash was commenced with statements obtained from EH and other witnesses. The wide load truck and escort were identified through CCTV as belonging to Ostojic Transport. A copy of the permit was obtained, and a scan of the water tanker completed. The maximum width of the water tanker was 4.4 metres, within the 4.5 metre limit specified in the permit.

At the time of the crash, Major Crash Investigators noted a drop-off from the edge of the road surface to the dirt shoulder in the vicinity of the crash of up to 100 millimetres (10 centimetres). On 24 September 2024 a Fatal Accident Report Form was completed by a Road Operations Officer from Department of Infrastructure, Planning and Logistics. The drop off was noted on the report however it was deemed to be within safe tolerances.



Drop off from road surface to shoulder (MCIU photo)

Location:

The crash occurred on the Arnhem Highway, Humpty Doo, approximately 350 metres west of the Trippe Road intersection. The road is a straight bitumen road with one eastbound lane and one westbound lane separated by a broken white line. The outer edges of the lane are identified by a solid white fog line with a small amount of bitumen extending past the fog line before the road surface drops away to dirt with a 10cm drop-off. The dirt edge remains flat before sloping down from the raised roadway to the surrounding scrub.

The speed limit in the area is 100 km/h and the road surface was dry and appeared to be in good condition.

Weather:

On the day of the crash, the weather conditions were fine with light, scattered cloud and the road and surrounding edge were dry. The incident occurred in clear, daylight conditions.

Vehicles involved:

Vehicle 1 was a 2017 Ford Ranger utility bearing NT registration; and the deceased held a current NT driver's licence.

Vehicle 2 was a 2019 Volvo FMX 500 Prime Mover bearing Northern Territory registration coupled with two trailers. The driver, UH, held an appropriate driver's license.

Vehicle Inspection:

The Ford Ranger utility was inspected by MVR Vehicle inspector who defected the vehicle due to crash damage and was unable to test the vehicles systems due to that damage.

The Motor Vehicle Registry (MVR) Chief Transport Inspector attended the crash scene to inspect the Volvo truck and trailers. He found no pre-existing mechanical defects in the truck or trailers that may have caused or contributed to the crash. The truck and trailers were defected due to the crash damage they had received. A copy of a prestart checklist completed by UH was obtained from the prime mover with nil issues identified.

Tests and/or Calculations Conducted:

Due to the severity of damage to the Ford Ranger, imaging of the Ford Ranger's event data recorder (EDR) was not possible with current equipment available to the Major Crash Investigation Unit (MCIU). There was insufficient scene evidence (pre-crash tyre friction or yaw marks) to calculate a pre-impact speed for the Ford Ranger.

The drop-off from the road edge to the shoulder may have been a contributing factor to unsettling the Ford Ranger when it returned to the road surface, however, there is insufficient data and research to make conclusions regarding that theory.

Laser scans taken at the scene and of the Caterpillar water tanker were entered into Faro CAD software to show the estimated positions of the vehicles prior to the crash based on the information provided by witnesses to the crash.

The scan of the Water tanker on the road with its edge inside the inbound fog line and a model of a Ford utility with the same dimensions as the Ford Ranger alongside it was consistent with witness accounts. From the edge of the water tanker to the side of the road there was approximately 2.8 metres, which is sufficient for most vehicles to pass without leaving the road surface.

Water tanker and Ford utility reconstruction (Faro)

Opinion as to the Cause of Crash:

Based on the information available to investigators, there is no clear evidence to indicate why the deceased lost control of the Ford Ranger while attempting to return to the road surface causing it to cross onto the incorrect side of the road and into the path of the road train.

Decision not to hold an inquest:

Pursuant to 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. 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.