IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0026/2024

Police No: 24 12254

CORONERS FINDINGS

ROAD DEATH 4 OF 2024

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 34 YEAR OLD INDIGENOUS MALE** and without holding an inquest, find that he was born on **31 January 1990** and that his **death occurred on 3 February 2024, at Stuart Highway, Noonamah in the Northern Territory.**

Introduction:

These findings concern the death of a vulnerable pedestrian. He suffered from schizophrenia and psychosis, was under the care of the Adult Guardian, and lived in supported accommodation with rotational 24/7, 1:1 carers.

He was known to wander from his care home and a plan was in place for when that occurred. Sadly, during the evening of 3 February 2024 he managed to wander from his care home sometime after 7.20 pm, unbeknownst to his career who was busy doing other tasks.

He walked along the edge of the Stuart Highway in the direction of his family home but was very difficult to see and was struck by a Commodore driver at about 7.58 pm. Given the posted speed limit of 100kph and the limited visibility of the pedestrian, investigating police determined the crash could not be avoided.

The crash had occurred and he had already passed away, when his carer discovered that he was missing at 8.40 pm.

He was very close to his family, and he is his death is a tragedy for them and the wider 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 (pedestrian)**

1(c) **Diagnosed mental health illness**

Following an autopsy on 5 February 2024, the Forensic Pathologist, 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.
- The decedent had fractures of both tibia and fibula which were in keeping with "bumper fractures", abrasive injuries to the body and traumatic almost complete amputation of the left arm. Radiological findings confirmed the limb injuries, the presence of significant head injuries and measured the level of the lower limb fractures radiologically. Toxicology showed therapeutic levels of prescription anti-psychotic medication and presence of a cannabinoid metabolite which were not considered contributory to the cause of death.
- The injuries on the deceased at post-mortem examination was that of a high-impact collision injury with severe multiple limb injuries and head injuries.
- I have no reason to believe with the information available and findings made during external and radiological examination of the body that the death was due to any other cause than the injuries sustained during the motor vehicle collision.

Background:

The deceased pedestrian was born and grew up in rural Darwin. His mother said he was a quiet and shy boy whose family was everything to him. He had a good sense of humour, and he never complained. He suffered from schizophrenia and psychosis and was under Adult Guardianship and was living in 24/7, one-on-one, Supported Independent Living care when he passed away.

He had a Wandering Behaviour care plan. The plan directed his carers as follows:

> Staff must redirect him by offering to take him wherever he wants to go in a car to avert the danger of him walking away from the service.
>
> If he declines to get into the car, staff must follow him at a safe distance whilst in contact with either house coordinator or on call so that we have a sense of direction he would have taken.
>
> Staff should be able to describe the clothing he is wearing if he absconds because police require such information.
>
> Staff are to make sure he wears hi-vis all the time for easy identification and clear visibility during the night when he leaves the premises unsupervised.
>
> Staff are to follow a transporting protocol.

He was reported to have a good relationship with his support staff.

Circumstances:

On Saturday 3 February 2024 he spent the day at his care house and also visited his family home. In the evening, he had dinner and his medication.

At about 7.00 pm he requested to be taken back to his family's house. But as it was getting dark, his carer said that they would go back in the morning, after breakfast. He smoked a cigarette and walked to his room.

At about 7.05 to 7.10 pm he walked out of his room and left the care house. His carer watched him from the veranda. About 10 minutes later he returned to the care house and took the lounge room TV into his room, shutting and locking the door behind him.

The carer then conducted general cleaning of the house.

At some point, whilst the carer was cleaning or perhaps going to the toilet, he left his room and walked away from the care house.

He started walking south on the Stuart Highway, likely walking towards his family's house in Noonamah.

Dash camera footage provided by a passing driver captures him walking along the left side fog line, just south of the Elizabeth River bridge. The footage shows how difficult it was to see him on the side of the road, in the poorly lit conditions.

Stills from dash cam footage which reveal how difficult it was to see him. (Courtesy Major Crash Investigation)

That passing driver later provided an account to police and said, "He just popped out of nowhere. There was sort of a road sign there, I could see the reflection on the road sign and then he sort of come out of that. I didn't really see him until I was very close, I dunno, 20 metres maybe" and "because it happened so quick I didn't have time to veer around. He would have been very close to my car, maybe a metre or something like that".

Persons in another vehicle passed him between Elizabeth River Bridge and the intersection with Jenkins Road. That driver said that he had his high beams on and that he saw him out of the corner of his eye, about 8 to 10 metres away from him. The driver said he swerved to the right as he nearly hit him. The passenger said that she saw him walking near the solid white line in what she described as the bike lane and she "only saw him last minute".

The pedestrain passed the intersection with Jenkins Road. The intersection has street lighting installed which were inoperative on the night of the crash. Information provided by the

Department of Lands and Planning notes that the street lighting fault was reported Tuesday 2 January 2024 and that a work order had been generated and was classed as "ongoing".

At this time, a 2004 Holden Commodore driver was driving his station wagon south, in the left lane, on the Stuart Highway, travelling to Stapleton.

At about 7.55 pm the Commodore driver struck the pedestrian approximately 140 metres south of the intersection of the Stuart Highway and Jenkins Road. Scene evidence indicates that the pedestrian was positioned on the left side of the left lane when struck by the Commodore.

He was struck by the front passenger side of the Commodore. He wrapped onto the bonnet of the vehicle then struck the top of the windscreen and roof, causing the windscreen to shatter and the roof to slightly collapse. He was vaulted over the top of the Commodore subsequently striking and breaking the leading roof rack. He fell to the road surface where he tumbled and slid to a stop just inside the left edge of the left lane. During the crash event he suffered fatal injuries.

The Commodore driver steered off the road, stopped and called emergency services to report the crash at 7.58 pm.

A fellow motorist arrived moments after the crash, stopped and also called emergency services. Neither motorist went to the pedestrian’s location.

At 8.05 pm General Duties police arrived at the scene, located the pedestrian and found no signs of life.

The General Duties police spoke to the Commodore driver about the crash and breath tested him which produced a negative result.

Police from Darwin Traffic Operations attended the scene.

The Commodore driver was cautioned and asked about the crash. He said "I was driving along, come through the lights and this person appeared outta nowhere... I was right next to the fog line and that's where I hit 'em... Traffic lights were green, and I had the cruise control set on a hundred." He said his lights were on, "on low beam."

The Commodore driver was taken to the Palmerston Hospital and blood samples were obtained for toxicological analysis.

Major Crash members were called onto duty and attended the scene.

The pedestrian was photographed in situ, including photographs of visible injuries and he was conveyed from the scene by funeral services. He was not carrying any form of identification upon his person and was later identified by fingerprints.

The crash scene was processed, photographed and a terrestrial survey obtained.

Meanwhile, at about 8.40 pm his carer knocked his bedroom door and discovered he was not there. His carer conducted a search of the rest of the house and the outside areas.

At about 9.10 pm his carer contacted his employer to report him missing.

His carer extended his search by using the care house vehicle to drive to Noonamah. The carer searched near the pedestrians family home and surrounds in an effort to locate him walking along the road. When he could not find him the carer returned to the care home. Shifts were handed over between carers, all of whom continued to search for him at the locations he liked to frequent.

The pedestrian was identified via fingerprints on Sunday 4 February 2024 and his family were notified.

Location:

The crash occurred in the left southbound lane of the Stuart Highway, south of the intersection with Jenkins Road, Noonamah. There the Stuart Highway is four lanes with two south and two northbound lanes. The south and northbound lanes are divided by a nature median strip. The road surface is sealed and in good condition. The southbound lanes are divided by a broken white line. The lane edges are delineated by a solid white fog line.

The left side of the road has a small gravel and dirt shoulder that leads down into a grassy ditch which acts as a natural runoff for the road. The grass in the ditch was overgrown.

The posted speed limit is 100 km/hr.

Vehicle:

The vehicle was a 2004 Red Holden Commodore Station Wagon bearing NT registration. The driver was in receipt of a Current NT Multi Combination Licence.

An inspection of the headlights of the Commodore was conducted. The passenger side headlight was inoperative due to the substantial damage caused during the crash event. However, testing revealed that the headlight bulb intact. It was removed from the headlight casing and inspected. The headlight bulb was an Osram Bilux 12V 60/SSW H4. Once the passenger headlight was removed the driver's side was tested and found to be operational. Both headlights appear to have been operational at the time of the crash.

Weather:

At the time of the crash the weather was fine with light cloud. There was no street lighting installed on the outbound side of the Stuart Highway at the location of the crash. Street lighting was installed on the inbound side, opposite the location of the crash, at the intersection of Jenkins Road, however, the street lighting was inoperative at the time of them crash.

Sunset occurred at 7.18 pm. Civil Twilight ended at 7.41 pm. The crash occurred during Nautical Twilight which ended at 8.07 pm.

Tests and/or Calculations Conducted:

A human factor analysis of the circumstances of the crash was conducted by a Major Crash Detective Acting Sergeant. Given the available lighting and clothing of the pedestrian, the recognition distance was determined to be 33 metres. Tat the posted speed limit, the average driver response distance was 50 metres. In those circumstances the analysis concluded that the crash was unavoidable for the average driver.

Prosecution:

The Commodore driver’s toxicological analysis returned a positive result for methamphetamine and amphetamine.

He was charged with drive with prohibited drug in body, s 28 *Traffic Act* 1987. On 23 October 2024 he was found guilty and fined a total of $1150.

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.