CITATION: *Inquest into the death of Geoffrey James Hewitt* [2012] NTMC 027

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0066/2011
DELIVERED ON:	3 August 2012
DELIVERED AT:	Darwin
HEARING DATE(s):	1 June 2012
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Car accident, collision with truck, methamphetamine, amphetamine, cannabis, heart failure**

REPRESENTATION:

Counsel Assisting:	Dr Peggy Dwyer
Family of the Deceased:	Mr James Stoller, North Australian Aboriginal Justice Agency (NAAJA)

Judgment category classification:	B
Judgement ID number:	[2012] NTMC 027
Number of paragraphs:	14
Number of pages:	49

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0066/2011

In the matter of an Inquest into the death of

Geoffrey James Hewitt

ON 7 May 2011
AT Arnhem Highway, 6.2 kilometres east of the Point Stuart turnoff

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. On 7 May 2011, at approximately 3.15pm, Mr Geoffrey James Hewitt was driving a Toyota Hilux on the Arnhem Highway about 6.2 kilometres east of the Point Stuart turnoff, when his car veered onto the wrong side of the road. As a result, he was side swiped by a truck whose driver, Mr Graeme Lacey, was on the correct side of the road travelling north.

2. When Mr Lacey noticed the Hilux coming towards him, he attempted to take evasive action and swerved to the left. Unfortunately, he could not avoid contact between the vehicles and the truck and Toyota Hilux clipped each other, causing the Hilux to roll over. The deceased was ejected from the driver's seat and landed some 15-20 metres away from his vehicle. Although CPR and other first aid was provided by a number of concerned citizens who stopped to render assistance, he died at the scene around half an hour after the accident.

3. The jurisdiction and functions of the Northern Territory Coroner are set out in the *Coroners Act* NT ("the Act). Section 34(1) states that I "must, if possible" make findings in relation to:

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act; and

(v) any relevant circumstances concerning the death.

4. Those functions are expanded upon in s 34(2) of the Act, which provides that:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated".

5. Section 35 (1) and (2) grants a broad power to make recommendations that are related to the death, and reads as follows:

"(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) a coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner".

6. As it their right, the 'Senior Next of Kin' relied on s 23 of the Act to object to an autopsy being carried out on the ground that it would have offended the cultural beliefs of the deceased and his family. On 13 May 2011, the application was heard in the Darwin Supreme Court where her Honour Justice Kelly ruled in favour of the family, deciding that the need to identify the cause of death did not outweigh their cultural objections.

7. In those circumstances, I am not able to fully discharge my statutory function pursuant to s 34(1) to determine the cause of death, and neither can I be confident of all the relevant surrounding circumstances. In the absence of autopsy results I cannot ascertain the medical cause of death, nor can I exhaustively identify any factors affecting the deceased that may have contributed to the accident. Although I am satisfied that the deceased veered into the path of an oncoming vehicle, causing the accident, it is not possible to determine whether his driving was affected by a medical condition.

8. In the absence of clear medical evidence, my findings after inquest rely on circumstantial evidence and surrounding facts and I am able to advance a number of **possible** causes of death, and **possible** factors that contributed to the accident.

9. The Officer in Charge (OIC) of the investigation was Senior Constable Adrian Morris, who was meticulous in assembling the brief of evidence and preparing the matter for inquest. He is currently based at Nightcliff Police Station working with Darwin traffic operations.

10. In addition to the OIC, Senior Constable Morris, I heard oral evidence from Sergeant Mark Casey, who currently leads the Major Crash Investigation Section at Nightcliff Police Station and Forensic Pathologist, Dr Jane Vuletic.

11. A number of exhibits were tendered in the proceedings. The coronial Brief of evidence was exhibit 1 and the birth certificate of the deceased was exhibit 2. I was particularly pleased to receive a letter from the family, which became Exhibit 3. It gave me some insights into the character of the deceased and why those who knew him remember him so fondly and continue to grieve for him.

Relevant circumstances surrounding the death

Background

12. The deceased was born in Darwin on 16 June 1966, and was a member of a large, well respected local family. He was the youngest son of Marjorie and Ken Hewitt and had four sisters and seven brothers. I was informed that the deceased had a great love and respect for his parents and during the last years of their life he was devoted to caring for them.

13. The deceased was a descendant of the Marratheil people from the Daly River region. His Aboriginal name was Walu and although he went to school in Darwin and did not live a traditional life, he valued his culture. He was a gifted painter, woodcarver and didgeridoo maker and he enjoyed teaching children about Aboriginal art. He spent time at the family outstation, Delye, and he started a market garden there with friends and family.

14. As a teenager at Nightcliff High School, the deceased met Kathy Raymond and they had two sons, Damien and Geoffrey (Junior), who he raised along with his stepdaughter, Domi Raymond. In 2003 he commenced a relationship with Joelene Pettersen and the following year his daughter Iesha was born. His youngest child, Shakur, was born in 2008. The deceased had a deep love for his children, and it is obvious that he was an engaging father, nephew, son, uncle, brother and grandfather.

15. The deceased worked in a variety of jobs, but his primary focus was his art and I learnt that he travelled to many places in Australia to sell art and artefacts. He enjoyed that life of travel and freedom.

16. Medical records reveal that the deceased was not well at the time of his death and had been afflicted by a chronic heart condition for some time. In 2009, he had been diagnosed with cardiovascular disease after suffering from a heart attack and he had very high blood cholesterol.

17. As a result of those conditions, the deceased was prescribed medications, although it is apparent from the toxicology results that he was not taking them at the time of his death.

The accident on 20 July 2011

18. On the morning of 20 July 2011, the deceased left Darwin around lunch time and drove his white Toyota Hilux towards the Daly River region.

19. There was evidence before me to suggest that the deceased had been driving erratically on at least one occasion before he finally lost control of his vehicle. In the afternoon of 20 July, Mr Allan Sutherland was heading north returning to Darwin when he saw a white Toyota Hilux about five minutes after he had turned left onto the Arnhem Highway from the Point Stuart Road turnoff. I am satisfied that the Hilux was being driven by the deceased, given the description and location of the vehicle, and how few other cars were on the road at the time.

20. The Hilux was heading south and as it approached Mr Sutherland it veered onto the wrong side of the road, causing the side tyres to cross the white lines of the highway. Fortunately, on that occasion the deceased corrected his path of travel in time to avoid a collision but when Mr Sutherland looked

in his rear vision mirror after the near miss, it appeared to him that the driver nearly lost control.

21. Truck driver Graeme Lacey had been working all day in Kakadu and at 3pm, he was heading back to the Bark Hut. About 15 minutes into the journey he was negotiating a downhill sweeping left hand bend when he saw the white Toyota Hilux approaching him from the opposite direction. At that stage, the Hilux was about 15-20 metres away and the vehicle was veering right so that the driver's wheels were about two foot over the centre line and drifting towards the truck. Mr Lacey immediately veered left and he managed to steer the passenger side wheels of the truck onto the dirt shoulder of the road. Sadly, he was not able to avoid contact and his truck clipped the side of the Hilux driven by the deceased.

22. Mr Lacey was so focused on not tipping his truck that he didn't see the collision, but he stopped as soon as possible and saw a cloud of dust in his rear view mirror. When he got out he could see the Hilux in the bushland. It had rolled after being struck by Mr Lacey's truck and the deceased had been ejected from his vehicle.

23. Numerous travellers recognised that there had been an accident and they pulled their vehicles up to try and render assistance. Craig Herbert was the first person to attend to the deceased. He saw that he was lying on his stomach in a culvert about 15-20 mtrs away from his vehicle and was having increasing difficulty breathing.

24. Around 10 minutes later other members of the public stopped. They spoke to the deceased who was still conscious at that stage and was asking them to rub his back because it was sore. Ms Shara Huren was conducting a guided tour when she came across the crash site. She had first aid training and some equipment in her vehicle. Ms Huren, along with other citizens, Mr Murray Richardson and Mr Selwn Hornsell, worked together to provide CPR, including oxygen (using a face shield) and chest compressions. On the last

set of breaths the deceased vomited blood and was placed into the recovery position, after which only chest compressions were done.

25. After at least 30 minutes of continuous CPR, a doctor who was holidaying in the Northern Territory noticed the crash site and stopped to offer his assistance. Professor Ian Alexander is a doctor with nearly 30 years experience and at the time of this accident he held the position of Professor in Paediatrics and Molecular Medicine at the Westmead Children's Hospital in Sydney.

26. Professor Alexander observed that the deceased had no obvious compact fractures or external injuries, but that there were areas of contusion on the skin across his abdominal area, and the abdomen itself was distended and tense. Other civilians told him that they had been attempting resuscitation for the last 25-30 minutes, but that no oxygen had been given for the last 10 minutes. Professor Alexander examined the deceased and noted that he had no capillary return and no detectable femoral or carotid pulse. The deceased was pale and his pupils were fixed and dilated and did not respond to light. On the basis of these clear clinical signs of death, Professor Alexander advised that resuscitation efforts were futile and could cease. All of those who offered assistance at the scene did an admirable job of trying to save the deceased's life and I was impressed by the care and commitment they showed to a fellow citizen.

27. The first police officer on the scene was Senior Constable Rowan Wake, who was off duty and returning to Jabiru when he came across the crash. Senior Constable Wake found a significant quantity of cannabis in the Toyota Hilux, and he seized those drugs from the car and waited for officers from Humpty Doo to arrive.

28. Humpty Doo police had been notified of the crash at 3.22pm and arrived on the scene at 4.10pm. Further police attended to assist with traffic control and the Major Crash investigation Team was on scene at around 7.30pm.

29. The forensic examination carried out by the Crash Investigation Team clearly supports the version of events provided by Mr Lacey. I have carefully reviewed the "Field Sketch" of the crash scene and the information recorded therein to determine how the crash occurred, and I have had the benefit of detailed written and oral evidence given by Sergeant Mark Casey as to how to interpret the results of the police investigation. Sergeant Casey pointed out, for example, that an examination of the road revealed gouges, scrapes and tyre friction marks that were consistent with the deceased crossing onto the opposite side of the road. It was clear that the earliest part of the impact was on the wrong side of the road as far as the deceased's vehicle was concerned. Tyre prints and the location of debris were consistent with the Toyota Hilux clipping the side of the truck and then rolling to the spot in which it was located.

30. The truck driver involved in the crash, Mr Lacey, was breathalised and returned a negative result. There is no suggestion that he was in any way at fault in relation to the accident and it must have been a traumatic and frightening experience for him.

31. The crash occurred on a sealed section of the highway, which is in reasonably good condition and was dry on the day. The speed limit in the area was 130 km/h and speed does not appear to have been a factor in the crash. Both the Toyota Hilux driven by the deceased and the truck driven by Mr Lacey were examined and, although both had pre-existing faults, they were not faults that contributed to the accident.

Possible causes of the accident

32. It seems clear that the direct cause of the accident was that the deceased veered onto the wrong side of the road and side swiped the truck. That impact tore the right front wheel of the Hilux from the axle and the rear tyre

from the rim and caused it to roll over. Police found that the seat belt of the Hilux was not damaged, which may indicate that it wasn't worn by the deceased and would explain why he was ejected from the vehicle when it rolled.

33. What remains unclear is why the deceased's car veered onto the wrong side of the road and into the path of the truck driven by Mr Lacey. White centre lines on the relevant stretch of the road clearly indicate that drivers cannot overtake at that point, and the evidence of Mr Sutherland suggests that it was not the first time the deceased had drifted onto the wrong side of the road that afternoon.

34. What caused him to lose control of the vehicle and drift onto the other side of the road? Was it a heart attack or another medical issue? Was his ability to drive so badly affected by illicit drug use? Did he have a micro sleep? Was he distracted by something else in the car? There is circumstantial evidence that allows for a number of alternative theories, but the most likely scenario is that illicit drug use affected the deceased's ability to control the vehicle, or that he suffered a heart attack shortly before he veered into the path of the oncoming truck. Either way, it is likely that illicit drug use had a role to play in causing this death.

Cause of Death

35. When notified that the Coroner intended to do an autopsy to help determine cause of death, the Senior Next of Kin raised an objection on the grounds that an autopsy was not culturally acceptable and would cause unjustifiable hurt to the family of the deceased.

36. The *Coroner's Act* dictates the procedure that must be followed when the family raises an objection to an autopsy. The Coroner must not proceed with the autopsy unless they believe it must be performed immediately and the Senior Next of Kin may apply to a Justice of the Supreme Court who makes

a decision about whether to order the autopsy after weighing competing considerations. Section 23 of the Act provides:

> "Objections to autopsy
>
> (1) Where the senior next of kin of the deceased person asks a coroner not to direct that an autopsy be performed but the coroner decides that an autopsy is necessary, the coroner must immediately give notice in writing of the decision to the senior next of kin.
>
> (2) Unless the coroner believes that an autopsy needs to be performed immediately, where a request has been made under subsection (1), an autopsy must not be performed until 48 hours after the senior next of kin of the deceased person has been given notice of the coroner's decision under that subsection.
>
> (3) Within 48 hours after receiving notice of the coroner's decision under subsection (1), the senior next of kin of the deceased person may apply to the Supreme Court for an order that an autopsy not be performed and the Court, in its discretion, may make an order that no autopsy be performed".

37. On 13 May 2011, Justice Kelly ruled in favour of the family, deciding that the benefit of an autopsy in helping to determine cause of death did not outweigh the cultural objections raised.

38. As a result of that determination, no autopsy was carried out. A document entitled "Provisional cause of death" was completed by Forensic Pathologist Jane Vuletic, but the conclusion she reached was that the cause of death was "undetermined". Dr Vuletic gave oral evidence and she was able to offer an opinion as to possible causes of death on the basis of an external examination of the body of the deceased, toxicology results and medical records.

39. An external examination revealed a number of abrasions on the face, the trunk and on the lower limbs, consistent with contact of the skin on the road surface. Although these were not fatal injuries, they may have been suggestive of internal injuries that could not be seen or felt on visual

examination. In the absence of an autopsy, she could only speculate as to whether more serious, internal injuries had been sustained by the deceased following the collision with the truck.

40. Dr Vuletic reviewed the medical history of the deceased and learnt that he had a history of heart disease and had suffered a heart attack in 2009. She also knew that he had been prescribed medication, but was not taking it at the time of his death. In those circumstances, it was possible that the deceased had a heart attack immediately before losing control of his vehicle and that this ultimately caused his death. If the heart attack had been operating on the deceased for six to eight hours prior to his death, then it would have been detectable at autopsy. However, if the heart attack had a sudden onset, even an autopsy would not have yielded any positive proof of it.

41. It is clear that the deceased had used illicit drugs for a number of years and was under the influence of drugs at the time of the accident. A small sample of blood taken to allow for drug and alcohol analysis revealed the following substances:

> "1. methylamphetamine – 0.7mg/L
>
> 2. amphetamine – 0.04mh/L
>
> 3. ephedrine – 0.06mg/L"

42. In the car driven by Mr Hewitt, police found a large quantity of marijuana. There were two zip lock bags of cannabis, two small deal bags of cannabis, and one taped package of deal bags totally 100.4 grams. Mr Hewitt was well known to the police drug squad and they believe that the cannabis was destined for Jabiru or Oenpelli. Although a joint of marijuana lay on the

front seat, toxicology results showed that it had not been consumed by the deceased at the time of death.

43. Although it was not possible to state a definitive cause of death, Dr Vuletic posited three possible causes:

> " a) Multiple internal injuries sustained as a result of impact when the deceased was ejected from his vehicle
>
> b) A heart attack
>
> c) Heart failure caused by the shock of non-life threatening injuries sustained in the accident".

44. Dr Vuletic commented that the illicit drugs consumed by the deceased may have impacted on his death in two significant ways. Firstly, since those drugs clearly affect perception and function, on 20 July 2011 they may have caused him to drive erratically and lose control of the vehicle. Alternatively, drug use may have contributed to the medical condition that was the direct cause of death. Dr Vuletic gave evidence that long term illicit use of amphetamine and methamphetamine contributes to heart failure. The use of those drugs causes high blood pressure which in turn affects the arterial system within the heart and may led to fatal heart attacks.

Concluding remarks

45. As the Coroner of the Northern Territory, I am only too aware of how many families are devastated by the loss of a loved one in car accidents on our roads. I was reminded by Sergeant Mark Casey that the Northern Territory's road toll is more than twice the national average. In some years, it is more than three times the national average.

46. Illicit drug use is a factor contributing to the heavy road toll and is likely to have been a factor in this case, either directly or indirectly. Given the combination and amount of illicit drugs in the body of the deceased, I am confident that it affected his capacity to drive and may have led to him losing control of the vehicle. If the deceased was experiencing a heart attack immediately before he swerved onto the other side of the road, I have no doubt that his long term drug abuse contributed to his chronic heart condition.

47. Driving and drug use is a deadly combination and puts the lives of the drug user and other members of the public at risk. This sad inquest is a salutary reminder for those who share our roads that illicit drug use can lead to tragic vehicle accidents.

48. The deceased was a much loved member of his family and he will be deeply missed by them. I learnt a lot about him from a letter tendered by Counsel for the family, Mr Hewitt (Exhibit 3). A quote from that letter coveys the feeling the family have for the deceased and how much they will miss him.

> "At heart, Oogie was a family man who was good at cooking and enjoyed cooking for his family and he made many tasty meals for them. He had a great love for his young family as well as for his first family and was always there for all of them, 2 adult sons and 2 young daughters.
>
> To his brothers and sisters and their partners, nieces and nephews, and the Raymond Family, Oogie will be fondly remembered for his generosity and kind heart".

Formal Findings

49. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings in relation to the death of Geoffrey James Hewitt, as required by the Act:

i. The identity of the deceased was Geoffrey James Hewitt who was born on 16 June 1966 in Darwin in the Northern Territory of Australia.

ii. The time and place of death was at approximately 4.00pm on 7 May 2011 on the Arnhem Highway.

iii. I am unable to determine the medical cause of death.

iv. Particulars required to register the death:

a. The deceased was male.

b. The deceased's name was Geoffrey James Hewitt.

c. The deceased was of Aboriginal descent.

d. The cause of death was reported to the Coroner.

e. An autopsy was not performed because of objection by family.

f. The deceased's mother is Marjorie Hewitt and his father is Ken Hewitt.

g. The deceased lived at unit 42, number 45 Progress Drive, Nightcliff in the Northern Territory of Australia;

h. The deceased was employed as a labourer.

Dated this 3rd day of August 2012.

GREG CAVANAGH
TERRITORY CORONER