CITATION: *Inquest into the death of Cynthia Diane Ching* [2006] NTMC 039

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO:	A0039/2004
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HEARING DATE(S):	6 March to 9 March 2006
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Unexpected & accidental death, work place fire, reference to DPP & Commissioner of Police.

REPRESENTATION:

Counsel:

Assisting:	Mr Michael Grant
Counsel for Mr Edward Lee:	Mr Michael Williams SC

Judgment category classification:	A
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IN THE CORONER'S COURT
AT ALICE SPRINGS IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No: A0039/2004

In the matter of an Inquest into the death of

CYNTHIA DIANE CHING ON 27 MAY 2004 AT THE ROYAL ADELAIDE HOSPITAL AS THE RESULT OF BURNS SUSTAINED AT KINGS CREEK STATION IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

(Delivered 4 May 2006)

Mr Cavanagh SM:

The background to the inquest

1. Cynthia Diane Ching ("the deceased") was tragically burnt on the evening of 15 April 2004. Those burns arose from the use of a makeshift lantern which employed aviation gas ("Avgas") as a fuel. The deceased was a Canadian national. Prior to the injury, the deceased was enjoying a working holiday with her sister in Australia. She was, at the time, working on Kings Creek Station outside Alice Springs in the Northern Territory of Australia.

2. The incident took place at the residence of two helicopter pilots who operated a tour concession from the Station. The makeshift lantern had been constructed by one of those pilots. The burns were sustained during an attempt by one of those pilots to refuel the lantern using an open beaker of Avgas. The deceased was entirely uninvolved in the construction, use or refuelling of the lantern. The deceased was visiting the residence in company with other workers from the Station as part of a social gathering. She was in all respects an innocent bystander who sustained injury as a result of the stupidity of another and the cruelty of fate.

3. The deceased died some six weeks later at the Royal Adelaide Hospital from multiple infections that she sustained as sequelae to the burns.

Jurisdiction of the Northern Territory Coroner

4. Following the deceased's death in South Australia, the South Australian Coroner determined that a post-mortem examination was not required. The formal cause of death given by the intensive care unit at Royal Adelaide Hospital was septicaemia due to enterococcus bacteria leading to multiple organ failure.

5. The Territory Coroner has jurisdiction in the matter by reason of the fact that the cause of death occurred in the Territory. Section 12 of the *Coroner's Act* ("the Act") defines "reportable death" as follows:

> "reportable death" means –
>
> (a) a death where –

(i) the body of a deceased person is in the Territory;

(ii) the death occurred in the Territory; or

(iii) the cause of the death occurred in the Territory,

being a death –

(iv) that **appears to have** been unexpected, unnatural or violent or to have **resulted, directly or indirectly, from an accident or injury**;

(v) that occurred during an anaesthetic;

(vi) that occurred as a result of an anaesthetic and is not due to natural causes;

(vii) of a person who, immediately before death, was a person held in care or custody;

(viii) that was caused or contributed to by injuries sustained while the person was held in custody; or

(ix) of a person whose identity is unknown; "

6. Following her death, the deceased's recent medical history was referred to Professor Anthony Ansford, a consultant forensic pathologist who also holds a chair at the University of Queensland. Professor Ansford has opined that if there were no burns there would have been no subsequent infection and death. Given this causal nexus, I have jurisdiction. Professor Ansford's evidence is subject to further examination later in these Findings.

Nature and scope of the inquest

7. Section 34(1) of the Act details the matters that an investigating coroner is required to find during the course of an inquest into a death. The section provides:

"(1) A coroner investigating –

(a) a death shall, if possible, find –
(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; or…"

8. Section 34 of the Act requires a coroner to find, amongst other things, the cause of the death. This connotes a finding both as to the medical cause of the death and the manner in which it took place. The traditional categories of finding in relation to the cause of death are unlawful homicide, lawful homicide, suicide, misadventure, accident, natural causes, and an open finding.

9. A coroner is also required in these circumstances to find any relevant circumstances concerning the death, to explore issues relevant to the administration of justice and public health and safety, and to make relevant recommendations, if any, with respect to the prevention of future deaths in similar circumstances. To that end, s34(2) of the Act operates to extend the coroner's function as follows:

"(2) 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."

10. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s35 of the Act, which provides 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.

"(3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

11. These duties reflect the fact that one of the primary purposes of the coronial jurisdiction is "to seek out and record as many of the facts surrounding the death as public interest requires": see *R v South London Coroner; Ex parte Thompson* (1982) 126 Sol J 625 at 628. This function requires a coroner to draw together the investigation materials to see what can be learned and understood, and what may be done to avoid repetition of adverse events. In undertaking this process, a coroner is operating independently of the political and prosecutorial processes.

12. The public Inquest in this matter was heard at the Alice Springs Courthouse between 6 and 9 March 2006. Counsel assisting me over the course of the Inquest were Mr Michael Grant and Ms Helen Roberts. Mr Michael Williams SC of the Sydney Bar sought leave to appear in a limited capacity on behalf of Mr Edward Lee, one of the helicopter pilots. He was present during Mr Lee's examination-in-chief, asked various questions of Mr Lee, and presented a statement to the Inquest from Mr Lee's parents at the conclusion of his evidence. Mr Williams took no further part in the matter. His participation and assistance were appreciated.

13. Counsel called the following witnesses during the course of the Inquest:-

(1) Detective Sergeant Wayne Newell, who was the police officer who investigated the matter on behalf of the coroner and the Northern Territory Police.

(2) Carolyn Ching, a sister of the deceased who bears the burden of having witnessed the accident that led to her sibling's death.

(3) Ben Harris, one of the helicopter pilots who lived at the residence in question. Mr Harris was not involved in the incident, and did not see the incident, but he was able to give contextual evidence in relation to the use of the lanterns.

(4) Anna Williams, an employee at the Station who witnessed the accident.

(5) Edward Lee, the other helicopter pilot who lived at the residence in question. It was Mr Lee who was refuelling the lantern when the incident occurred. It should be noted that Mr Lee agreed to give video evidence from New Zealand. The Territory Coroner had no coercive power to require him to attend in person.

(6) Cameron Jellie, the maintenance manager on the Station. Mr Jellie witnessed the accident.

(7) Sergeant Alistair Taylor, the Officer in Charge of Kulgera Police Station. The manager of Kings Creek Station made a conversational

reference to or report of the accident to Sergeant Taylor the following day.

(8) Michael Van Der Zypp, the managing director and chief pilot of The Helicopter Group, which operated the tour concession on the Station.

(9) Josef Schofield, a worker at the Station at the time. Mr Schofield operated the sunset camel ride on the Station and was widely known as "Camel Joe". Mr Schofield was in attendance at the social gathering. Quite coincidentally, and fortunately, Mr Schofield was also a qualified nurse and was the person who applied the initial first aid to the deceased. His ministrations were, of course, to no avail.

(10) Ian Conway, the owner and manager of Kings Creek Station. He attended at the aftermath of the incident.

(11) Sally Conway, the daughter of Ian Conway and a worker at the Station. She witnessed the accident.

(12) Dr Nai An Lai, the Intensive Care Registrar at the Royal Adelaide Hospital during the course of the deceased's confinement and treatment there.

(13) Professor Anthony Ansford, the expert forensic pathologist.

(14) Dr Peter Thatcher, a Forensic Scientist with special qualifications in relation to flammable materials.

(15) Steven Jordan, the Royal Flying Doctor flight nurse who accompanied the deceased to Alice Springs.

(16) Dr Peter John Setchell, the General Manager of the Health Services for Central Operations of the Royal Flying Doctor Service

14. Whilst not called as witnesses, the parents of the deceased, Rafael and Sandra Ching, made oral statements at the conclusion of the Inquest outlining their thoughts and concerns in relation to the matter. They also thanked coronial staff and Counsel assisting me, and noted the "professional", "unbiased" and "fair" conduct of the Inquest. I was grateful for their input and appreciative of the grace they displayed in what were obviously trying circumstances.

15. The Inquest also received statements from a further 10 witnesses who assisted in or were present during the treatment of the deceased from the time of the initial incident until her subsequent death.

16. Having heard from these witnesses, and having considered the statements, I was satisfied that all matters directly and indirectly germane to the deceased's death were canvassed during the course of the Inquest.

Formal Findings

17. The mandatory findings pursuant to s34(1) of the Act are as follow.

(1) The identity of the deceased was Cynthia Diane Ching. She was born in Vancouver, British Columbia on 10 December 1974.

(2) The death occurred at 2:40 a.m. on 27 May 2004 at the Royal Adelaide Hospital.

(3) The cause of death was multiple organ failure following persistent sepsis occurring as a complication of severe burns following an accident.

(4) The particulars required to register the death are:

(i) the deceased was female;

(ii) the deceased was of Canadian nationality;

(iii) the South Australian Coroner determined that no post-mortem examination was required;

(iv) the father of the deceased is Rafael Kakeng Ching;

(v) the mother of the deceased is Sandra Patrice Ching, nee Blackstock;

(vi) at the time of her death the deceased was ordinarily resident in Richmond, British Columbia; and

(vii) the deceased's occupation was that of a Legal Assistant.

Relevant circumstances concerning the death

18. The bare factual background to the death of the deceased is set out in the opening paragraphs of these Findings. The broader context is as follows. As stated, the deceased was a Canadian citizen. In September 2003 the deceased came to Australia on a working holiday. She was joined by her sister in December 2003. They stayed in Brisbane until January 2004. Thereafter, they travelled to Sydney. They met up with the deceased's mother in March 2004. They travelled with her until 10 April 2004, when the mother departed Alice Springs to return to Canada. The deceased commenced work at Kings Creek Station outside Alice Springs on 13 April

2004. She was accompanied by her sister. They were employed as general cleaners and kitchen hands.

19. Kings Creek Station is located in central Australia, approximately 450 kilometres southwest of Alice Springs. Its primary activity is camel farming. It also operates a tourist venture involving accommodation, food and fuel, motorbike and camel safaris, and helicopter flights. Kings Canyon is in relatively close proximity. The helicopter business on the station was run under licence by an entity styled The Helicopter Group. The business employed two helicopter pilots to conduct flights from the Station to Kings Canyon.

20. On 15 April 2004, the deceased and her sister attended a social function at the helicopter pilots' residence on the station. Earlier that evening, approximately 20 staff members had dinner in the station restaurant to celebrate one of the staff leaving. Following dinner, some staff continued to drink and talk at the tables outside the restaurant. Between approximately 8:30 p.m and 9 p.m., a number of staff went back to the pilots' residence to continue the celebration. Some went directly. Others, including the deceased, returned to their own residences first in order to freshen up.

21. The pilots' residence was comprised by a “demountable” (a transportable residential unit) eight metres long and four metres wide with an attached treated pine deck approximately three metres long. The residence was approximately 75 metres from the helipad on the station. There were two tables and various chairs on the deck. A rectangular table was situated contiguous to the wall of the demountable. A circular table was situated toward the open side of the deck. Eleven (11) other people were present on

the deck with the deceased at the relevant time. Most were seated. There were two homemade lanterns in use. Their location is dealt with further below. The lanterns were made from beer cans filled with a sand and Avgas mixture, which was ignited. The beer cans had had their tops cut off. The pilots later told investigating Police that the lanterns were used to provide exterior lighting as no electric or other lighting was provided to the exterior of the residence. The lanterns had apparently been in use for some four weeks prior to the incident in question.

22. At or about 10:15 p.m.., Lee attempted to reignite a lantern that had gone out. In doing so he set his left arm alight causing him to release, or possibly throw, the jar of fuel he was using to refill the lantern. The spilt fuel ignited and splashed over the deceased. The precise mechanism by which the fuel initially ignited is also dealt with further below.

23. Lee immediately assessed the situation, grabbed the deceased and pulled her from the deck and onto the ground, and rolled himself and the deceased in the sand until the flames were extinguished. Whilst Lee is to be commended for his quick thinking and bravery in so doing, that commendation is necessarily tempered by the fact that he was the author of the deceased's misfortune in the first place. The deceased received burns to her legs, arms and chest.

24. The deceased was taken to a shower and placed under cold running water. Mr Schofield, the station employee who is identified above as Camel Joe, provided initial first aid. The clinical nurse from the Kings Canyon Resort arrived at 11:35 p.m. She discussed the situation by phone with the District Medical Officer. The nurse was unable to cannulate the deceased in order to administer fluid because the deceased had peripherally shut down due to

cold, burns and shock. The deceased was administered morphine for pain relief and Maxalon for nausea.

25. The deceased and Lee were subsequently conveyed to the airstrip to await the arrival of the Royal Flying Doctor Service. The Royal Flying Doctor Service aircraft arrived at 12:25 a.m. The flight from Kings Creek Station to Alice Springs took approximately 45 minutes. The deceased arrived in Alice Springs at 1:35 a.m. She was transported to the Alice Springs Hospital by the St John Ambulance. She arrived at the hospital at 2:10 a.m. on Friday, 16 April 2004.

26. On arrival at the Alice Springs Hospital, the deceased was diagnosed with burns to 60% of her body. She was stabilised and immediately underwent surgery to her right arm to release pressure.

27. At 6 a.m. on Friday 16 April 2004, the deceased was flown to the Royal Adelaide Hospital. She arrived at about 2:30 p.m. on that day. There, the deceased's burns were cleaned, she was intubated, and broad spectrum antibiotics were administered. Skin grafts were applied on 22 April 2004. Further grafts were applied on 27 April 2004. On 30 April 2004, the deceased suffered respiratory failure and required ventilation support. The deceased went into septic shock, which exacerbated an original bacterial infection. On 3 May 2004, the deceased developed acute renal failure. On 25 May 2004, various organs were removed. Gangrene became apparent in the deceased's left thumb and foot.

28. The deceased died on 27 May 2004. She was 29 years of age at the time.

29. The death was reported to the Coroner's Constable in Alice Springs on 27 May 2004. An investigation was conducted. Statements were obtained from all persons present at the scene of the incident. Those statements were tendered as part of Exhibit 1 during the course of the Inquest. As stated above, all material witnesses were called to give oral evidence during the course of the Inquest.

30. On 31 January 2005, the Office of the Director of Public Prosecutions opined that there were reasonable prospects of a conviction of Lee for "Dangerous Act Causing Death" contrary to s154 of the Northern Territory Criminal Code. An information was subsequently filed.

31. Lee is a New Zealand national. He returned to New Zealand following the death of the deceased. Attempts to extradite him from New Zealand were unsuccessful because there is no counterpart offence to "Dangerous Act Causing Death" in that country. It should be noted that the offence of "Dangerous Act Causing Death" does not require any intention to harm. It is a modern, and rather unique, reformulation of the old offence of criminal negligence. Whatever else the evidence may have disclosed, there is no doubt that this was not an intentional act on the part of Lee.

32. The criminal charges have since been withdrawn. That was a determination within the exclusive province and made in the exercise of the prosecutorial discretion of the Director of Public Prosecutions. That is not a matter into which I may usefully inquire. I would only observe that it came to light during the course of the Inquest that the parents of the deceased were not advised of the withdrawal of the charges through any official channel. They found out from a friend who had apparently seen a press report to that

effect. That there was no timely official communication with the parents of the deceased in relation to the matter is to be regretted.

33. Against that factual background, the issues that arise for particular consideration are as follows:-

(1) The circumstances leading to the burns, including a consideration of the safety of the lamp devices.

(2) Whether the matter should be referred to the Director of Public Prosecutions and the Commissioner of Police to consider a belief by me that a crime may have been committed in connection with the death.

(3) What occupational health and safety responsibilities the owner/manager of the helicopter business and the owner/manager of the Station had in relation to the use of the devices.

(4) The timeliness of the deceased's aeromedical evacuation from the Station, and her subsequent transfer to Adelaide.

(5) The ultimate cause of death and the appropriateness of the deceased's medical treatment.

(6) The account given by the Station manager to the Northern Territory Police, and the fact that investigations were not conducted until after the death of the deceased.

The precise mechanism of the injury

34. The precise mechanism of the injury is relevant to both public safety issues and the determination whether a crime may have been committed requiring referral of the matter to the Commissioner of Police and the Director of Public Prosecutions.

35. The first observation to be made in this respect is that the participants were all drinking alcohol at dinner. The evidence would seem to disclose that all were drinking moderately. I can find on the basis of Carolyn Ching's evidence that she and the deceased had one beer each during dinner. It is unclear precisely how many Lee had during dinner. He says one in the statement he initially gave to Police. I see no reason to doubt the estimate he made at that time.

36. The gathering moved to the deck at the pilots' residence at or about 8:30 p.m. Lee, Harris and Dan Antonik were drinking from that time. Others came in staggered fashion until approximately 9 p.m. All were drinking in varying quantities up to the accident in question. The time of the accident may be put with some precision at or about 10:15 p.m. This is based on Mr Conway's very clear recollection that he was fetched at 10:30 p.m., a time he specifically noted from the bedside clock, and that this was some 15 minutes after the incident.

37. There is conflicting evidence as to whether Lee, or indeed anybody else present, drank in sufficient quantities between 8:30 p.m. and 10:15 p.m. so as to be intoxicated. Lee said in his evidence that he had approximately four beers over the period. That estimate may be correct. I do not intend to do Lee any disservice in observing that in the circumstances this would be,

if anything, an underestimation rather than an overestimation of the quantity he consumed; such is human nature.

38. The bulk of the witnesses in attendance on the deck, and in fact all but one, say that no one present was intoxicated. It is of particular note that Carolyn Ching did not perceive anybody present to be intoxicated. It should be noted that those witnesses were participants in the gathering which was, by all accounts, a generally convivial and high-spirited affair. Their recollections must be viewed in that context.

39. Ranged against those recollections, the maintenance manager, Cameron Jellie, observed that Lee was "tipsy". That recollection received some support from observations made by Mr Conway to the effect that Lee appeared intoxicated immediately after the event. Mr Conway's observations after the event must be seen in light of what had transpired. His assessment of Lee's condition might have been attributable to the trauma and shock to which Lee had been subject. Lee himself was quite badly burnt. Having said this, the observations cannot be totally disregarded in circumstances where Mr Conway has a long and broad experience of life, including exposure to trauma over the years in the context of road and other accidents on and in the vicinity of Kings Creek Station. On the other side of the coin, I note Van Der Zypp's evidence that when Mr Conway reported the matter to him some days later, Mr Conway indicated that intoxication was not a factor in the accident.

40. In assessing this evidence, I also take into account the fact that Mr Jellie is Mr Conway's nephew. There was nothing in their respective demeanours, and nothing apparent from any other contextual factor, which gave rise to

any suspicion or concern that the concurrence in their recollections in this respect was attributable to familial collusion.

41. Having regard to that evidence, I find that Lee consumed at least four full strength beers over the period on the deck. Given that level of consumption, he was necessarily affected by alcohol to some degree. In saying this, I do not suggest that he was out of control or that his judgement was impaired. He simply experienced the relaxing effects and the mild social disinhibition that any fit, young man would enjoy having consumed that quantity of alcohol. Given the objective facts, the Jellie description that Lee was "tipsy" rings true. Conversely, I find that the deceased was unaffected by alcohol at the time. Carolyn Ching's evidence was that the deceased had, perhaps, half a beer over the period on the deck.

42. What happened next is beyond any real doubt. The makeshift lanterns were in use on the deck. If one accepts the evidence of Lee and Harris, their primary purpose was to provide light. Having regard to Mr Conway's evidence in relation to the ambient light sources from inside the residence and the nearby machinery shed, I consider it likely that the lanterns were not necessary for that purpose and were used principally for "mood" (in the manner of candles on a dining room table).

43. Lee sought to refuel one of the makeshift lanterns. It was located on the rectangular table described above. In order to do so he used a large, open-necked glass jar that was provided by the fuel company for the purpose of draining Avgas from the tanks at the helipad. It is at this point that Dr Thatcher's evidence assists in determining the chain of events. Avgas is an extremely volatile hydrocarbon compound with similar properties to petrol. It is Dr Thatcher's thesis that fuel spilled from the jar onto the table, as one

might expect in the course of pouring fluid from a large container into a receptacle of relatively small diameter, such as the beer can in this case. The vapour from that spilt fuel and the surrounding air formed a mix that reached explosive limits and was ignited by the flame from the other makeshift lantern located at the opposite end of the table.

44. It is possible to conclude from Dr Thatcher's evidence that the ignition point was not located on the circular table on the open side of the deck. The evidence from those witnesses in attendance is that at the point of ignition the flame was confined to the area of the rectangular table. With the benefit of retrospective examination, that evidence indicates a point of ignition somewhere between the first and second makeshift lanterns, with the flame travelling along the vector of the air/vapour mix to the glass jar held by Lee. Had the point of ignition been located on the circular table, the gas would have ignited at a point in the middle of the deck somewhere between the circular and rectangular tables, and the flame would have travelled along that vector back towards Lee.

45. For that same reason, I am able to discount the possibility that the point of ignition was a static spark or caused by somebody lighting a cigarette elsewhere on the deck. Finally, I am also able to discount the possibility that the rim of the beer can remained hot due to the fact that it had been burning for some time prior to the refuelling process, and that this formed the point of ignition. It was Dr Thatcher's evidence that he had conducted tests in that respect, and that the rim of the can was incapable of retaining sufficient heat to act as an ignition point.

46. Once ignition had taken place, the flame ran to the jar and up Lee's arm. At this point, Lee was facing the rectangular table. The deceased was seated

behind and slightly to Lee's side. Lee reacted, naturally, by pulling his hand away from the jar. In performing that manoeuvre, as demonstrated by Lee and a number of the other witnesses during the course of evidence, he doused the deceased with the fluid. In order for that to occur, the fluid travelled either behind him or around his body to make contact with the deceased. I am able to make the positive finding that the deceased was doused with fluid on the basis of the Thatcher evidence. Dr Thatcher opined that the only conclusion to be drawn from the severity of the burns sustained by the deceased is that there was Avgas on her clothing operating as a fuel.

47. Any discussion of the mechanism of the injury would be incomplete without some examination of the provenance of the lanterns. I find, on the balance of probabilities, that they were devised by Lee. Mr Van der Zypp gave evidence of a conversation with Lee, where Lee stated that he had known of the devices from New Zealand. Harris gave evidence to the effect that his recollection was that Lee devised the lantern using a shallow dish containing sand infused with Avgas. That then developed into the beer can design in use on the night of the accident. Lee did not seek to deny the accuracy of those recollections. It was his contention in evidence that he could not recall how, when or by whom the lanterns were devised.

Reference pursuant to s35(3) of the Act

48. It falls then to determine whether the matter should be referred to the Commissioner of Police and the Director of Public Prosecutions. That calls for an assessment of the danger inherent in the use of the lanterns. I find that refuelling the lantern in the circumstances was manifestly dangerous. Dr Thatcher described the danger in the following terms:

"I see. All right. You've given some consideration in your report as to the practise of burning fuel in a can containing sand. What's your opinion in that respect, for his Honour?---I think that you've got to be careful here in defining what we're talking about in burning fuel in a can. If we're just talking about a can with sand in it and petrol absorbed into the sand burning it's actually not particularly dangerous. It's the actual preparation of that torch or whatever you want to call it that is absolutely very dangerous. Once it's lit technically, theoretically, it's not particularly dangerous and even if the can falls over, and my experiments show that it doesn't spill out of the can anyway. It's not the burning of the can so much as the filling of the can and the ignition of the can.

All right, and why is that such - - -?---And that is – sorry?

Why is that such a hazardous activity?---Because when the can is burning no vapour can be released from the can without it also burning. That's why you have a torch effect. But when you're actually filling the can near an ignition source you've got a large amount of vapour being produced from the delivering vessel to the receiving vessel and that's where the danger lies because sooner or later you are going to reach those explosive limits.

…..

It's difficult to talk about it on scales, but just in lay person's terms how dangerous is that activity?---With a naked flame near it, are we talking about?

Yes?---Oh, 10 out of 10. It's absolutely a lethal situation. It's only a matter of time before the vapour from the delivering vessel would catch fire because it would flash back from the ignition source back to the delivering vessel."

49. This expert evidence only confirms the commonsense view that the activity was dangerous. This is not simply a reconstruction with the benefit of hindsight. Schofield and Jellie gave evidence that upon seeing the lanterns on the night in question they were concerned about the danger that they presented. One of those present even raised the matter with the pilots, but

was assured that the practice was safe. It should have been apparent to Lee and Harris that the use of the lanterns in that fashion was inherently dangerous. All the witnesses, save Lee, accepted that.

50. The relevant section provides that "a coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner". (Emphasis added.)

51. Section 154 of the Northern Territory Criminal Code provides:

> **"154. Dangerous acts or omissions**
>
> (1) Any person who does or makes any act or omission that causes serious danger, actual or potential, to the lives, health or safety of the public or to any person (whether or not a member of the public) in circumstances where an ordinary person similarly circumstanced would have clearly foreseen such danger and not have done or made that act or omission is guilty of a crime and is liable to imprisonment for 5 years.
>
> (2) If he thereby causes grievous harm to any person he is liable to imprisonment for 7 years.
>
> (3) If he thereby causes death to any person he is liable to imprisonment for 10 years.
>
> (4) If at the time of doing or making such act or omission he is under the influence of an intoxicating substance he is liable to further imprisonment for 4 years.
>
> (5) Voluntary intoxication may not be regarded for the purposes of determining whether a person is not guilty of the crime defined by this section."

52. In order to establish a breach of s154 the Crown would need to prove that: (1) on 15 April 2004, Lee refuelled the lantern in question; (2) that in refuelling the lantern, Lee performed an act which caused serious actual danger to the life of the deceased; (3) that Lee's act of refuelling the lantern was done in circumstances where an ordinary person similarly circumstanced would clearly have foreseen serious actual danger to the life of the deceased and would not have committed the act; and (4) that when Lee performed the activity he did not hold an honest and reasonable, but mistaken, belief in the state of affairs which, if it had been the true state of affairs, would have meant that his act would not have caused serious actual danger to the life of the deceased. So far as the latter element is concerned, a purported belief, for example, that Avgas vapour would not be ignited on exposure to a naked flame might well not qualify as a reasonable belief.

53. The relevant provision in the Act requires only that I hold the belief that a crime "may" have been committed. Given the breadth of s154, which has frequently been the subject of judicial comment, I am compelled to find that the circumstances in this case may constitute a breach of the provision. That is to say, in my view the accident causing the burns leading to the death may have involved the commission of a crime Having made that finding, I have no discretion. The relevant provision in the Act requires that I "shall report" the matter to the Commissioner of Police and the Director of Public Prosecutions.

54. In drawing this conclusion, I am cognizant of the fact that the charge has previously been laid and withdrawn. I am also cognizant of the fact that previous attempts at extradition have failed for the technical legal reasons already described. Those previous transactions are irrelevant to the discharge of my function. Whether any further step should be taken having

regard to the history of the matter is within the exclusive purview of the Commissioner of Police and the Director of Public Prosecutions.

55. In determining to make this reference, I feel compelled to advert to the position put by Carolyn Ching, the sister of the deceased, during the course of her evidence. She stated:

> "Carolyn I'm going to ask you, what is it if anything that you want to see come out of this process, this Coronial process which is here to identify all the relevant circumstances and to see whether anything can be done, procedures changed to prevent recurrences in the future. What would you like to see come out of it?---Come out of this process?
>
> Yes?---I'm just looking forward to it being over. I'd like whatever questions my parent's have to ask, I'd like for them to be able to ask them and then I would just like it to be done. I think, that it was just a really, really, horrible, very tragic accident. I think it should have just been left at that because I don't particularly think that anyone is to blame for it. It was just horrible and I hope that it never ever, ever happens again and that's it, I don't know."

56. Whilst I respect the humanity of her approach, it remains the case that a crime may have been committed and appropriate steps must be taken in accordance with the legislation.

57. It might be seen as a matter of some regret that Lee did not, in his evidence, accept any responsibility, or that he was in any way at fault, in relation to the incident and subsequent injury. To do so may have assisted the parents of the deceased achieve closure in the matter. That refusal was also inconsistent with his expressions of regret immediately following the incident. At that time he was heard to say repeatedly that he was sorry. I can only speculate why Lee adopted the position he did during the course

of evidence. He may have feel felt constrained by legal advice. It may be that his reticence was a function of his youth, disposition or personality. Whatever the reason, his denial is not determinative of whether a crime may have been committed.

58. I do note, however, that Mr Lee's Counsel presented a statement from Mr Lee's parents to the Inquest expressing their deep sympathy for the parents of the deceased. As that statement observed, "only parents can appreciate the worst of all bereavements, the loss of one's own child". I have no doubt that expression of sympathy was heartfelt.

Occupational health and safety issues

59. There is another matter that arises from the circumstances immediately surrounding the initial injury to the deceased. That is the question whether the operators of the tourist venture on Kings Creek Station, or the operators of the helicopter business, had any knowledge of the use of the lanterns. The related issue is whether, if so, the operators of either of those ventures had any occupational, health and safety obligations in relation to the use of the lanterns in circumstances where they were located in the pilots' residential accommodation. I also note in this context that following the accident the Work Health Authority formed the view that it did not have jurisdiction to investigate the matter because it did not occur at a "workplace" within the meaning of the legislation.

60. Section 29 of the *Work Health Act* (NT) provides relevantly:

Duties of employers

29. Duties of employers

(1) An employer shall, so far as is practicable -

(a) provide and maintain a working environment at a workplace that is safe and without risk to the health or safety of the workers working at the workplace; and

(b) ….

Penalty: In the case of a body corporate - $125,000.

In the case of a natural person - $25,000.

(2) Without limiting the generality of subsection (1), an employer contravenes that subsection if he or she fails to -

(a) ….;

(b) ….;

(c) maintain, so far as is practicable, a workplace under his or her control and management in a condition that is safe and without risk to health;

(d) ….; or

(e) …..

(3) ….

(4) ….

(5) …. .

61. The requirement under the legislation is that the employer maintain a safe workplace "so far as is practicable". The evidence heard by the Inquest is uniformly to the effect that neither Ian Conway nor Van der Zypp were aware of the use of the lanterns at the residence. Conway had not had

occasion to visit the residence after dark when the lanterns might have been in use. Van der Zypp's area manager, who was stationed at Yulara (Ayers Rock), had not visited overnight during the period in which the lanterns had been in use. In all the circumstances, it would have been impractical to implement some system of inspection which would have ascertained that the lanterns were in use.

62. It is the case that Jellie observed the lanterns in use on the night in question. That was the first time he had seen the devices. He discussed the use of the devices with one of the pilots in order to ascertain their safety, or at least to ascertain the pilots' view in relation to their safety. He did not direct them to desist in the use of the lanterns. With hindsight, he thinks he should have. Whilst it is true that Jellie held the position of maintenance manager with the Station, I cannot reasonably find that the owner of the operation was responsible for an error of judgement on Jellie's part during the course of a social gathering. It is also not possible to judge Jellie too harshly in relation to the matter. The lanterns were in use only at the pilots' residence. The pilots might rightly have claimed some dominion, up to a point, in relation to the manner in which they comported themselves at that residence. Jellie might reasonably have been comforted by the fact that the pilots did not harbour any concerns in relation to the safety of the devices, in circumstances where pilots might be expected to have some understanding of the properties of Avgas.

63. Had this tragic incident not occurred, and had the use of the lanterns continued in the days and weeks after management of the Station was possessed of constructive knowledge of their use, the situation might be different.

64. The matter was referred to the Work Health Authority (through NT WorkSafe) for consideration. By letter dated 5 April 2005, the Authority advised as follows in relation to the requirement in ss 46 and 48A of the *Work Health Act* that accidents or occurrences at a workplace causing death be notified:

> "The moot point in this interpretation is whether the accident occurred at a workplace for the purposes of carrying out work. In this case as the staff were not working at the time it would not be unreasonable to assume that the employer did not perceive this accident as a workplace accident for the purposes of occupational health and safety in the workplace."

65. Section 3 of that legislation defines "workplace" to mean "a place, whether or not in a building or structure, where workers work". In *Castrol Australia Pty Ltd v Veronica Mary Mitchell* [1995] NTSC 93, the Supreme Court of the Northern Territory held that in the rural context where a worker is required to travel between various places, all incidents of that travel formed part of the "workplace". This is consistent with other authorities to the effect that where a worker is required to live and work in a camp situation, it may not be only the narrow area within which paid work is actually performed that comprises the "workplace": see, for example, *Hatzimanolis v. A.N.I. Corporation Limited* (1992) 173 CLR 473. In saying this, I accept that the question that generally arises in those authorities is whether an injury "arises out of or in the course of employment".

66. Quite apart from these authorities, the Inquest heard evidence to the effect that the pilots' residence housed a computer that was used for work purposes, and that the pilots conducted work-related activities in the residence. That staff were not working at the time of the accident may not be sufficient to deprive the structure of its character as a "workplace".

67. For these reasons, I do not agree with the opinion that the demountable was not a "workplace". I recommend that NT WorkSafe conduct a review in relation to the meaning of "workplace" as it appears in s46 of the *Work Health Act,* both generally and as regards the matter of this death.

68. I have also given some consideration to the broader circumstances surrounding this incident. Young men with pilots qualifications are put into remote localities and largely left to their own devices in running operations, such as helicopter tour operations, that require a high degree of responsibility. Some query naturally arises as to whether it is appropriate to vest young men with this degree of responsibility, and whether the helicopter company in this case should have been more discriminating in its selection of staff for the purpose of running the operation on Kings Creek Station.

69. I have come to two conclusions in this respect. First, any such consideration is a matter too remote from the coroner's functions in relation to this death. Secondly, even were that not so, I would find myself unable to criticise the helicopter company on this ground. In the first instance, the pool of pilots prepared to live in remote localities and outside the usual familial environment is probably limited largely to young men. In the second instance, young though they were, these men were both adults and qualified pilots, and the helicopter company was entitled to expect that they would take an adult's approach and exercise caution in relation to their dealings with volatile fuels.

The timeliness of the deceased's aeromedical evacuation from the Station, and her subsequent transfer to Adelaide

70. The deceased was evacuated from the Station by the Royal Flying Doctor Service. There is some question as to the route taken by the Royal Flying Doctor Service on the night of the accident, in that the plane received the call in relation to the deceased whilst it was *en route* to Ayers Rock. The plane continued to Ayers Rock to pick up a child patient there before diverting to Kings Creek Station to pick up the deceased. Some question was also raised in relation to the initial evacuation of the deceased to the Alice Springs Hospital, before transfer to the Royal Adelaide Hospital.

71. As to the first issue, the evidence heard by the Inquest establishes that any delay was insubstantial and immaterial to the final outcome. Dr Setchell's evidence in that respect was as follows:

> "From the flight times and the information we have from the flight reports I think you could argue that under the circumstances the RFDS aircraft reached Cynthia sooner by the mechanism that we used than had it been either launched directly from Alice Springs. The only way it would have been there maybe 10 minutes earlier would have been to divert on the way to Ayers Rock, but that would only happen if the clinical priority coding had put that task ahead of the child who had pneumonia.
>
> ….
>
> Had the decision been made at 2300 hours to divert to Kings Creek Station rather than continuing to Ayers Rock or Yulara what time would the plane have arrived at Kings Creek Station?---On the assumption that at 2300 we were about halfway to Ayers Rock my guess is that we would have probably been at Kings Creek maybe at about 2340, 2345, that sort of time.

All right, so there is then a – perhaps a 40 minute difference?---Maximum 40 minute difference.

So if it had gone directly to Kings Creek Station it would have got there 40 minutes earlier?---Correct.

At about a quarter to midnight rather than 25 past. In your clinical assessment would that 40 or 35 minute difference have made – or had any impact in terms of the progression of the treatment or the progression of Cynthia's condition?---I don't believe so."

72. The Inquest heard evidence that there was, and remains, only one Royal Flying Doctor Service plane on night-time duty at the Alice Springs base. This is because the level of need does not warrant maintaining two planes and crews for nighttime services. The issue still arose, however, as to whether the deceased would have been evacuated at an earlier time if a second plane had been available to travel from Alice Springs at 2300 hrs. Dr Setchell's evidence in that respect was as follows:

"Let's assume that there was already – or rather there wasn't a call on the plane's time prior, so it wasn't already en route, or that you had another plane, another spare plane back at Alice Springs. If the call had gone in at 2300 hours and that plane at Alice Springs had been mobilised, even in accordance with the Code 1 requirements, what time would that plane have left Alice Springs?---Code 1, as I say, they would need – a need for flight planning, fuel loading, equipment checking, time for staff to wake up, get to the airport, they would have left at midnight, 2400.

And what time would the plane have arrived at Kings Creek Station, had it gone directly there?---Kings Creek is 45 minutes from Alice Springs so - - -

Forty-five minutes past midnight?---Forty-five past midnight.

And in actuality in the circumstances this plane arrived at Kings Creek Station at 25 minutes past midnight?---Correct.

So if the plane had been deployed from Ayers Rock – rather from Alice Springs it would have arrived 20 minutes later than it did in fact arrive?---Correct.

THE CORONER: So it was almost a matter of good luck that there was a flight flying over in that direction?---Certainly, we call it opportunistic in that the resource is in the right place at the right time. I mean the scenario might have been that the child with pneumonia was at Harts Range, exactly the same distance in the opposite direction in which case the whole equation would have been vastly different.

But just assuming that there was no such plane a phone call to Alice Springs about Cynthia and a flight to pick her up would have meant she was back there in Alice Springs for treatment 20 minutes later than as occurred?---Correct."

73. As to the second issue, it would appear that it was necessary to travel first to Alice Springs in order to stabilise the deceased before she was further evacuated. Even leaving aside that medical necessity, as a matter of practicality the planes have a limited range. Dr Setchell's evidence in that respect was as follows:

"Thank you. And then the final issue that I'd like you to address, Doctor, is why it is or what principle of aero-medicine dictated that you take the child to Alice Springs Hospital rather than, assuming it's feasible, the Royal Adelaide Hospital direct?

THE CORONER: You mean Cynthia or the child?

MR GRANT: Sorry, Cynthia?---RFDS operates in about 85% of the country. The only place that we don't have a base is in Darwin for the top end of the Territory. And across all of our bases the basic presumption of aero-medical practice is that our role is to transfer patients to the nearest higher definitive level of care from the source of an accident, injury or an illness in order that they are stabilised by skilled people as soon as possible and then re-assessed for whether they can be managed locally or need to be transferred further on. The basic principle being is that pre-flight preparation is an

> imperative but when long flights take place, it's about a 3 and a half hour flight say down to Adelaide, it's vital that that patient has all the drips, all the monitors, all the systems ready to go that during that 3 and a half hour flight hopefully nothing needs to be touched because it's all done beforehand. So the basic principle is that we go to the highest level of care locally available, which is Alice Springs Hospital."

74. It should be noted for sake of completeness that the medical treatment provided to the deceased by the Royal Flying Doctor Service staff during the course of the evacuation was of a high standard. So much is apparent from Professor Ansford's evidence. Dr Setchell also gave evidence in relation to that matter in the following terms:

> "Now, Doctor, I presume that part of your duties as the operations manager include, to a degree, assessing or monitoring the performance of your – clinical performance of staff who are involved in evacuation exercises; is that the case?---Correct, yes.
>
> Having had opportunity to review the materials relevant to this case how did you assess the performance of Mr Jordan, the flight nurse?---I think in the very difficult circumstances Steve did an extraordinary job. I think his clear mindedness about identifying the severity, identifying that plans needed to be made quickly and put in place quickly and his skills in being able to get a line with some fluids into Cynthia so that intravenous resuscitation could be commenced were admirable under the circumstances."

75. Having considered the medical notes and the other evidence heard during the course of the Inquest, I concur with that assessment. It should also be noted that whilst the initial radio report provided to the regional medical officer by the clinical nurse who was attending on the deceased at the Station could have contained more detail, it did not compromise the deceased's treatment. The flight nurse was able to assess the situation quickly and stabilise the deceased.

The ultimate cause of death and the appropriateness of the medical treatment provided at the Royal Adelaide Hospital

76. The medical cause of the deceased's death has already been canvassed above. The deceased suffered multiple organ failure following persistent sepsis occurring as a complication of severe burns. On 30 April 2004, the deceased suffered respiratory failure and required ventilation support. The deceased went into septic shock, which exacerbated an original bacterial infection. On 3 May 2004, the deceased developed acute renal failure. On 25 May 2004, various organs were removed and gangrene became apparent in the deceased's left thumb and foot. She died shortly thereafter.

77. Professor Ansford has independently reviewed the case and expressed the view in evidence that the deceased's treatment was appropriate. There are four matters that require some particular attention.

78. The first relates to the prophylactic treatment of bacterial infection. Infection is a common consequence of burns. That being so, it might appear to the lay person that antibiotics could be administered from the early stages of treatment in order to stop infection. Dr Lai was able to address that matter in the following terms:

> "… in terms of prophylactic antibiotics to prevent infection what we [have] found is, in experience and a lot of literature as well, if you start using prophylactic antibiotics what you will find is there will still be bacteria colonising the wounds and different organs of the patient, but they will be of the resistant type. Basically what you do you're just selecting for more resistant bacteria. Good burns care usually consists of reverse barrier nursing, very good infection control measures to try not to allow resistant bacteria from outside or

from the start and then reverse hand washing before and after looking at the patient to prevent that from happening and also active surveillance and frequent review of the patient to look for any signs of infection because there's a big difference between colonisation and infection. A lot of burns patients are colonised by bacteria, as normal people are, but not all of them get infection. So we need to really, really be careful in terms of jumping in and giving prophylactic antibiotics because at the end you might still get infection but what you're getting is infections with bacteria which are very resistant to all the antibiotics. You're basically running out of choices and you're putting yourself in a difficult situation in that way. That's the experience of a lot of burns units in the world and that's why we accept it in the literature about the infection control measure, that's what we practise at the Royal Adelaide."

79. I am also satisfied that the bacteria in question did not colonise as a result of any failure in the infection control procedures within the Royal Adelaide Hospital. The evidence in that respect was as follows:

> "MR GRANT: Doctor, again in layperson's terms I understand you to be saying that the pseudomonas bacteria is something that would have been on her skin at the time of the burn or somewhere in her environment at the time of the burn that she would have brought with her; is that a fair lay summary?---That is a possibility and it could be from her, it could be from the environment.
>
> And the entrococcus bacteria you're talking about is a bacteria that's found all through the human body and again the … bacterial infection that she contracted was from a bacteria that she was carrying herself in her oesophagus or in her anal region or something like that?---Yes, that's correct."

80. The second matter relates to the trial administration of Xigris to the deceased during her treatment at the Royal Adelaide Hospital. It was acknowledged that the mother of the deceased had provided consent to the trial. The medication was, at the time, an experimental drug. The parents of the deceased expressed some concern and desire to know whether the

trials were successful, and whether the administration of the drug might have played any part in the deceased's medical outcome. That was also addressed by Dr Lai in the following terms:

> "Can you tell us what Xigris is?---The actual name for Xigris is activate protein C and protein C is one of the natural proteins in our body and its usual function is actually to thin the blood to prevent clotting. And what happened is there was a discovery earlier, you know, probably late 1990s by some of the American and European researchers about the fact that septic patients or patients in septic shock are fairly deficient in this protein so – and in earlier trials they find that if you give this protein, activated protein C or Xigris, to patients who are in septic shock they do better. So there are earlier trials, even before this trial happened in 2004 that shows Xigris is beneficial in improving the survival in patients with septic shock. And the trial that Cynthia was on was actually to try to see whether or not a combination of Heparin, which is also another anti-coagulant, with Xigris whether or not it will give you additional benefits compared to Xigris alone. So although Xigris at that point hadn't received approval it is now approved by the Australian Drug Administration as well as the United States for severe septic shock in patients in Intensive Care.
>
> All right. If I can put it this way, Doctor, and tell me whether I'm correct, the general trial indicated that Xigris was effective and safe as a drug but unfortunately it didn't work in Cynthia's case in terms of reversing the course of her sepsis?---Yes, yes, that's correct."

81. The third matter relates to the removal of certain of the deceased's organs on 25 May 2004. This is, quite naturally, an emotive issue. At the time of the Inquest, the father of the deceased still harboured some concern in relation to the matter. The deceased's injuries were such that her body had difficulty healing. The parents of the deceased were advised as much early in her treatment. Their query is why radical surgery would be undertaken if the deceased was effectively unable to make any recovery from such surgery, and if the outcome at that stage was already determined.

82. Dr Lai's evidence in that respect was as follows:

> "Now, Doctor, there was surgical exploration on that same day and that resulted in the stomach, the pancreas, the spleen and the colon being removed as emergency measures?---Mm mm.
>
> The parents have got a series of questions they've put to me and I just want to relay them to you for your response, if you can give one. The first is, can somebody live without those organs, if not what's the therapeutic purpose of taking them out and is it possible that the removal of the organs caused a premature death? Now are you able to respond to those questions?---It is a difficult question. The procedure was performed as an emergency procedure and I'm not a surgeon myself, but from Intensive Care experience patients are able to survive without individual organs, like if you are missing your stomach or if you're missing your pancreas, if you're missing a spleen or you're missing your colon you can survive, but having – I haven't actually seen any patient with a combination of all of those organs absent in a body and survive to be honest. So I'm not sure that I can give you a fair answer with my limited experience in surgery as well as in Intensive Care.
>
> ….
>
> THE CORONER: I want him to keep on answering but I assume that the – all those organs were removed because, to use a layman's term, they were dead; is that right?
>
> MR GRANT: Doctor, is - - -?---Yes.
>
> You heard that question?---Yes. Yep.
>
> So those organs were dead when they were removed?---They were not viable, that's why they were removed. And that was confirmed on the histological examination under the microscope that those organs were not viable.
>
> ….

MR GRANT: Does that mean they were dead, Doctor?---Yes, they were dead.

Let me put another very, very blunt question to you. Was there any other choice but removal of those dead organs in the circumstances?---There is another option. You can leave them in but that's only if the situation is hopeless, because leaving dead tissues in a patient will definitely hasten death.

All right?---So removal of the organs is a last ditch attempt to try to save Cynthia's life.

Is it possible that that hastened her death or is it just impossible to say whether the outcome would have been any quicker or slower if they'd been left in as opposed to taking them out?---It's probably very difficult to say, but I would say that common medical knowledge would probably tell me that if you leave them in the chance of dying is probably, you know, greater or, you know, imminent if you leave, you know, such large amount of dead tissues in a patient with potential, you know, for further infections and further necrosis of the organs. So I do not think – yep - - -

Sorry?---I do not think the removal of the organs in any way sort of jeopardised her prognosis in a way, but I can't really comment because we haven't really got, you know, in terms of comparing between whether or not you leave it in or you take it out, whether or not, yeah, things will be different."

83. Professor Ansford gave the following evidence in relation to the matter:

"Now, Professor, then on 25 May the treating clinicians found evidence of death of the stomach tissues and spleen?---Yes.

They were subsequently removed, the stomach, spleen and part of the large bowel removed by a – through a hole in – and the hole in the duodenum was closed? ---Yes.

What was the purpose of that procedure?---Well she had dead bowel in there and that – she was in a parlous state at that time, from my reading of it, but to leave that dead bowel in situ would have aggravated her state and I believe that was what you might call an

> heroic last ditch measure to save her life, to remove those dead organs so that, you know – and to give her a chance to survive although she seems to have been in a very serious condition at that stage.
>
> It would have given only a very minimal chance of survival though, wouldn't it, Professor?---I would believe so.
>
> But what was her chance of survival if the dead organs had been left in situ?---Well I think she would have died quicker and not a – a very unpleasant death."

84. It is apparent from this evidence that the organs were dead. Had they been left in situ, the deceased would certainly have died, and probably more quickly than was the case. The removal of the organs was a last ditch effort to save the deceased. The chances of success were minimal. The attending medical practitioners clearly considered it better to try rather than not, even if the prospects of success were minimal. I do not criticise that decision. Having said this, I also acknowledge that although the decision is capable of rationalisation in this way, Mr Ching's continuing emotional response to the matter is entirely understandable.

85. The final matter of concern arising from the deceased's medical treatment involved the fact that whilst at the Alice Springs Hospital she received an operation on the right arm to relieve the pressure from severe contracture of the skin as a result of the burns. There is no doubt that this is a standard procedure for burns victims. The matter is complicated by the fact that the parents of the deceased have a recollection that Dr Greenwood, who was the plastic surgeon at the Royal Adelaide Hospital, told them that during the course of that particular operation the surgeon in Alice Springs may have cut a little deeper than necessary. They are concerned that this matter

may have compromised the deceased's recovery, particularly having regard to other medical advice received in relation to healing difficulties.

86. I am satisfied from Dr Lai's evidence that the wound resulting from that operation did not have any material impact on the management of the deceased's condition while she was in the Royal Adelaide Hospital, nor did it contribute to the ultimate outcome.

The report to the Northern Territory Police

87. The final matter for consideration relates to the manner in which the incident was reported to Northern Territory Police. As stated, the matter was not formally reported to the Coroner's Constable in Alice Springs until 27 May 2004 following the death of the deceased. There is no doubt, however, that police knew of the matter prior to that time.

88. On the day following the incident, Sergeant Alistair Taylor, the Officer in Charge of Kulgera Police Station, attended at Kings Creek Station as part of a routine patrol. During that attendance, Mr Conway made a passing reference to the accident to Sergeant Taylor during conversation. There may have been some miscommunication. Sergeant Taylor recalls being told that a staff member had been burned after a disposable cigarette lighter had exploded and was believed to be the cause of the fire and the burning. He also recalls being told of the involvement of a lantern or flare that was in close proximity to the lighter.

89. The reference to a lighter is understandable in circumstances where a damaged lighter was found the following morning and eventually provided to Police during the course of the coronial investigation. The lighter was

probably damaged as a result of the fire. As was subsequently established, it was certainly not the cause of the fire.

90. The timing and nature of the report gives rise to two questions. The first is whether it should have led to any further investigation by Sergeant Taylor at that time. The second is whether Mr Conway was less than forthcoming in his report of the incident.

91. As to the first matter, Sergeant Taylor's evidence was as follows:

> "MR GRANT: When you were being told about this incident and the lighter did it occur to you that it might be necessary to go behind what you were being told by Mr Conway and perhaps speak to some of the actors in the incident to find out their account?---No, it didn't.
>
> And why is that?---I didn't take it as being an official police report about an incident that police needed to be involved with. I just took it as something happened here last night, I thought I'd let you – you know, just let you know about it because I've seen you and that was the end of it.
>
> I take it you yourself decided that it wasn't a police matter?---I did.
>
> And was that based on the description of the incident involving a disposable lighter overheating when it was left too close to a flare?---That's right.
>
> Now had you been told that the incident involved the refuelling scenario that we now know was the case - - -
>
> THE CORONER: The kind of thing that you have heard about in the last two days, I noticed you've been sitting there.
>
> MR GRANT: - - -might, and I know we're speaking hypothetically and in retrospect here, but are you able to say whether your decision as to whether it was a police matter may have been different?---Yeah, I think if I'd have known that someone had discarded a volatile substance onto another person and they've been burnt in that

circumstances I would have had to have looked into it in case there was a deliberate act or some sort of offence had occurred, yes.

What about the severity of the injury involved; would that key into your decision whether or not to conduct further inquiries or whether or not to treat the matter as a police incident?---Yeah, definitely. If I believed that someone had life threatening injuries then I would have investigated it further.

Why is that?---Because I know that a coronial file would have been required.

If somebody had died?---That's right, yeah, so I would have obtained at least – the very least witness statements and had a look at the area – sorry, the witness details and had a look at the area where it occurred.

What if you'd just been told that it was because of the disposable lighter being left near a flare it had overheated but one of the people involved had suffered third degree burns and was quite seriously injured, would that have been enough to prompt you to treat the matter as a police matter or to conduct further inquiries, rather, as a police officer?---It may have been, but I may not have either. It would have depended on, you know, third degree burns on how much of their body or – yeah, I can't answer that really, to be honest.

What about this then, given the information that you did have, that is that some people have been injured, some staff had been injured or a staff member had been burnt and there'd been an aero-medical evacuation, is that not something that might have prompted you to at least have made an inquiry of the hospital in Alice Springs to see what the extent of that staff member's injuries were?---No.

And why is that?---Because I just thought it was an incident that was mentioned in passing. I would have expected to have been told if there was a life threatening injury involved. I also would have expected to have been told at the time if there was some sort of foul play or something that needed to be brought to my attention. It's not a matter – household accidents aren't something that we have to report on as police, in general. You know, someone getting taken to hospital isn't something that we're interested in, generally.

> I take it then that you put this in the sort of category of somebody at home with their barbecue and suffering burns when their gas bottle misbehaves?---Exactly right, or someone pouring petrol on a fire to try and get it started, that type of incident. That's how I took it, yeah.
>
> And you don't consider those incidents to be ones that require police investigation, per se?---No, they don't get reported to police those type of incidents."

92. The upshot of this evidence is that Sergeant Taylor may have conducted further investigations had he been aware that the incident was caused by a volatile liquid being spilled by one person onto another. The mere fact that somebody had been burnt, and evacuated to Alice Springs, did not prompt the same response. There is an argument that Sergeant Taylor should have investigated further, even on the information which he had to hand from Mr Conway. It is a matter on which minds might reasonably differ. On balance, however, I do not criticise Sergeant Taylor for his failure to do so. I accept the analogy that household burns suffered in the usual course do not attract or warrant any police investigation.

93. That leaves the nature of Mr Conway's report. Mr Conway largely agreed with Sergeant Taylor's account of the report. Although that report was not as complete as it could have been, I find that Mr Conway did not have any ulterior motive, and was not attempting to conceal any matter, when he was making the report. He made mention of the burns. He made mention of the evacuation. He made mention of the involvement of a lantern. He did not have any interest or motive in discouraging police investigation. I have read the suggestion that Mr Conway wished to protect the tourism industry, either on his property specifically or in Central Australia generally. I do not accept that suggestion for two reasons. First, Mr Conway impressed me during the giving of his evidence as an honest and decent man. Secondly, I

cannot see that scrutiny or publicity in relation to an accident of this nature would, or would have been expected, to impact upon tourist numbers.

94. Any suggestion that Mr Conway was seeking to downplay or cover up the incident is also inconsistent with his subsequent conduct. He made three calls to the Police on the morning following the incident. One purpose of those calls was to seek assistance from the police in relation to counselling his employees who had witnessed the incident. On the day following the incident, Mr Conway called all the employees together and told them that they needed to talk through the issues and should not bottle up their feelings.

95. There was some suggestion in the initial statement to Police given by Ms Williams (a station employee at the relevant time), that she had the feeling nobody was talking about the matter and that it was somehow being suppressed. Ms Williams subsequently withdrew that contention without any prompting from any other person, and indeed made a further statement to Police in order to correct the record. From her evidence, I had the distinct impression that Ms Williams's initial feeling that nobody was talking about the matter was prompted by the fact that on the night following the incident another employee who was not aware of events had queried her drawn appearance.

96. The suspicion surrounding the matter led to an unfortunate incident in March 2005 when Mr Ching travelled out to the Station in company with a Canadian lawyer, a journalist and a cameraman. They were ejected from the Station. The matter was widely reported and the footage was the subject of a story on the ABC "Lateline" program. The matter was unfortunate because Mr Ching was denied the opportunity to visit the place

where the accident occurred. It was also unfortunate because it reflected badly on Mr Conway, in circumstances where he was apparently acting on advice from his insurance company and lawyer.

97. Mr Conway's actions on the day are also more understandable when viewed in context. He gave the following evidence in relation to the matter:

> "Right, can you tell his Honour what that was about?---The first contact that we had from anyone in Canada was a gentleman by the name of Patterson. And he told us that he was a lawyer in his emails and that he was representing Mr – doing some investigation for Mr Ching in relation to his daughter's death. So he asked quite a few questions about various things of which we answered. We answered them after we had consulted with a lawyer and also consulted with our insurance company, et cetera, et cetera. So we gave him the basic answers which he required. A little bit later down the track he sent us an email saying that he was going to visit and I thought nothing more of it for a little while and then I contacted my insurance company and also my lawyer and I spoke to them about it and they said, 'Well under the circumstances we don't want Mr Patterson to visit with Mr Ching on the property,' because by this time we knew that Mr Patterson was a lawyer and he was a litigating lawyer and in fact we had on I think it was Cynthia's job application that she'd actually worked for him for 4 years. So I was advised by my lawyer and insurance company to renege on the okay for them to come onto our property, which I did.
>
> How had that okay previously been given?---I'm not sure whether it was an email or what it was but I did send an email back to him – or Kath sent an email back to him saying, no, you're not welcome on the place or something like.
>
> ….
>
> All right?---But anyway we got – so we didn't think any more of it, we thought oh well that's okay, they're up in Darwin and, you know, he's obviously doing something in relation to Cynthia's death – death with the Coroner or whoever it may have been at that time. On the

day in question I was unaware that they'd actually come into our place and - - -

So you knew that they were in the Territory?---I knew Mr Ching and his lawyer were in the Territory.

Yes, all right?---Now the purpose of the visit, so they tell us, was to seek closure.

Who told you that?---They did.

What, then on the day?---Yes, on the day as well.

All right?---And I think prior to. I think I've got it in an email. From my point of view if you're going to seek closure to the death of one of your children you don't bring a television crew, a journalist, a lawyer and book in under somebody else's name, which they did.

Into Kings Creek Station?---Yes."

98. It is not within my purview to attempt any resolution of those issues, nor to make any findings or recommendations in relation to them. It can only be hoped that the parents of the deceased do find closure, and I note their expressed appreciation of the coronial process in providing some assistance in this regard.

Dated this 4th day of May 2006

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GREG CAVANAGH

Territory Coroner