CITATION: *An inquest into the death of Kheng Hav Eng* [2001] NTMC 28

TITLE OF COURT:	CORONERS COURT
JURISDICTION:	NORTHERN TERRITORY
FILE NO(s):	20006310 46/00
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DELIVERED AT:	DARWIN
HEARING DATE(s):	22 and 23 March 2001
JUDGMENT OF:	Mr Greg Cavanagh

CATCHWORDS:

CORONERS---INQUEST

Motor Vehicle Accident - accident investigation

REPRESENTATION:

Counsel:

Assisting the Coroner	Ms Elizabeth Morris
For the deceased:	Mr Phillip Cantrill
For Mr Brocklehurst	Ms Cheryl Watson

Solicitors:

For the Deceased	T S Lee & Associates
For Mr Brocklehurst	Davis Norman

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 20006310

AN INQUEST INTO THE DEATH OF

KHENG HAV ENG

FINDINGS

(Delivered 30 March 2001)

Mr Cavanagh SM:

THE NATURE AND SCOPE OF THE INQUEST

1. Kheng Hav Eng ("the deceased") died at around 8.33pm on 24 March 2000 as the result of multiple injuries received from a motor vehicle accident.

2. Section 12(1) of the *Coroners Act* ("the Act") defines a "reportable death" to mean a death that:

> "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury".

3. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and this Inquest is held as a matter of discretion pursuant to s15(2) of the Act. I exercised this discretion for a number of reasons, including the request of the family of the deceased, who wished to have a public hearing into the circumstances surrounding the death.

4. 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. That 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;

(v) any relevant circumstances concerning the death.

5. Section 34(2) of the Act operates to extend my function as follows:

> 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.

6. The duties and discretions set out in ss 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.

7. The public Inquest in this matter was heard at the Darwin Magistrates Court on the 22nd and 23rd of March 2001. Counsel assisting me was Deputy Coroner, Ms Elizabeth Morris. Mr Phillip Cantrill sought leave to appear on behalf of Mrs Eng, and Ms Cheryl Watson sought leave to appear on behalf of Mr Peter Brocklehurst. I granted leave pursuant to s40(3) of the Act.

8. During the Inquest evidence was tendered by consent, and four witnesses were called. They were Senior Constable Robert Lovell of the Accident Investigation Unit, Mr Peter Brocklehurst, Ms Jennifer Byrne and Dr Didier Palmer, Director of Emergency Medicine at Royal Darwin Hospital.

9. The evidence tendered included the Coronial investigation brief prepared by Senior Constable Lovell, as well as other documentation and records.

10. This evidence enables me to make the following formal findings as required by the Coroner's Act:

FORMAL FINDINGS

(a) The identity of the deceased was Kheng Hav Eng, an Asian male born on the 30th of December 1954 in Cambodia

(b) The time and place of death was on the Stuart Highway, near the Mitchell Creek area, Northern Territory, shortly after 20:33 hrs on the 24th of March 2000.

(c) The cause of death was multiple injuries from a motor vehicle accident where the deceased was a driver.

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

1. The deceased was a male.
2. The deceased was of Asian origin.
3. The death was reported to the Coroner.
4. The cause of death was confirmed by post-mortem examination.
5. The death was caused in the matter described in paragraph (c) above.
6. The pathologist viewed the body after death.
7. The pathologist was Dr Michael Zillman of the Royal Darwin Hospital.
8. The details of the father and mother of the deceased are unknown to this Office.

9. The usual address of the deceased was 7 Smythe Road, Howard Springs, in the Northern Territory of Australia.

10. The deceased was seafood processor and businessman.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING COMMENTS, REPORTS AND RECOMMENDATIONS

The accident

11. The evidence produced at the Inquest leads me to find that the deceased had been at his home at 7 Smythe Road, Howard Springs, on the evening of the 24th of March 2000. He was a married man with four children. The family business was seafood processing, (in particular the processing of mud crabs). He was well respected in the local Cambodian and wider Darwin community.

12. On the 24th of March the deceased decided to drive into town to see friends. He travelled inbound along the Stuart Highway in his Toyota Landcruiser 4X4 stationwagon, Northern Territory registration 572803, which was registered in his name. There was no other person in the car. The time was shortly after 8.00pm. Later toxicological testing revealed that the deceased did not have any alcohol present in his blood.

13. At around the same time, Mr Peter Brocklehurst was driving a Holden HQ Utility, Northern Territory registration 513184 outbound on the Stuart Highway. He had spent a long day at work, approximately 11 hours. He was "tired" and "miserable" and he told me that on driving home he was feeling "somewhat weary". After work he had stopped and collected petrol and groceries, before commencing his journey home to 59 Hillier Road, Howard Springs. Mr Brocklehurst gave evidence that he had not consumed any alcohol that day, and there is no evidence to the contrary. I accept his evidence on that point. He travelled in the left lane of the dual carriage way.

14. Also heading outbound was Ms Jennifer Byrne. She was driving a Holden Commodore Sedan registration 569733. This vehicle was registered to the Commonwealth agency, Dasfleet and had been leased to Senator Trish Crossin. At the time Ms Byrne was the girlfriend of Senator Crossin's son, Paul.

15. Ms Byrne had also worked that day, and afterwards collected her child and her boyfriend Paul Crossin, and travelled to a friend's residence at Howard River Park. Whilst there Ms Byrne says she consumed 3 cans of light beer. It may be possible to conclude from the evidence that she consumed a little more than this. However, just how many cans she consumed or of what kind is largely irrelevant, because there is scientific evidence of Ms Byrne's later blood alcohol reading. Blood taken from Ms Byrne at the Royal Darwin Hospital at 21.40hrs that evening (some 70 minutes after the accident) has been tested and revealed a blood alcohol reading of .054%.

16. Subsequent forensic testing on that blood also revealed no trace of any other drugs (legal or illegal). This testing was requested by my Office due to information from treating Ambulance officers that Ms Byrne had been treated with Narcan. Narcan is the tradename of the drug Nalozone, which is sometimes given to people (especially for those persons effected by drugs) with respiratory depression or loss of consciousness.

17. Evidence was called from Dr Didier Palmer, the Director of Emergency Medicine at the Royal Darwin Hospital. Dr Palmer did not treat Ms Byrne, but had read her medical file and was aware of the circumstances of her treatment, including the statements of the Ambulance Officers who treated Ms Byrne.

18. Dr Palmer largely agreed with the earlier tendered report of Dr Campbell, which stated that there was no evidence that Ms Byrne was affected by narcotics around the time of the accident, or that she was a regular narcotics user. In Dr Palmer's opinion there was no evidence of a significant clinical response to the administration of the Narcan. He attributes Ms Byrne's unconscious state at the accident scene to head injuries received during the accident. She did not fully recover consciousness until later in the Emergency Department of the Royal Darwin Hospital.

19. This evidence was not controverted by either counsel appearing before me, indeed Counsel for the family in final submissions stated the "possibility of there being a drug-related factor has been laid to rest….nothing could be said to suggest any

further that drugs were in any way….a factor in this matter." (T: 96) It is very clear from the evidence that this was the case.

20. After some time Ms Byrne left her friend's residence at Howard River Park to drive to Palmerston to pick up some videos and more alcohol. She was alone in the car. After completing her tasks, she commenced driving back to her friend's property along the Stuart Highway. She travelled in the right lane of the dual carriageway. The speed of Ms Byrne's car at the time of the accident, according to Ms Byrne was 100 km/h. The actual speed limit on this part of the highway was 100km/h. Her evidence was the she was "cautious" driving the car, that she never goes over the speed limit and that she had checked the speedo. (T: 60) Ms Byrne agreed that she usually drove a 4 cylinder "Gemini" motor vehicle, and was relatively inexperienced at driving the 6 cylinder Holden.

21. Mr Brocklehurst describes the sedans speed as a "fair speed" (T: 44) "going very fast" (T: 45) "speeding". He gave evidence that he was used to cars passing him at 100km/h whilst he was doing 80km/h, and that this car was going faster than 100km/h.

22. There is no technical evidence to assist me in determining Ms Byrne's speed. Senior Constable Lovell states that there was nothing that indicated Ms Byrne was going faster than the speed limit. (T: 36) Reluctantly the Senior Constable gave a "ballpark figure" of between 100 and 120 km/h.

23. Given the relative inexperience of Ms Byrne with a more powerful car I can easily imagine the speed creeping over the limit, despite her endeavours and observations. However in the absence of further evidence I am unable to do more than the police officer, and place a ballpark figure of between 100 and 120 km/h on her speed. She may well have been driving at the limit of 100, or she may have been over in that range. In any event, I find that excessive speed did not play a major part in the death of the deceased.

24. What occurred next is under some dispute between the evidence of Ms Byrne and that of Mr Brocklehurst, and I quote from the evidence of Ms Byrne (T: 60).

"MS MORRIS: Now as you're driving back, the accident happened; can you just tell the coroner, as you can remember it, what happened?---I can tell you from the way – from exactly where it happened. There was a car in front of me. I was travelling in the right-hand lane all the way from Palmerston and this other car was in the left and I didn't have enough room to get past at all. And I braked and swerved to the left to avoid hitting him. I just missed him and swerved to the right to regain control of the car which had lost control after I braked and swerved".

And (T: 71)

"MR CANTRILL: You see, you've heard Mr Brocklehurst today and I think on other occasions say something to the effect that you were some 30 or so metres past him before you appeared to start veering, first to your left and then off to the right?---Well, that's incorrect.

Do you agree with that?---No I don't agree.

Where do you say you were in relation to his car when you first veered your direction either left or right?---When I swerved?

Yes?---I was behind him.

And how far behind him?---I was just about to pass, so it would have been ---

So was it a car length, or less than a car length; two car lengths?---Less than a car length. It was really close. Enough for me to have to brake so I avoid hitting him."

25. I find the following facts, on the balance of probabilities. At about 20:30hrs Ms Byrne, in the right-hand outward bound lane, approached the rear of Mr Brocklehurst's vehicle, which had been in the left-hand outward bound lane. As Ms Byrne approached to within a short distance behind Mr Brocklehurst, she noticed that his ute had without warning encroached into her lane. How far I am not able to say, but sufficient that it caused her to judge that she could not proceed without taking some evasive action. This straying into Ms Byrne's lane was not a deliberate action by Mr Brocklehurst, but would have stemmed from inattention, probably due to his weariness. Ms Byrne applied the brakes and swung left in order to pull in behind his ute. This manoeuvre caused her to lose control of her car, which she attempted to correct by a sharp right hand turn. Ms Byrne's ability to take quick and appropriate evasive action would have been detrimentally effected to some extent by her alcohol consumption. As a result of

her evasive manoeuvre the back of her vehicle began to slide, and it ran off the road on the right hand side, down the embankment, where it entered a drain area. The dynamics caused the vehicle to roll as it came out the other side and towards the path of oncoming traffic, including the vehicle driven by the deceased.

26. I find that the vehicle driven by Ms Byrne was already out of her control as it went into a slide and passed the right hand side of the vehicle driven by Mr Brocklehurst. I find that it went off the road a car length or two in front of Mr Brocklehurst. In coming to this finding I reject the evidence given at the Inquest by Mr Brocklehurst that Ms Byrne's vehicle went off the road some 30 yards in front of him. I note that in Mr Brocklehurst's initial statement to police he says (and I accept):

> "The car, a silver 4-door sedan, came past me on my right pretty quick and from what I could see of the car it did not look to be under total control. It appeared to be bobbing on its suspension from side to side, these were only small movements".

27. In making these findings in relation to the details of the actual accident, after consideration of all the evidence, including oral evidence given before me at the Inquest, except where otherwise indicated, I prefer the evidence of Ms Byrne to that of Mr Brocklehurst where there is conflict.

28. The deceased saw the approaching rolling vehicle and braked hard, however Ms Byrne's vehicle was completely airborne at this time. It had travelled some 26 metres across a grass division, which included a drain. The rear left wheel of her car penetrated the deceased's side cabin area, and the deceased was killed almost immediately. This collision was, to use the words of the accident investigator (Senior Constable Lovell) with whom I agree, "a very freak accident" (T: 25)

29. Whilst Mr Brocklehurst in his evidence says he saw this accident occur from his right hand window, he did not stop to render assistance. He did contact police at the Palmerston police station later that evening, indicating that he may be a witness.

30. Other witnesses did stop at the accident, and rendered assistance, including emergency first aid treatment, to both the deceased and Ms Byrne. Of special

note and commendation is the assistance given by Ms Elizabeth Stone and Mr Mark Eglington. Police and emergency services were notified by mobile phone immediately after the accident, and the first unit attended on the scene three minutes later.

The investigation

31. As a result of the death of the deceased a coronial investigation into the death and accident was carried out by Senior Constable Robert Lovell of the Accident Investigation Unit of the Northern Territory Police. The Senior Constable gave evidence before me of attending on the night of the accident, taking measurements and observations, of later taking statements and preparing the investigation file, which was tendered before me as Exhibit 1. Counsel for Mr Brocklehurst made some criticism of this investigation during closing submissions. However I am unable to find that the investigation was deficient.

32. Counsel for Mr Brocklehurst drew my attention to the transcript of criminal proceedings against Mr Brocklehurst which is in evidence before me. She states that Mr Brocklehurst was subjected to a series of questions intended to attribute blame to him. (T: 103) (Exhibit: 6, pages 45,47,52,53). It was also submitted that in the police interview with Ms Byrne she was not challenged as to the accuracy of her answers. Opportunity was given to Counsel throughout the Inquest to cross examine the witnesses, and put to them any allegations of bias, or to draw from witnesses any further information in relation to the investigation or the accident. This was not done. Both Ms Byrne and Mr Brocklehurst have told substantially the same story since their interview with police, both in this court and in the criminal proceedings.

33. During the course of the investigation and over the ensuing months regular contact was made with the family of the deceased by all relevant agencies as to the progress and procedure of the investigation. This included contact with the investigating officer, and a police officer who was a friend of the deceased's family, contact with the victim support officer from the Office of the Director of Public Prosecutions, in order to explain criminal proceedings, and contact with the Coroner's Constable and the Deputy Coroner in relation to coronial matters.

34. This is the sad death of a man much loved by his family and friends, who through no fault of his own had died on the road as the result of a motor vehicle accident; unfortunately a matter of a second one way or the other would have seen him avoid death. The accident was not caused by any intentional act, but rather a set of circumstances and factors, none of which had anything to do with the deceased, which culminated in the death.

Dated this 30th day of March 2001.

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GREG CAVANAGH

TERRITORY CORONER