CITATION: *Inquest into the death of Kenneth Alderson [2005] NTMC* 050

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO:	D0081/2004
DELIVERED ON:	19 August 2005
HEARING DATE(S):	15 and 16 August 2005
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Motor Accident, pedestrian walking into motor vehicle, death by misadventure

REPRESENTATION:

Counsel:

Assisting:	Mr Michael Grant
Representing the Department of Police, Fire and Emergency Services:	Mr Jack Lewis

Judgment category classification:	B
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IN THE CORONER'S COURT
AT DARWIN IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No: D0081/2004

In the matter of an Inquest into the death of

KENNETH ALDERSON ON 16 MAY 2004 AT THE ROYAL DARWIN HOSPITAL IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

(Delivered 19 August 2005)

Mr Cavanagh SM:

The nature and scope of the inquest

1. Kenneth Alderson ("the deceased") was hit by a police vehicle at 5.00pm on Saturday, 15 May 2004 whilst attempting to cross East Point Road. He was taken to Royal Darwin Hospital and pronounced dead at 4.00pm on Sunday, 16 May 2004.

2. An inquest into the death of the deceased was convened on the recommendation of the Deputy Coroner. There were three matters underlying that recommendation. The first was that the deceased was hit by a Police vehicle en route to an emergency call in circumstances where the vehicle's lights and sirens were not activated. The second was a suggestion by a member of the deceased's family that the deceased was well known to Police and that the collision may have been deliberate. The third matter of concern was the prevalence of the deaths of this type. That is to say, there is a long history of pedestrians under the influence of alcohol being involved in motor vehicle accidents. The deceased's blood alcohol content at the time of his death was 0.247%.

3. 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
>
> (b) a disaster shall, if possible, find –
> (i) the cause and origin of the disaster; and
> (ii) the circumstances in which the disaster occurred."

4. Section 34(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."

5. 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."

6. The public Inquest in this matter was heard at the Darwin Magistrates Courts over the days of 15 and 16 August 2005. Counsel assisting me over the course of the Inquest was Mr Michael Grant. At the commencement of the inquest, Mr Jack Lewis sought leave to appear on behalf of the Department of Police, Fire and Emergency Services. I granted that leave pursuant to s40(3) of the Act.

7. The family of the deceased was not represented during the course of the inquest. They have previously had dealings with the North Australian Aboriginal Legal Aid Service in relation to the matter. That Service was advised of the hearing date. Although the family was not represented, the Coroner's office arranged and paid for the attendance at the inquest of the deceased's brother, Philip Alderson. He gave evidence during the course of the matter. Various other members of the deceased's family also attended for the inquest, including his sister, daughter, son-in-law and various grandchildren.

Formal findings

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

(1) The identity of the deceased was Kenneth Alderson.
(2) The deceased died at Royal Darwin Hospital on 16 May 2004.
(3) The cause of death was blunt head trauma resulting from a motor vehicle accident in which the deceased was a pedestrian.
(4) The particulars required to register the death are:
    (i) the deceased was male;
    (ii) the deceased was of Aboriginal descent;
    (iii) a post-mortem examination was carried out;
    (iv) the pathologist viewed the body after death;
    (v) the pathologist was Dr Terence Sinton;
    (vi) the father of the deceased was William Alderson;

(vii) the mother of the deceased was (Minnie) Elanowa Gulanowa;

(viii) the deceased resided at Spring Peak Outstation at Kakadu National Park; and

(ix) the deceased was a pensioner.

Relevant circumstances concerning the death

9. The deceased was one of the traditional owners of country within Kakadu National Park. He was normally resident at Spring Peak Outstation in Kakadu National Park.

10. On the Tuesday prior to his death he had traveled into Darwin with his brother, Philip Alderson, and nephew, Eric "Laurie" Patterson. They stayed the first night at the Value Inn in Darwin. The following night they met a relative, Sally Munungurr, at the Casino. She invited them to stay with her at her unit in a complex at Parap. The invitation was accepted.

11. On the morning of 15 May 2004, the deceased began drinking and socializing with various friends and relatives. At one point, the group congregated in the vicinity of the manmade lake near Vesteys Beach. Precisely what happened thereafter is not entirely clear from the evidence.

12. The statements of Eric Patterson and Michael Davies indicate that Eric Patterson and Philip Alderson went to the bottle shop at the Parap Hotel to procure more supplies. After some time, the deceased left the lake to find them and was hit by the vehicle shortly thereafter.

13. Philip Alderson gave evidence to the effect that the whole party had returned to Munungurr's unit and had then gone to the bottle shop at the Parap Hotel. The party then started walking down Gregory Street back to the area of the lake, with the deceased approximately 200 to

300 metres ahead of his brother. On that account, the deceased had been hit by the time Philip Alderson reached Gregory Street.

14. There is also evidence from the deceased's son-in-law to the effect that he saw the deceased in the vicinity of the Nightcliff shops at or about 4 pm on that afternoon. If that is so, it is not clear how the deceased thereafter traveled to Vesteys Beach prior to his death. Even if Mr Payne is correct in that recollection, on the family's account the deceased was a very brisk walker and it would have been quite possible for him to have made the journey on foot in that time.

15. It is not necessary for these purposes to determine the deceased's precise movements on the afternoon in question in order to find the circumstances relevant to his death. It is beyond doubt that at the time immediately prior to the incident the deceased was on the beach side of East Point Road. It is also plain that the deceased found himself at that location of his own free will. He was not being pursued or harassed at the time. He plainly made an ill-fated determination to cross the road with tragic results.

16. The point at which the deceased chose to cross the road was approximately 35 metres on the city side of the junction between Gregory Street and East Point Road. .

17. The precise manner in which the deceased crossed the road was another matter in respect of which there was some divergence in the evidence. The inquest received evidence from Lorraine Corowa and Lauren Hogg. They were travelling in separate vehicles outbound along East Point Road immediately prior to the incident. Both saw the deceased cross the road ahead of them. Both recall that the deceased had run across the outbound lane and, without pause, directly into the path of the Police vehicle travelling in the inbound lane.

18. The evidence does not exactly match with that given by the driver of the vehicle, Constable Simon Neave, the passenger, Constable Adam Raimondo, or that of Major James Ayliffe, who was also travelling outbound along East Point Road immediately prior to the accident. Their evidence is that the deceased moved rapidly across the outbound lane and then paused or propped on the centre line for some seconds before stepping directly into the side of the Police vehicle travelling along the inbound lane. As is the nature of evidence given by several different “eye” witnesses to the same event, there are differences in recollection, and this is not unusual or, indeed, sinister.

19. I prefer the account of Neave, Raimondo and Ayliffe, they had a better view of the deceased's progress across the road. Corowa and Hogg had their views of the deceased obscured at various points of the deceased's passage. Again, this divergence in the evidence does not have any bearing on my conclusions. Even if the evidence of Corowa and Hogg was preferred, a scenario that had the deceased running directly across the road without pause into the Police vehicle is even less capable of sustaining a finding of fault on the part of the driver.

20. The witnesses to the incident are consistent in one matter, and that is that the deceased stepped or ran into the vehicle. This account is borne out by the evidence in relation to the point of impact. The deceased did not make contact with the leading edge of the vehicle, or any part of the front of the vehicle. The deceased made contact with the vehicle at or about the point of the rear vision mirror on the driver's side door. His head then came into contact with the "cage" on the back of the Police van. That contact proved fatal.

21. It should also be noted that the driver of the vehicle was breath tested by the Shift Sergeant who attended immediately after the incident. Constable Neave returned a zero reading on test.

22. It falls then to consider whether the driver of the vehicle had opportunity to take evasive action. In the minutes prior to the collision, the vehicle had been undertaking routine patrol duties at East Point Reserve. The members received a call from the Communications centre requiring their attendance at an attempted suicide in Stuart Park. The members responded to that call and proceeded along East Point Road past the Darwin Sailing Club to the Gregory Street intersection. The analysis conducted by the Accident Investigation Unit indicates that the vehicle was travelling between 67 and 72 kilometres per hour at the time of impact. That is consistent with the estimates given by the passenger in the vehicle and eyewitnesses to the effect that the vehicle was travelling somewhere between 65 and 70 kilometres per hour at the time.

23. Constable Neave's account when he gave a recorded interview the day after the death was that he did not see the deceased until he was 10 metres from the vehicle. At first blush, it appeared unlikely that the driver had not seen the deceased until that point. Prior to the conduct of the inquest, Constable Neave attended at the site of the accident in company with his counsel and solicitor. During that attendance he indicated that he had first seen the deceased at about the point of the median strip bisecting the mouth of Gregory Street as it joins East Point Road. Evidence received during the course of the inquest, and certain measurements taken at a view during the course of the hearing, establish that point to have been some 45 to 48 metres from the point of impact.

24. I do not see anything untoward in Constable Neave's initial underestimation of the distance, or his subsequent account that he first saw the deceased at a significantly greater distance from the point of impact. I accept that account. Constable Neave impressed me as a straightforward and honest witness who in the recent aftermath of the incident did not give full or close consideration to the distances involved. It is also clear from the evidence received during the course

of the inquest that Constable Neave was very much concerned for the deceased following the accident and remains disturbed about the incident.

25. For the reasons detailed above, it is my finding that the deceased paused on the line dividing the lanes for a number of seconds. Constable Raimondo had been observing the deceased's progress for a distance of approximately 100 metres from the point of impact. It is Constable Raimondo's clear evidence that the deceased reached the dividing line and paused when the police vehicle was approximately 50 metres from him. The deceased remained in that position until the vehicle was practically adjacent to him, whereupon he moved into it. The driver of the vehicle was entitled to assume that the deceased would remain in that position and would give way to the vehicle.

26. Given a scenario, it was not possible for the driver to break in time. The inquest received evidence to the effect that the normal person's reaction time is between 0.75 and 1 second. In that period, a vehicle moving at 70 kilometres per hour will travel between 15 and 20 metres. That is to say, the normal person could not be expected to apply the brakes in response to the threat of impact until the vehicle had travelled to between 15 and 20 metres from first site of the threat. Thereafter, of course, a further period of time and distance will elapse before the application of the brakes can bring the vehicle to a stop. In this case, I find that the deceased did not move into the path of the vehicle until it was significantly closer than 15 or 20 metres away. Accordingly, Constable Neave had no chance to avoid the collision.

27. That raises two questions. The first is whether the speed at which the vehicle was travelling at the relevant time was reasonable. The second is whether, having seen the deceased, Constable Neave should have manoeuvred the vehicle to the left of the lane in order to give himself more reaction time in the event that the deceased acted as he subsequently did.

28. The speed limit along that section of road is 60 kilometres per hour. The vehicle was travelling closer to 70 kilometres per hour. The vehicle was attending an emergency call. I find that speed was reasonable in the circumstances. Conditions were good. The day was light and clear. Traffic was moderate. Constable Raimondo was of the view that the speed was both reasonable and appropriate in the circumstances. None of the civilian witnesses indicated that the Police vehicle was travelling at anything other than an appropriate speed. Constable Neave had 22 years driving experience at the time of the incident. He has much experience with trucks, farm machinery and other technical driving activities. Constable Raimondo assessed him as a safe driver. During his emergency driving training he was assessed as a standard quality police driver. I am cognizant of the fact that much of that training took place after the accident, but there is no basis on which to consider that Constable Neave's abilities and aptitude for driving were of any lesser quality beforehand.

29. Constable Raimondo gave evidence to the effect that he thought the driver of the vehicle had "eased off" slightly upon seeing the deceased, and then reapplied the accelerator once it appeared that the deceased was going to maintain his position on the centre line. It was also Constable Neave's recollection that he had taken his foot off the accelerator upon seeing the deceased. Although there may have been some easing off, the vehicle's speed did not decrease markedly as it approached the deceased.

30. I find that there was no relevant failing on Constable Neave's part by reason of the fact that he did not reduce the speed significantly upon seeing the deceased. As stated, he was entitled to assume that the deceased would give way to the vehicle. It is also the case that even had Constable Neave been travelling, say, at 40 kilometres hour as he approached the deceased, the deceased's movement took place at a point so proximate to the vehicle that even at that speed Constable

Neave would not have been able to take action to avoid the incident. It is true that the injury sustained by the deceased may have been of a different order had the vehicle only been travelling at 40 kilometres per hour, but to what extent is entirely within the realms of speculation.

31. I am also unable to find any fault on Constable Neave's part in relation to his positioning within the lane. Both police and civilian witnesses gave evidence to the effect that the Police vehicle had moved towards the kerb as it approached the deceased. That movement cannot have been far completed prior to the point of impact. I say that having regard to Sergeant Ruehland's evidence that the skid marks commenced at a point relatively close to the centre line. Ranged against that evidence is Sergeant Ruzsicska's opinion that any line of travel close to the kerb in that vicinity would have been less than ideal. The lane is relatively narrow. The verge of the road is covered in dense vegetation. To travel too closely to the verge in those circumstances would have given rise to some risk in relation to unforeseen hazards to the driver's left.

32. In making these findings I am mindful of Sergeant Ruehland's opinion that the circumstances of this death gave rise to some *prima facie* concern of a lack of due care on the part of the driver. That opinion was based in large part on the assumption that the driver had not seen the deceased until he was some 10 metres away. I agree with Sergeant Ruehland that had this been so some real question would arise as to why the driver had not noticed the deceased at some earlier point. As discussed above, however, evidence received during the course of the inquest (which I accept) establishes that was not the case. Sergeant Ruehland also had some subsidiary concern in relation to the speed of the vehicle and its positioning in the lane. For reasons already detailed, I do not find that there was any breach of care on the part of the driver in those respects.

33. In any event, on the basis of Sergeant Ruehland's concerns the matter was referred to the office of the Director of Public Prosecutions to determine whether any prosecution action was warranted. The officer in charge of the summary prosecution unit provided an opinion to the effect that it was not. That opinion was reviewed by the Deputy Director, Mr Karczewski QC, who concurred. Sergeant Ruehland was satisfied with that outcome.

34. The Police are to be commended for the very rigorous investigation that was conducted. There can be no suggestion that the matter was not pursued vigorously because a Police vehicle was involved. The evidence shows the case to be quite to the contrary. The Police are also to be commended for referring the matter to the Director of Public Prosecutions for such prosecution action as might be warranted in the circumstances. I consider that it is always better in circumstances where a Police vehicle has been involved in a fatal accident to have the matter reviewed by that office in order to avoid any suggestion of a partisan approach to the question whether charges should be laid.

35. I have independently formed the view that there was no lack of care on the part of the driver in this case. The matter has already been referred to the Director of Public Prosecutions, and that office apparently reached the same view. For these reasons, there is no call for a report pursuant to subsection 35(3) of the Act.

36. It is also necessary to give some consideration to the circumstances in which the police vehicle was travelling inbound at the time. As already indicated, immediately before the incident the vehicle had been patrolling East Point Reserve. The members received a call from Communications to attend an attempted suicide in Stuart Park. Under the Communications protocols in place at the time, this attendance should have been designated a Code 1 task, and that designation should have been conveyed to the members by Communications. That

information was not provided to the members. The Communications auxiliary was subject to disciplinary action in relation to that failure.

37. The members apparently assumed that it was a Code 2 task and, further, that the activation of lights and siren was optional for tasks in that category. Under the protocol in place at the time, lights and sirens were required to be activated for both Code 1 and Code 2 tasks, except in circumstances where stealth was required. This protocol have been changed since the accident. That change was entirely unrelated to the circumstances of the accident. Under the new protocol, the determination whether to activate lights and siren is left to the discretion of the members for both Code 1 and Code 2 tasks.

38. That calls for some consideration whether there was a failure on the part of the officers concerned in not activating the lights and siren and, further, whether the activation of the lights and sirens would have averted the accident. As to the first matter, there is no doubt that technically the officers should have activated the lights and siren at the time. That is no longer the case. That the protocol has changed undermines the relevance of the technical breach. Had the members been operating under present circumstances, they would have been quite entitled to use their discretion to determine whether to activate lights and siren.

39. Both members gave evidence to the effect that they did not consider lights and siren necessary in the circumstances. Traffic was moderate. The light was good. The inquest also heard evidence from Sergeant Ruzsicska, the officer in charge of the Police Driver Training Unit, as to the many considerations that must be taken into account in determining whether to use lights and siren in any given circumstance. He did not consider that the members were at fault for not using lights and siren in the circumstances. I am also unable to find fault in that respect.

40. It is not possible to say whether the use of lights and siren would have avoided the accident. Constable Raimondo gave evidence to the effect that the deceased looked squarely at the Police vehicle as it approached. In those circumstances, it would seem highly unlikely that he was unaware of its approach. If that was so, the activation of lights and siren would not have increased his level of awareness. In addressing this issue, I am also mindful of the deceased's level of intoxication. That is relevant in two senses. First, it goes to provide some explanation as to why he moved into the vehicle if aware of its approach. Secondly, his impaired state also renders it impossible for me to make any determination as to what he may or may not have done had the lights and siren been activated.

41. Finally, there is the matter of the suggestion that the incident may not have been accidental. This was not raised at any stage during the course of the inquest. It was a matter that arose from a comment made by a family member when interviewed by investigating police. Suggestions of that nature require close scrutiny. It is true that the deceased was well known to police, and had served a number of substantial periods of imprisonment. Having said this, there was not a scintilla of evidence received during the course of the inquest to support a suggestion that the incident might have been anything other than accidental. It is also the case that neither Constable Neave nor Constable Raimondo had previously had any dealings with the deceased. They were entirely unaware of his existence prior to the collision. Constable Neave had only been in the police service for two years at the time of the incident. Constable Raimondo had only been on active duty for two weeks at the time of the incident. Therefore, I reject the suggestion.

42. It is also of some note that the deceased had previously been hit by a civilian vehicle in Coconut Grove in 2002. He was similarly intoxicated at that time.

Conclusion

43. In the final analysis, it is my conclusion that responsibility for the occurrence lies with the deceased. He chose to cross East Point Road in dangerous circumstances and in a dangerous fashion. He did not avail himself of the pedestrian crossing some 50 metres up the road. He first crossed the outbound lane in the face of oncoming traffic. The deceased then appears to have entirely misjudged the passage of the Police vehicle in the inbound lane. That miscalculation led to him stepping into the vehicle as it passed. Although it is unfortunate that I must do so in circumstances where the deceased has lost his life, I find that his conduct was careless to the point of recklessness. Conversely, Constable Neave did not display any lack of care in terms of what a reasonably prudent driver would have done in response to the deceased's conduct.

Dated this 19th day of August 2005

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GREG CAVANAGH

Territory Coroner