CITATION: *Inquest into the death of Louisa May Turner* [2007] NTMC 007

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coronial
FILE NO(s):	D0150/2005
DELIVERED ON:	26 February 2007
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HEARING DATE(s):	20 February 2005 18 April 2005 17 July 2006 21 August 2006 10 October 2006
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Motor vehicle accident, quality of coronial investigation by police, belief as to crimes.

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
NT Police:	Mr Michael Grant QC
Europcar:	Mr Ben O'Loughlin

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

No. D0150/2005

In the matter of an Inquest into the death of

LOUISA MAY TURNER
ON 23 AUGUST 2005
ON THE ARNHEM HIGHWAY, JABIRU

FINDINGS

26 February 2007

Mr Greg Cavanagh SM:

1. The deceased, Louisa May Turner, was a seven year old child fatally injured in a motor vehicle accident on 23 August 2005. The collision involved two vehicles, one in which the deceased was travelling with her grandparents and the other driven by a tourist visiting from Germany, Mr Luthar Eibofner. The circumstances of the collision, to which I will return, was such that the fault was on the part of Mr Eibofner.

2. The death was investigated and reported to the Coroner as it fell within the definition of a reportable death pursuant to section 12 of the *Coroners Act*. The public Inquest was held pursuant to my discretion under section 15 of the *Coroners Act*. Section 34 of the *Coroners Act* sets out the matters that a Coroner investigating a death shall find, if possible:

> "(1) A Coroner investigating -
>
> (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

3. 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."

4. The five hearing days took place over several months, due to a long illness of the investigating police officer. The Commissioner of Police and the police officers were represented by Mr Grant QC. Mr O'Loughlin appeared later in the inquest on instructions from Europcar. The material tendered before me consisted of the initial investigation brief prepared by Senior Constable Humphreys as well as several additional statements and reports, totalling 14 Exhibits.

FORMAL FINDINGS

5. Pursuant to s. 34 of the Act, I find, as a result of evidence adduced at the public Inquest as follows:

(i) The identity of the deceased person was Louisa May Turner born on 8 December 1997 at Darwin in the Northern Territory of Australia.

(ii) The time and place of death was at the Arnhem Highway at Jabiru at 10:15am on 23 August 2005.

(iii) The cause of death was a broken neck.

(iv) Particulars required to register death:

1. The deceased was a female.

2. The deceased's name was Louisa May Turner.

3. The deceased was Caucasian Australian.

4. The death was reported to the Coroner.

5. The cause of death was confirmed by post-mortem examination and was a broken neck.

6. The pathologist was Dr Terence John Sinton of Royal Darwin Hospital.

7. The deceased's mother is Penny Louise Turner and her father is Wayne Edward Turner.

8. The deceased lived at 110 Collard Road, Humpty Doo, NT.

9. The deceased was a school student.

10. The deceased was born on 8 December 1997.

CIRCUMSTANCES OF THE DEATH AND INITIAL INVESTIGATION

6. On 23 August 2005 Louisa was travelling with her grandparents to attend a citizenship ceremony of a relative in Jabiru. Derek James, the husband of Jennifer Lawrie (Louisa's grandmother) was driving the car. The group left the Humpty Doo area at about 8:00am and headed towards Jabiru along the Arnhem Highway, driving generally at about 100 kilometres per hour. Not long before the accident they stopped for a short roadside break because they had a dog also travelling in the car. This was no more than 5 minutes and they set off again. Louisa was wearing her seat belt. Ms Lawrie is certain about this and her recollection is consistent with the observations made by Dr Sinton, the forensic pathologist who performed the autopsy, of characteristic seatbelt injuries. About 15 minutes later, approaching the turnoff to Ubirr, Ms Lawrie heard her husband exclaim, and she saw a silver vehicle in their lane which appeared to be coming directly towards their car.

7. The silver vehicle was a Kia Cavalier with Victorian registration which had been hired from the Europcar outlet at Cairns Airport by the driver, Mr

Luthar Eibofner. Mr Eibofner had travelled from Cairns with his wife and daughter, in convoy with friends Max and Barbara Lemmerz.

8. The accident occurred at the junction where the Oenpelli Road meets the Arnhem Highway, approximately 2 kilometres west of Jabiru. The Kia started to turn right across the path of the Toyota Camry driven by Mr James and the impact occurred between the two vehicles on the outbound lane. That is the lane in which the Camry was travelling. The vehicles collided almost head on. Ms Lawrie and Mr James were both seriously injured. Ms Lawrie spent over 3 months in hospital and had several operations. Mr James remains in an extremely seriously condition, even now.

9. The deceased child received non-survivable injuries and died very shortly after the accident (if not immediately), as a result of a broken neck.

10. The Jabiru police members arrived on the scene, including Sergeant Pusterla and Senior Constable Mader. Senior Constable (now Sergeant) Mader gave oral evidence at the Inquest in addition to his statement which forms part of Exhibit 3. He arrived at the scene and commenced initial investigations. After observing the passengers in the Camry and seeing that they were being treated by medical personnel he went to speak with Mr Eibofner, who identified himself as the driver of the other vehicle. Mrs Barbara Lemmerz, the friend of the Eibofners, could speak English well and so most of the communication was directed through her. It became clear from discussions that the Lemmerz' couple and the Eibofners initially believed that the accident had occurred because the Camry came out of the Oenpelli Road. Sometime later at the police station, Senior Constable Mader explained that this was not what had apparently happened and after some discussion Mr Eibofner appeared to accept that it was in fact him turning into the Oenpelli Road in the Camry's path that had caused the accident. Mr Eibofner became extremely distressed at this realisation, to the point that Senior Constable Mader asked for assistance from the Health Clinic to ensure his health and

safety. Senior Constable Mader confirmed in evidence that, although not mentioned in his statement, he had used a hand held breath test on Mr Eibofner which proved negative. About two hours after the accident the Accident Investigation Unit (AIU) [members Wedding and Humphreys] arrived from Darwin, and the investigation was handed over to them.

11. Mr Eibofner was not available to give evidence before me at the Inquest. He had returned to Germany and he was contacted prior to the Inquest by Superintendent Rennie at the request of my Counsel Assisting. Superintendent Rennie spoke to Mr Eibofner by telephone using a telephone interpreter about three times between January and April 2006. He related to the court that Mr Eibofner was reluctant to participate but indicated that he would perhaps do so (by way of video link) if the proceedings could be closed; or he would perhaps agree to answer written questions. Given that one the of essential elements of Coronial proceedings are that they are held in public, I declined to have him participate on this basis. He also told Superintendent Rennie that he was continuing to receive counselling in relation to the crash and he was reluctant to raise the incident again. Therefore the only version of the accident that I have directly from Mr Eibofner is his record of interview with the Accident Investigation Unit members, which I shall return to. In that interview he gives essentially no explanation for why he turned right in front of an oncoming vehicle. It appears that the most probable conclusion is that he did not look for the vehicle, perhaps due to momentary confusion over the fact that he was used to driving on the right hand side of the road and therefore would not need to check for oncoming traffic when turning right.

12. That momentary confusion has had tragic and far reaching consequences. One matter of significant additional distress to the Turner family is their perception that the administration of justice miscarried with regard to the process for charging and dealing with Mr Eibofner in the criminal jurisdiction. The allegation of that failure was investigated by an internal

review and I have the results of that investigation in a report under the hand of Assistant Commissioner Payne (Exhibit 14).

13. The motor vehicle accident causing the death of Louisa was investigated by Senior Constable Shane Humphreys who has been a police officer for about 11 years, and has been attached to the Accident Investigation Unit for about 6 of those years. Sen. Const. Humphries has previous qualifications as a mechanic and he has long standing experience in the inspection of motor vehicles. He has also completed the Advanced Accident Reconstruction course and various technical courses around the investigation of motor vehicle accidents. He investigated the mechanics of this accident and I find that investigation was done to a good standard (albeit that the overall investigation was not).

14. After the scene investigation out at Jabiru, he arrived back in Darwin at midday on Wednesday 24 August, along with his colleague, Senior Constable Wedding. Mr Eibofner and his wife attended the police station as requested but the language barrier was such that an interpreter was obviously required. Arrangements were initially made for Thursday 25 August, but the interpreter was unavailable that day and the next arrangement was for them to come back on Friday 26th. That meeting did not occur because Sen. Const. Humphreys was contacted by Mr Peter Elliott, a lawyer who had been retained by Mr Eibofner. He indicated that he wished to attend the Police Station with Mr Eibofner and so his availability, along with that of the interpreter, had to be considered. It transpired that the time that both Mr Elliott and the interpreter were available, was Saturday morning.

15. Sen. Const. Humphreys was aware of what at that stage was a directive (it had not yet become part of a General Order) that Major Crime Detectives were to become involved in the investigation of fatal motor vehicle accidents if the accident investigator or his supervisors deemed that

necessary. Sen. Const. Humphreys had made contact with the officer in charge of the Major Crime Unit on the Wednesday to request a detective to attend to conduct the interview with Mr Eibofner. Detective Sen. Const. Cummins was allocated to assist. The interview did not proceed during the week and Detective Cummins was not available on the Saturday morning (no doubt because she was working an ordinary Monday-Friday shift). Senior Constable Humphreys did not recall becoming aware of her unavailability in advance. However, in his statement made soon after the death, Senior Constable Wedding recalls Senior Constable Humphreys raising it with him on Friday; and asking him to assist in the interview instead. It seems more likely on the evidence that Senior Constable Humphreys made the decision to have Senior Constable Wedding in the interview as second member, knowing in advance that the CIB member could not attend. He did not take the option of pursuing the issue with his superiors. He decided that given the previous scheduling difficulties, his priority was to proceed with the interview "*so that the matter could be brought before the court due to the impending departure of the Eibofners*". They were due to depart Australia, and did so, on Wednesday 31 August 2005.

16. In any event the failure to have a detective present or assisting with the interview did not constitute a failure to adhere to the General Orders applicable at the time. However, the formulation of the questions and the conduct of the interview was not of a good investigative standard. This was also the finding of Assistant Commissioner Payne in his report and so much was conceded before me by Mr Grant QC, counsel for the Commissioner for Police and involved officers.

17. The charge of doing a dangerous act causing death contrary to section 154 of the *Criminal Code* was not considered appropriate by Senior Constable Humphreys (and by senior police and police prosecutors who also saw the file). In my view, however, I find that the facts as they stood are sufficient to satisfy the test in section 35 of the *Coroners Act*, that is, that a crime **may**

have been committed in relation to this death viz, "Dangerous Act" pursuant to section 154 of the *Criminal Code*. I am aware that the question of further charges has been considered by the Director of Public Prosecutions, however, I take the view that section 35 mandates my referral to him, even in those circumstances.

18. In my view the overall coronial investigation was not of a good standard. Deficiencies included the quality of the record of interview, the presence of another witness (Mr Eibofner's wife) in the interview prior to that witness providing a statement, and the failure to obtain adequate (or any) statements from other potential eyewitnesses prior to making a decision as to charges. The other witnesses, including Mr Lemmerz (who was driving the vehicle behind Mr Eibofner) and Ms Lawrie (in the passenger seat with Mr James) had not provided any evidence at the time charges were finalised and the matter was brought before the court. In Ms Lawrie's case I accept that she was very seriously injured and it may not have been appropriate to interview her within a couple of days of the accident. With regard to the Lemmerzs' I accept that there were some difficulties with the interpreter but the approach that was taken, namely waiting for the availability of Mr Elliott, was somewhat flawed in that the Lemmerz' were not defendants who required legal advice but merely eyewitnesses.

19. The matter came before the court on the Monday after the accident. Mr Eibofner pleaded guilty to a charge of Driving without Due Care and he was dealt with by way of a sentence suspended immediately. He returned to Germany. The Turner family were not told that Mr Eibofner's traffic charges were coming before the Court on the day that they did; and this has contributed to the distress of the family. It was clear that Mr Turner was interested in the outcome of the investigation as he had telephoned Senior Constable Humphreys a number of times and even asked him whether Mr Eibofner would be going to gaol. In his evidence in chief it was put to Sen. Const Humphreys that the family "should have been brought up to speed at

all times" and he agreed with this proposition. He also agreed when it was put to him that he would have handled the matter differently in hindsight. He was further asked:

> "I know that you've already said in evidence that you would do it differently in hindsight, but is there a reason that you didn't notify the Turner family that the matter was going to court on the Monday following the accident?---No real reason apart from the fact that the Turner family were going through a traumatic period at the time and I put together a file that was going to court, and further notification to the family didn't happen. I just didn't do it."

20. The new General Order "Crashes" commenced in about April 2006. Paragraph 46 of that General Order mandates that:

> the divisional officer of a member investigating a fatal or serious injury crash will ensure an experienced investigator from either crime, command or the regional investigation section is allocated to provide oversight and assistance with all facets of the investigation including but not limited to participating in record of interviews. The level of involvement by an experienced investigative member will vary, depending on the seriousness of the crash, of if prosecution is envisaged.

21. I heard evidence in this Inquest (and am also aware anecdotally through my Office) that it is now the case that Major Crime detectives do become involved in fatal motor vehicle accident investigations consistent with that General Order. It is not intended, or certainly I do not understand the Order to envisage, that the investigation of fatal motor vehicle accidents somehow be "transferred" to Major Crime, but rather there be cooperation so that each officer involved can provide his or her particular expertise.

22. There is an additional separate issue which was raised during the Inquest and that is whether there ought to have been any further warning provided by Europcar with respect to the road rules in Australia. It does appear to be the case that Mr Eibofner's familiarity with driving on the right hand side of the road contributed to the crash. I arranged for Sen. Const Wedding to further investigate precisely what safety information is provided to

international visitors hiring vehicles and his initial investigation into that issue raised a suggestion that information provided by Europcar at Cairns International Airport may have been lacking.

23. Mr O'Laughlin of counsel sought leave to appear at the Inquest on the instructions of Europcar to address my concerns. It appears that the brochures reminding drivers to drive on the left hand side of the road were probably not available at Cairns International Airport at the time Mr Eibofner hired the car. He had, however, received such a warning on the documentation provided by his German travel agency (who booked the vehicle). The evidence was that Europcar "ran out" of the pamphlets in about August 2005 and only recently have newly printed pamphlets been available. Those provide simple safety tips in several languages, including reminding the driver to drive on the left hand side and suggesting that the driver have passengers continue to remind him, particularly at intersections. In any event it is worth noting that at the time of this accident Mr Eibofner had driven close to 6,000 kilometres in Australia after leaving Cairns and was obviously aware of the road rules. I am satisfied that Europcar took my concerns seriously and have responded promptly to them.

RECOMMENDATIONS

24. I report this matter to the Director of Public Prosecutions and the Commissioner of Police pursuant to section 35 of the *Coroners Act*, as I believe that a crime may have been committed in connection with this death.

25. I make no further formal recommendations with respect to this death.

Dated this 26th day of February 2007.

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GREG CAVANAGH
TERRITORY CORONER