QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Geoffrey George Candlin**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2011/1075
DELIVERED ON:	23 January 2015
DELIVERED AT:	Cairns
HEARING DATE(s):	12 to 14 January 2015
FINDINGS OF:	Jane Bentley, Coroner
CATCHWORDS:	Coroners: inquest, traffic accident, heavy vehicle, Bruce Highway, Department of Transport and Main Roads, National Heavy Vehicle Accreditation Scheme, Maintenance Management Scheme, Transport inspectors.

REPRESENTATION:

Counsel Assisting:	Ms Stephanie Williams
Office of Fair and Safe Work, Queensland:	Mr McCabe, Crown Law
Department of Transport and Main Roads:	Mr McMillan i/b DTMR
Mr Gordon:	Mr Geeves i/b Malcolmson Lawyers

Introduction

Section 45 of the *Coroners Act 2003* provides that when an inquest is held the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations. These are my findings in relation to the death of Geoffrey George Candlin. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

These findings and comments:

1 confirm the identity of the deceased person, the time, place and medical cause of his death;

2 consider whether the actions or omissions of any third party contributed to his death; and

3 consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Summary

On the morning of 29 March 2011 Mr Candlin was driving his yellow and blue Renault Kangaroo van, Queensland registration 732RCA, in a southerly direction on the Bruce Highway at Julago.

Rodney Wayne Gordon was driving a blue Kenworth prime mover, Queensland registration 044HZK, towing two trailers in a B double configuration, in a northerly direction on the Bruce Highway at Julago.

Mr Gordon was employed by McAlpine Freightlines Pty Ltd (McAlpine).

At about 4.55am at a location between Julago Street and Lowe Road, Julago, the prime mover veered to the left and travelled almost completely off the roadway on the western side of the highway and onto the grassed table drain area. It travelled a distance along the table drain before veering back onto the road.

The prime mover and the first trailer (A trailer) narrowly avoided a 2.5 metre deep drain but the second trailer (B trailer) entered the drain area and impacted with the opposite bank of the drain before it re-emerged onto the roadway. The right rear light assembly of the B trailer struck the driver's side of the Renault.

The impact tore the complete right rear tail light assembly and a section of fibreglass from the B trailer.

Mr Candlin sustained severe head injuries and died almost instantly.

The Renault continued in a southerly direction and came to rest in the western side of the roadway on the grass table drain area. Mr Gordon did not stop at the scene of the accident. He continued to drive north.

Autopsy results

Professor Williams, Senior Specialist Pathologist, conducted an autopsy and found that Mr Candlin died from head injury he sustained in the accident. He noted that the injury would have been rapidly fatal.

Investigations

Queensland Police Service

Police attended the scene of the accident and noted that there had been another vehicle involved.

On the morning of 29 March 2011 Edward Handley was driving a prime mover north on the Bruce Highway. As he was driving past the AIMS turnoff heading towards Townsville he was overtaken by a blue Kenworth prime mover with white B double trailers. That vehicle had been following him for some time. The driver called Mr Handley over the radio and told him he was going to overtake.

As the vehicle overtook him Mr Handley saw that the rear lights were intact and in working order.

A few minutes later, after passing the service station at Alligator Creek, Mr Handley saw the Renault van on the grass on the side of the road. He thought it was parked there. He continued to drive into Townsville and he saw the blue Kenworth prime mover again. At this time he saw that the rear right lights were completely missing from the B trailer.

Later that morning, Mr Handley was told that there had been an accident involving a van and someone had been killed. He thought it possible that the Kenworth prime mover might have been involved in the accident and so told police what he had observed.

Police located Mr Gordon and the prime mover at business premises of Carter & Spencer Group at Mount Louisa. The B trailer was being unloaded.

Mr Gordon told a police officer, Constable Jessen, that he was the driver of the prime mover, that he had driven it from Mackay and that he left Mackay about midnight.

Police saw that the rear of the B trailer was damaged. The lights were missing and the remaining wiring had been tied up along the side of the trailer. There was blue and yellow paint along the rear right side of the trailer. One of the front support legs of the trailer was bent and was being supported by some wooden pallets.

Police ascertained that Mr Gordon had arrived at Wholesale Fruit and Vegetable warehouse at West End, South Townsville at 5.11am. Zbigniew

Baran the Managing Director of Townsville Wholesale Fruit and Vegetables, saw that the right rear tail light assembly was missing and it looked like it had been ripped out. He asked Mr Gordon what had happened and Mr Gordon said he didn't know.

Robert Nelson, a delivery driver for Wholesale Fruit and Vegetable Warehouse, also saw the damage to the truck and asked Mr Gordon if he had hit something. Mr Gordon said that he didn't recall hitting anything. He then asked Mr Nelson to help him straighten the leg on the trailer. It was bent in towards the middle of the trailer. Mr Nelson asked Mr Gordon what had happened to it and Mr Gordon replied that it must have been like that when he collected the truck.

Mr Baran had telephoned Mr Gordon at 4.53am on 29 March 2011. During that conversation Mr Gordon said that he was just going past Alligator Creek. Mr Nelson also phoned Mr Gordon at about that time and he said he was at Alligator Creek.

At about 5.30am that morning. Jeffrey Miller, the Operations Manager of McAlpine, phoned Mr Gordon on his mobile telephone. Mr Gordon told Mr Miller that he had hit something but he didn't remember doing it and he hadn't seen anything. He said that one of the trailer legs was bent back about six inches and there was a hole in the fuel tank. He said there was a complete set of tail lights missing from the right hand rear of the B trailer.

At about 7.05am Mr Gordon spoke to Stephen Robinson, the warehouse supervisor at Carter & Spencer. Mr Gordon said that either he had hit something or someone else had and he would need to put some pallets under the leg so he could get the other trailer out. He said the lights had been ripped off and he didn't know whether he had done it or the previous driver.

Nigel Sheriff, the driver who handed the truck over to Mr Gordon in Mackay, told police that there was no damage to the prime mover or the trailers at that time.

Mr Gordon was arrested. He refused to participate in an interview or answer any questions about the accident. He was taken to the Townsville watch house. Constable Alberich later attended the Townsville watchhouse to take Mr Gordon to the Townsville Hospital.

Constable Alberich saw that Mr Gordon was asleep in a cell. He was snoring loudly. It took some time to wake him. He noted that Mr Gordon's eyes were bloodshot and glassy. He was continually yawning and appeared to be very tired.

Blood was taken from Mr Gordon at the hospital. Analysis of the blood revealed that Mr Gordon was not under the influence of alcohol or drugs at the time of the accident.

Mr Gordon was returned to the watchhouse where, after obtaining legal advice, he again refused to answer any questions.

Investigators of the Forensic Crash Unit of the Queensland Police Service investigated the accident.

Scientific testing confirmed that the prime mover had been the other vehicle involved in the accident.

Both vehicles and the trailers were mechanically inspected by the QPS Vehicle Inspection Officer, Simon Bradshaw.

The Renault was in a satisfactory mechanical condition with no defects which could have contributed to the accident.

The prime mover was found to be in a potentially dangerous mechanical condition, especially whilst in a laden state, due to the following defects:

- the second drive axle left service brake chamber was completely inoperative which is unsatisfactory, and appeared to have been in that state for a reasonable duration of time due to the resultant corrosion noted to the associated componentry;

- both first axle drives required adjustment and had the stroke alerts visible which is also unsatisfactory;

- both second drive axle linings were worn to expose the rivet heads and all drive axle brake drums were excessively worn which is unsatisfactory;

- in relation to the steering the pitman arm was loose which was unsatisfactory;

- the right number plate lamp and right front spotlamp were inoperative which is unsatisfactory.

Mr Major concluded that the brakes of the prime mover were in a potentially dangerous condition, especially whilst laden, and the conditions of the brakes were indicative of a gross lack of maintenance.

The first trailer was found to be in an undesirable mechanical condition due to the following defects:

- the left first and second axle shock absorber catch straps were split and in an undesirable condition;

- one of the right clearance lamps was intact but inoperative;

- the first axle right inner tyre, the second axle right inner tyre and both third axle right tyres were devoid of sufficient tread depth to sections of their tread widths which is unsatisfactory.

The second trailer was found to be in an unsatisfactory mechanical condition due to the following defects:

- both first axle brakes, the second axle left brake and the third axle left brake were due for adjustment;
- the third axle right lower brake shoe was only making limited contact with its respective brake drum which is unsatisfactory;
- the first axle right shock absorber and both second axle shock absorbers were loose which is unsatisfactory;
- the second axle left airbag and mounting plate were offset which is undesirable;
- both number plate lamps, the left front upper clearance lamp and the left fourth clearance lamp were intact but inoperative which is unsatisfactory.

The Fleet Work Detail report for the prime mover, obtained from McAlpine by my office, indicated that the prime mover had work done on its braking system on 7 January 2011. On that date the odometer reading was 728,007. There is no record of any further work being carried out on the brakes prior to the accident on 29 March 2011. On that date the odometer reading was 805,499.

FCU investigators concluded:

- the reason that the prime mover veered from the roadway could not be ascertained;
- the vehicle veered left for approximately 100 metres before returning to the road;
- it was raining heavily at the time of the accident;
- the road was in good condition with no defects which could have contributed to the accident.

Mr Gordon was charged that on 29 March 2011 he dangerously operated a vehicle on the Bruce Highway and caused the death of Geoffrey George Candlin and he ought reasonably to have known that Mr Candlin had been killed and he left the scene of the incident before a police officer arrived. On 29 May 2013 in the District Court at Townsville a jury found Mr Gordon not guilty of that charge.

Department of Transport and Main Roads Investigations

DTMR investigated the accident with a view to ascertaining whether there were any road factors that might have contributed to the cause or severity of the crash. The Technical Officer found that the road was in good condition with no visible defects which could have contributed to the accident.

The report included information about previous crashes at the location of the accident. As at 18 April 2011 there had been thirty four crashes in total and three fatal crashes at the site including the accident that caused the death of Mr Candlin.

The second fatal crash involved a northbound four wheel drive vehicle losing control and rolling into the oncoming lane killing the driver of a southbound sedan. Alcohol and fatigue were contributing factors.

The third fatal crash occurred when a vehicle entered the highway from an intersection and failed to give way to a southbound petrol tanker.

Of the remaining 31 crashes 10 were single vehicle crashes. Seven of those involved vehicles veering left off the road, overcorrecting and then losing control – five of those were northbound vehicles:

- five involved undue attention by drivers;
- three were fatigue related;
- two involved improper overtaking;
- one involved a distraction in the vehicle;
- one involved hitting an object on the roadway.

The remaining 21 crashes were multi vehicle crashes:

- 13 resulted from drivers failing to give way to oncoming traffic;
- four involved following too closely;
- five were undue care and attention;
- two resulted from animals on roadway – one cow and one horse;
- two involved alcohol and/or drugs.

The report concluded that no road feature contributed to the accident that caused the death of Mr Candlin and no further action was required by the Department.

Office of Fair and Safe Work Investigations

OFSWQ was advised of the accident by police. OFSWQ did not undertake an investigation into the death for the following reasons:

- OFSWQ was not advised of any maintenance issues with either of the vehicles;
- QPS was the lead agency;
- There were no workplace health and safety issues identified;
- DTMR had jurisdiction to investigate issues such as driver fatigue.

On 23 December 2013 a Memorandum of Understanding between OFSWQ, QPS and DTMR, in relation to traffic incidents, came into effect. Prior to that date there was no such MOU.

The purpose of that MOU is to build and maintain a professional relationship between the departments and to clarify specific working arrangements between the agencies in relation to the attendance, investigation and reporting of traffic incidents and to provide specific information on the respective roles, responsibilities and obligations of the departmental officers. A further purpose is to ensure that coroners are informed of the extent of each agency's investigation into a reportable death.

The departments agreed to ensure that relevant agency officers are provided with appropriate training and resources to enable them to give effect to the MOU. It was agreed that a coordinating officer would be established to lead the investigation and facilitate cooperation and completion of the investigation.

The MOU notes that where a traffic incident relates to …roadworthiness of the vehicle … there are specific regulations surrounding these matters administered by DTMR, however, it is recommended that QPS has primary jurisdictional carriage. The MOU notes that such matters would not normally be investigated by WHSQ.

The MOU states:

> *DTMR is specifically interested in and should only be contacted regarding accidents that relate to heavy vehicle and passenger transport vehicle fatalities; or in the event of a major incident where QPS requires specific specialist support about matters relating to either the Transport Operations (Road Use Management) Act 1995 or the Transport Operations (Passenger Transport) Act 1994.*

The MOU provides that OFSWQ will undertake preliminary enquiries to determine whether … inadequate maintenance … of road vehicles and associated attachments (e.g. trailers) may have contributed to the incident. If OFSWQ determines the matter does not have a degree of work-related cause the QPS officer will be advised that OFSWQ does not intend to further investigate the matter.

The MOU contemplates advice being provided to the coroner by OFSWQ and QPS but not by DTMR.

Rodney Gordon's Driver's licence

On 10 June 2011 Mr Gordon was driving a prime mover towing two trailers in a B double configuration. He was still working for McAlpine. At about noon the vehicle driven by Mr Gordon left the highway near Killymoon Creek, on the way into Townsville. Police attended the scene of the accident. There was debris over the roadway. Mr Gordon was in the process of changing a tyre on the rear of the B trailer of the B double combination. Mr Gordon told police officers that the tyre blew causing the rear trailer to leave the road but he managed to regain control and stop the vehicle.

Police conducted an examination of the area which revealed that the vehicle had completely left the road surface and travelled for a distance in the grass

table drain area before returning to the roadway. Police concluded that the vehicle had crossed over onto the incorrect side of the roadway and come into contact with the bridge supports before returning to the correct side of the road.

Forensic Crash Unit investigators found that it was highly unlikely that a tyre blowing on the rear trailer would cause such an event.

Police spoke to Jeffrey Miller about this accident. He told police that Mr Gordon had told him that the event occurred because Mr Gordon had not secured the A trailer locking pins correctly and the trailer had slid back onto the B trailer causing the vehicle to travel off the road. Investigators concluded that this scenario was also unlikely.

Because of the similarity between the accident causing the death of Mr Candlin and the incident occurring shortly after on 10 June 2011 Senior Constable Eggins of the FCU held concerns about whether Mr Gordon should continue to drive heavy vehicles. Senior Constable Eggins recommended that the information obtained by police be forwarded to the Chief Executive of DTMR and that the Department consider an immediate suspension of Mr Gordon's driving licences.

Mr Gordon's traffic history at that time reflected that he had, on six occasions, been charged with driving for times exceeding the maximum allowable, that he had three convictions for failing to record information in his log book appropriately and that he had been convicted of towing a non-compliant load. The traffic history also contained other minor entries.

As discussed below, although DTMR was requested by the office of the Northern Coroner to provide all material and information relevant to the accident involving the death of Mr Candlin, no information in regard to the actions taken by DTMR was provided until a couple of days before the inquest. That information consisted of some documentation which seemed to indicate that Mr Gordon's licence was cancelled on 18 August 2011 and reissued on 19 August 2011 after he provided a medical certificate from a General Practitioner.

The inquest

A pre-inquest directions hearing was held on 2 December 2012. QPS, DTMR and OFSWQ appeared as parties to the inquest. A Senior Legal Officer for DTMR appeared by telephone.

DTMR had been advised of the coronial investigation and information sought by the Office of the Northern Coroner from that Department as to the investigations which had been carried out into the accident. Those enquiries commenced in November 2013.

On 24 January 2014, DTMR, through its Senior Legal Officer, was asked whether the Department had investigated the roadworthiness or otherwise of the heavy vehicle involved in the accident. No information was provided.

On 24 February 2014, and in response to a direction issued by me to provide information, DTMR provided a report written by Denise Elrick which set out her investigations into the condition of the road at the location of the accident. That report was completed by Ms Elrick in 2011 but had not, previous to the direction, been provided to me.

In October 2014, DTMR was advised that an inquest would be held. The Senior Legal Officer asked Counsel Assisting for guidance as to whether it would assist the coroner for the Department to take part in the inquest, as:

> *Based on our Fatal Crash Report, there does not appear to be any issues for the Department to address.*

Counsel Assisting advised the Senior Legal Officer that, as the inquest would investigate the scope of each Department's investigation and their role in investigations into accidents of this kind, DTMR's appearance would be of assistance.

On 28 October 2014, DTMR was provided with the brief of evidence for the inquest which encompassed all the material held by the coroner.

At the hearing on 2 December 2014, Counsel Assisting summarised the matter stating the circumstances of the accident and summarising the investigations which had been carried out (as known to her at that time). In relation to DTMR she stated:

> *DTMR considered that the crash was due to the action of Mr Gordon. It noted in its investigation report that Police considered that no road features contributed to the crash. DTMR concluded that no further action was required.*

Although information as to its investigations, particularly as to roadworthiness of the vehicle, had been specifically requested as had all material relevant to the inquest, and despite the fact that it must have been apparent to the Senior Legal Officer of DTMR, from the above paragraph, and the brief of evidence, that my office was unaware of further investigations that the Department had carried out, the Department still provided no further information.

At the directions hearing Counsel Assisting advised that the issues to be explored at the inquest were:

1. The circumstances surrounding the death of Geoffrey Candlin and

2. The nature and extent of the investigations into the death by QPS, DTMR and OFSWQ, including the criteria for investigation by each department in relation to such accidents.

Despite DTMR being in possession of information and material that was directly relevant to the second issue, the Senior Legal Officer neither advised Ms Williams of that fact nor provided any of the material.

In fact, as will be seen below, DTMR had been involved in the suspension of Mr Gordon's driver's licence and also had conducted, as the Queensland agent of the National Heavy Vehicle Accreditation Scheme, a complete audit of the fleet of McAlpine. That audit had resulted in that company losing its accreditation. Such information was distinctly relevant to the issues to be explored at inquest, as known to the Department. If that information had been provided in a timely manner and prior to the commencement of the inquest, the scope of the inquest would have very likely been significantly narrowed resulting in savings to the Court and the Departments that appeared.

In addition to failing to provide relevant information, after the directions hearing, the Senior Legal Officer of DTMR advised Counsel Assisting that she considered that the Department did not need to appear at the inquest and also requested leave to appear by telephone. After further discussions in which the Senior Legal Officer was advised that the role of the Department was very relevant to the inquiry, DTMR briefed Mr McMillan on 18 December 2014.

Unfortunately, as well as failing to disclose the relevant information to my office the Department also failed to disclose it to its Counsel. Mr McMillan was unaware, when he appeared at the inquest, of the significant investigations that DTMR had undertaken in relation to the accident and the outcome of those investigations. In addition, DTMR did not send an instructing solicitor to the inquest. The court time lost during adjournments to allow Mr McMillan to track down relevant witnesses and obtain statements from them was exacerbated by the absence of an instructing solicitor.

At the commencement of the second day of the inquest DTMR produced 40 pages of documents relating to a show cause issue notice issued to McAlpine under the NHVAS. A witness was identified who could give evidence pertaining to that. Ultimately, the statement of that witness and the witness were not available until the third day of the inquest.

At the end of the first day of the inquest, when it became evident that evidence would be called which would concern the NHVAS accreditation of McAlpine and the state of its fleet at the time of the accident, Counsel Assisting contacted the managing director of Alpine Fresh Pty Ltd, Mr McAlpine, and advised him of that and asked whether he wished to obtain legal advice and/or appear at the inquest.

Mr McAlpine stated that he was willing to appear at the inquest if required.

The evidence

Counsel Assisting tendered a brief of evidence encompassing 34 exhibits. Twelve witnesses appeared at the inquest. Ten of those were scheduled to appear and two further DTMR witnesses were identified and called during the inquest.

Peter Glen Alberich

Sergeant Alberich attended the scene of the accident. He first saw Mr Gordon in the Townsville watchhouse between 10am and 11am the same day. Mr Gordon was asleep and was difficult to wake up. Sergeant Alberich took him to the Townsville Hospital for a blood specimen to be obtained and then returned him to the watchhouse. Mr Gordon was yawning and appeared tired during that time.

Kylie Jessen

Senior Constable Jessen saw Mr Gordon at 7.39am on 29 March 2011 at the premises of Carter & Spencer. He told her he had driven the truck from Mackay after leaving there at about midnight. He seemed calm and was not showing any signs of fatigue at that time.

Simon Bradshaw Major

Mr Major is a Vehicle Inspection Officer with the Queensland Police Service. He inspected all four vehicles involved in the accident – the prime mover, the A trailer, the B trailer and the Renault.

He found that the prime mover was in a potentially dangerous mechanical condition at the time of the accident because of the condition of the brakes.

Mr Major said that the brakes had been in that condition for some time as the surfaces were rusty. They had been like that for more than a week but he couldn't be more specific as their appearance would depend on the distance the vehicle had travelled and the conditions.

Mr Major said that under normal driving conditions it may appear that the brakes were operating normally but in an emergency braking situation the stopping distance would be increased as the brakes would not be functioning as well as they should.

Mr Major said that all the defects he found were due to a lack of maintenance. The vehicles had not been looked after appropriately.

Mr Major said that the condition of the prime mover and trailers was indicative of a very poor level of maintenance. There were lots of very simple basic measures that had not been carried out.

The worn state of the tyres also demonstrated a lack of routine maintenance as, if the vehicles had been serviced regularly and properly maintained, the tyres would have been rotated.

Mr Major said that heavy vehicles should have the lights and tyres checked on a daily basis and the brakes adjusted every 10,000 kilometres at the most, depending on the type of driving they were doing.

Mr Major said that the defects to the B trailer and the prime mover would result in those vehicles being classed as defective vehicles under the *Transport (Operations and Road Use Management) Act* 1995.

Mr Major said that none of the defects identified by him could have contributed to the accident as none would cause the vehicle to veer from the road.

Mr Major stated that these vehicles were maintained by the owner under the National Heavy Vehicle Accreditation Scheme which was, at the time of the accident, and still is, administered in Queensland by DTMR.

Mr Major said that he his enquiries revealed that McAlpine was accredited under the Maintenance Management arm of the Scheme at the time of the accident.

Mr Major said that, in his experience, some vehicles subject to the Scheme were poorly maintained as they were not often subject to audits under the Scheme and often only inspected after they had been involved in accidents.

Mr Major said that he submitted his inspection report, outlining the defects in the vehicles, to DTMR for the purposes of the NHVAS. Mr Major produced emails that he had received in reply in which Chantal Pedley, Senior Adviser of Road Safety and System Management Division of DTMR advised that an audit had been conducted of the vehicles operated by McAlpine.

The evidence of Mr Major resulted in further inquiries being conducted by Mr McMillan as to the nature of investigations conducted by DTMR. Prior to Mr Major's evidence the fact of the audit was unknown to the inquest as it had not been disclosed by DTMR.

The inquest was adjourned for the afternoon of the first day in order for Mr McMillan to take instructions and identify appropriate witnesses to give evidence of the Scheme and the audit.

Stephen Robinson

Mr Robinson had known Mr Gordon, as the driver for McAlpine, for three years as at March 2011. Mr Gordon had driven for two other companies prior to being employed by McAlpine's and Mr Robinson also had contact with him during that employment.

When Mr Robinson saw Mr Gordon on the morning of 29 March 2011 he appeared alert and calm. He told Mr Robinson that he couldn't get the leg on the B trailer to wind down and either he had hit something or the previous driver had. Mr Robinson pointed out to Mr Gordon that he had no tail lights and asked him whether he had checked them at handover. Mr Gordon replied that it had been too dark at that time.

Jeffrey Miller

Mr Miller said that McAlpine is now Alpine Fresh Pty Ltd. He has worked there for seven years altogether. He said that Mr Gordon's employment ceased in about May 2011.

At about 5.30am on 29 March 2011 Mr Miller phoned Mr Gordon and Mr Gordon told him that he had lost a set of tail lights from the truck. He said he didn't know what had caused the damage and couldn't recall hitting anything. Mr Robinson said that he should carry on to the next customer and they would sort out repairs later.

Mr Miller later spoke to Mr Sheriff and asked whether the tail lights were ok when he left the truck and he said they were.

Mr Gordon sent a photo of the damage to Mr Miller. When Mr Miller saw the damage he thought that Mr Gordon must have driven over something really large and was surprised that he hadn't seen it and didn't know what he had hit.

Mr Miller said that the vehicles were checked every second day when they returned to Brisbane by the mechanic at their Rocklea depot. The mechanic checked the lights, tyres and oil every second day and the vehicles were serviced every 20,000 km.

Mr Miller said that McAlpine's was accredited under the NHVAS but Alpine Fresh never applied for accreditation so the vehicles operated by that company undergo the usual mandatory 12 month vehicle inspection.

Mr Miller said that Mr Gordon had always been a good driver – he was always available, punctual and good with his paperwork and the customers. Mr Miller said that there had been no accidents involving Mr Gordon prior to 29 March 2011 but there had been one after that date. About three months later the prime mover being driven by Mr Gordon ran off the road. Mr Gordon told Mr Miller that the front trailer pins weren't locked in and the front tyre blew. Mr Miller believed that the explanation was reasonable. However, management were concerned that Mr Gordon may have been affected by the accident involving Mr Candlin and he may have been distracted which is why he didn't couple the trailers properly.

Since the accident on 29 March Mr Gordon's attendance had dropped and his trips were taking longer. He was asked to leave on the day of the second accident.

In response to a question asked by Mr Geeves, Mr Miller stated that he would find it hard to believe that Mr Gordon would have felt the impact when he collided with the Renault.

Nigel Sheriff

Mr Sheriff said that there was nothing wrong with the vehicles when he handed over to Mr Gordon in Mackay at midnight on 29 March.

Mr Sheriff has been driving B doubles for five or six years. He was told of the damage done to the B trailer and he saw photos of the damage. He stated that he could not see how Mr Gordon would not have felt the impact of the collision that caused such damage.

Robert Eggins

Senior Constable Eggins gave evidence of his investigation into the accident. He said that, due to the weather conditions at the time, he could not determine the actual location at which the vehicles collided as there was no physical evidence of that collision on the roadway.

Senior Constable Eggins said that the Renault van had effectively been prised open like a can opener by the rear of the B trailer.

He formed the opinion that the heavy vehicle had veered from the roadway and part of it had gone into the drain and the collision had occurred as the driver was attempting to get it back onto the road. He believes that the impact would have occurred around the centre line of the road.

He couldn't ascertain why the prime mover had left the road as Mr Gordon refused to answer any questions.

Senior Constable Eggins discounted the possibility that the phone call by Mr Baran to Mr Gordon had contributed to the accident as it had occurred when Mr Gordon was 3 to 4 minutes away from the location of the accident.

In the absence of any information from Mr Gordon, Mr Eggins believed that two factors may have contributed to the accident – fatigue or Mr Gordon was driving too fast for the prevailing conditions.

Senior Constable Eggins believed that fatigue may have been a factor because he was present when Mr Gordon was awoken in the watchhouse later that morning and taken to the hospital. Mr Eggins observed that he was in a deep sleep and then went back to sleep in the police car and at the hospital and on the way back to the watchhouse.

Senior Constable Eggins said that there was no evidence that the Renault had left the road or was on the incorrect side of the road at the time of impact.

Senior Constable Eggins said that the road was in good condition and there was nothing about the road that would cause the prime mover to leave the roadway.

Senior Constable Eggins said that he believes that the B trailer went into the drain. In the weather conditions the road would have been like an ice skating rink. As it came out of the drain and back onto the roadway the rear trailer swung out and impacted the van on the other side of the road.

Senior Constable Eggins said that it was possible that Mr Gordon would not have seen the van and would not have known of the collision.

Senior Constable Eggins said at the time of the crash, when an accident involved a heavy vehicle, QPS would contact DTMR (Qld Transport at that time) and a transport inspector would attend the site and inspect and weigh the vehicle. That did not occur in this case as Mr Gordon left the location.

About two years ago Qld Transport advised QPS that transport inspectors would no longer attend the scene of fatal accidents involving heavy vehicles. As they no longer attend there is no opportunity to check the weight of the vehicle or maintenance issues at the scene.

Senior Constable Eggins said that FCU investigators are much assisted by transport inspectors attending at the scene because they are able to obtain evidence e.g. with mobile brake testing equipment, which may later be unobtainable. Senior Constable Eggins said that transport inspectors are able to do testing of brakes at the site that cannot be carried out later when the brakes have cooled.

Senior Constable Eggins said that QPS would share information with DTMR if requested. He said he has not received a request from DTMR as the NHVAS regulator.

In response to questions by Mr Geeves, Mr Eggins agreed that he could not categorically rule out the possibility that Mr Candlin's van crossed the centre line and the impact occurred on that side of the road. He said that he could not discount the weather as a factor which contributed to Mr Gordon veering from the road but that Mr Gordon should have been driving to the prevailing conditions and if the bad weather had contributed then he hadn't been doing so.

Rodney Gordon

Mr Gordon initially refused to answer questions in relation to the accident on the grounds that his answers might tend to incriminate him and he was directed to do so pursuant to s. 39(2) *Coroners Act* 2003.

Mr Gordon said that he is now retired from truck driving and a full time carer for his wife. He has not driven a heavy vehicle since he ceased employment with McAlpine and does not intend to do so again.

Mr Gordon said that on 29 March 2011 he started driving at about midnight in Mackay.

He said he could not recall passing another truck near Alligator Creek. He recalled taking a phone call from Mr Baran.

Shortly after that phone call it was raining heavily and "pitch black". Mr Gordon said that he drove off the roadway and then back on. He had to fight to get the truck back onto the road. He recalls seeing the table drain in front of him and

it was then that he realised that he had veered from the roadway. He had to turn sharply to avoid the prime mover going into the drain.

Mr Gordon said that it was fairly rough as he was bringing the truck back onto the road. He couldn't say whether the rear trailers were fishtailing. He thinks that the rear trailer would have stayed in the correct lane. Mr Gordon said that he believes this to be the case because the trailer would follow the direction that the prime mover was heading. He then said that to avoid the drain he steered sharply to the right and then back to the left.

At the time he left the road he could see only a short distance in front of him because of the weather. He did not see any other vehicles on the road. He didn't see the Renault van and was not aware that he had hit it.

Mr Gordon said that he was driving at about 100 kilometres per hour when he left the roadway. He now thinks that it was stupid to be driving at that speed and he was going too fast.

Mr Gordon said that he had slept for 8 to 10 hours before commencing driving that night and he was not tired.

Mr Gordon said that, at this first stop in Townsville he saw that the rear lights were gone and the leg of the trailer had been bent and he thought the damage had occurred when he went off the road.

He didn't tell Mr Miller or Mr Robinson that he had veered from the roadway.

In relation to the incident in June 2011 Mr Gordon said whilst he was driving one of the tyres blew out and at the same time the pin securing the front trailer popped out which caused the vehicle to pull to the left.

In relation to the suspension of his licence Mr Gordon said that he attended a sleep study on 9 August 2011 and then obtained a medical certificate from his GP.

Robert Eggins

Senior Constable Eggins, after hearing the evidence of Mr Gordon, was recalled to give further evidence. Senior Constable Eggins said that Mr Gordon was not driving to the conditions and, given Mr Gordon's description of what occurred, he believes that the rear trailer crossed the centre line and the collision occurred on Mr Candlin's side of the road.

Denise Elrick

Ms Elrick said that after investigating the road condition and prior accidents at that location she concluded that the road was in good condition and the infrastructure appropriate to the location. She said that most accidents involving vehicles veering from the road are not caused by road conditions but by drivers e.g. fatigue, speed, alcohol/drugs.

Dean Coggins

Mr Coggins explained that OFSWQ decided, after preliminary investigations, not to conduct a complete investigation into this matter due to the fact that there were no issues of maintenance or fatigue that directly contributed to the death of Mr Candlin.

Jacqueline Anderson

Ms Anderson, Principal Policy Officer of DTMR, produced a statement and gave evidence on the last day of the hearing.

Ms Anderson stated that on 8 July 2011 DTMR received a letter from QPS raising concerns about Mr Gordon's fitness to drive heavy vehicles.

On the same day DTMR issued a show cause notice to Mr Gordon proposing to cancel his licence on and from 9 August 2011. On 9 August 2011 DTMR issued an extension of time to Mr Gordon allowing him to make representations by 18 August 2011 for a show cause action in response to a document provided by Respiratory & Sleep Specialists.

As no information was received from Mr Gordon by 18 August 2011 his licence was cancelled on 19 August 2011.

On 19 August 2011 Mr Gordon attended the Mackay DTMR Customer Service Centre and applied to get his licence back. He declared that he did not have any medical condition that was likely to adversely affect his ability to drive safely and produced a medical certificate completed by his treating doctor which stated that he met the medical criteria for a conditional licence but required further review on 12 April 2012.

The Mackay CSC issued Mr Gordon with a probationary driver's licence which expired on 18 August 2012.

On 10 April 2012 Mr Gordon provided a further certificate from his treating doctor which declared that he met the medical criteria for an unconditional licence. Mr Gordon was issued with an open licence on 19 August 2012.

Ms Anderson stated that DTMR does not undertake any independent assessment of a person's fitness to drive safely. If a treating doctor certifies that a person is fit to drive, a licence is then issued to that person. DTMR is unaware of any tests that person has undergone or the information that they have relayed to their doctor.

Chantal Pedley

Ms Pedley produced a statement and gave evidence on the last day of the hearing. She is the Policy Officer, DTMR, and her responsibilities include participation in the management and oversight of a range of accreditation schemes operated by the DTMR.

One of these is the NHVAS. This is a voluntary alternative scheme to conventional heavy vehicle compliance methods and regulation. Operators accredited under the Scheme must demonstrate that their vehicles and drivers comply with standards set by the Scheme through periodic audits of their transport management systems and vehicle or driver assessments.

The Maintenance Management module of the NHVAS negates the need for accredited operators to obtain an annual Certificate of Inspection for their heavy vehicles in order to have the registration renewed. It is the obligation of the operator to maintain their vehicles according to NHVAS Business Rules and Standards.

McAlpine was accredited under the scheme on 4 July 2009 for a period of two years.

On 11 April 2011 Ms Pedley received an email from Mr Major concerning his inspection of the prime mover and trailers.

On the same day Ms Pedley organised a spot check of McAlpine's fleet of vehicles. That occurred at the company's Rocklea premises on 14 April 2011.

The Maintenance Management spot check report revealed that McAlpine Freight had 12 non-conformances with the NHVAS standards and 10 corrective actions were raised for the company to rectify the non-conformances.

Ms Pedley requested DTMR transport inspectors to carry out vehicle inspections in an Interim Maintenance Audit to identify whether the mechanical condition of McAlpine vehicles operating under the NHVAS complied with the appropriate standards.

The audit was conducted on seven heavy vehicles at the Rocklea premises on 5 May 2011. All vehicles were found to be defective with defects ranging from minor to major. Those vehicles were cleared of those defects by the end of May 2011.

On 4 July 2011 Ms Pedley issued a notice to the company which immediately suspended McAlpine's accreditation under the Maintenance Management scheme and required the company to show cause as to why the accreditation should not be cancelled. The company did not respond to the show cause notice and all accreditation of McAlpine under the scheme expired on 8 July 2011.

On 30 July 2011 Mc Alpine presented eighteen heavy vehicles for Certificates of Inspection by transport inspectors. Only two of those eighteen vehicles passed the inspections and the remaining sixteen failed due to defects identified as dangerous. Officers issued cease use notices with respect to those sixteen vehicles.

Ms Pedley stated that, as at 29 March 2011, McAlpine was a company which was of concern to DTMR due to the number of infringement notices that had

been issued to its drivers. However, it had not been subject to any audits or inspections by DTMR.

Ms Pedley said that as at 29 March 2011 the States and Territories administered the NHVAS. Now it is administered by a national body but DTMR acts on its behalf in Queensland. There are three DTMR inspectors who are responsible for carrying out all random spot checks across the state.

Accredited operators do not have to obtain annual certificates of roadworthiness. The only method of checking whether these operators are complying with their obligations under the scheme and maintaining their heavy vehicles appropriately are the random spot checks that are carried out by those three officers. There are no other inspections or audits carried out on an operator unless DTMR is advised of concerns e.g. by another department or transport inspectors.

Accredited operators are obliged to keep maintenance sheets and service schedules for each of their vehicles but these do not have to be submitted to the regulator. Operators are audited when they apply for renewal of their accreditation.

Ms Pedley said that although she is now aware that DTMR Compliance section held concerns about the number of infringement notices issued to McAlpine drivers those concerns had not been passed on to the section of DTMR administering the NHVAS.

At the time of the accident DTMR transport inspectors attended heavy vehicle crash scenes if requested by QPS. This ceased in about mid 2012 “due to workplace health and safety issues.”

Ms Pedley produced DTMR’s ‘Incident Attendance Policy’ which set out when DTMR officers would attend traffic accidents. Ms Pedley said the policy was in effect as at 29 March 2011 but it is no longer in force and there is no replacement policy.

Annexed to that policy is a document entitled “Coronial Investigations and Inquests, A Guide.” It was unclear from Ms Pedley’s evidence whether that was a current document. That guide stated that coroners may request information in relation to reportable deaths and all such information requests are coordinated through the Legal Services Unit of the Legal & Prosecution Services Branch. It states:

> *At the investigation stage of the coronial (sic) it may be that a well considered and detailed response from the Department results in the inquest (if there is to be one) being held on the papers without the necessity for departmental staff to give evidence.*

The Policy also advised:

A well prepared statement can be very worthwhile as it may avoid the need for an inquest or reduce the extent of questioning at the inquest.

Submissions

Ms Williams submitted that I consider making the following recommendations:

1. DTMR appoint a coronial liaison officer;

2. DTMR and/or NHVAS regulator consider reinstituting the attendance of Transport inspectors at fatal road crashes involving heavy vehicles.

In relation to the first recommendation Mr McMillan stated that DTMR does not object to that recommendation and would duly consider such a recommendation.

In relation to the second recommendation Mr McMillan submitted that it should be addressed to the national body which would at this time delegate investigations to DTMR but may, in future, have its own personnel to carry out such duties.

Mr McCabe and Mr Geeves, as was appropriate, did not make any submissions as to the proposed recommendations.

Comments, Recommendations and Findings

The scope of the Coroner's inquiry and findings

An inquest is not a trial between opposing parties but an inquiry into a death. The scope of an inquest goes beyond merely establishing the medical cause of death.

The focus is on discovering what happened; not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and, in appropriate cases, with a view to reducing the likelihood of similar deaths.

As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.

A coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable.

Proceedings in a coroner's court are not bound by the rules of evidence. That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven.

If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant department. A coroner may also refer a matter to the Criminal Misconduct Commission or a relevant disciplinary body.

Comments

Circumstances of accident

At about 4.56am on 29 March 2011 the prime mover being driven by Mr Gordon left the Bruce Highway when it veered to the left. The prime mover left the roadway because Mr Gordon was unable to see the side of the road due to the heavy rain and poor visibility. He was travelling at a speed of 100 kilometres per hour which was too fast for the poor conditions.

Mr Gordon realised he was off the road when he saw a concrete table drain directly in front of him. He steered the prime mover violently to the right and then to the left to get it back onto the roadway. The road was slippery and wet and he was fighting to keep control of the heavy vehicle. Mr Gordon said that such was his difficulty in getting the prime mover back onto the road that he didn't see Mr Candlin's car coming towards him.

I am satisfied that the B trailer of the B double configuration crossed the centre line of the road and collided with Mr Candlin's car. There is no evidence to indicate and no reason to believe that Mr Candlin's car crossed to the wrong side of the road at exactly the time that Mr Gordon was trying to get back onto the road. It was Mr Gordon's vehicle that was travelling out of control. Mr Candlin was on the correct side of the road at the time of impact.

When he saw the damage later that morning he told all of those to whom he spoke that he did not know how the damage had been caused and that he didn't know whether he or the previous driver had hit something. This was clearly untrue. Mr Gordon said in evidence that when he saw the damage he thought it must have occurred when he veered from the roadway. He may have thought that in relation to the damage to the leg of the trailer but the manoeuvres he described do not explain how the right rear lights of the rear trailer could have been damaged that way.

I am unable to determine whether Mr Gordon knew that he had collided with Mr Candlin's car. It is more likely than not that he did know given the impact of a collision that was sufficient to open up Mr Candlin's vehicle 'like a can opener' and spread debris over an area of 40 metres.

Investigations

The response to the coronial investigation and inquest by DTMR can only be described, as Ms Williams submitted, as woefully inadequate.

DTMR provided the report of Ms Elrick but did not provide the other information it held which was obviously relevant to the investigation into the death of Mr Candlin and the circumstance surrounding his death and the response of DTMR to the fatal accident.

The reasons for this failure to produce relevant information remains unknown as DTMR, through its Counsel at the inquest, and otherwise, provided no explanation. Further, Mr McMillan advised that he was instructed not to make any submission as to the submissions of Ms Williams as to the lack of cooperation and assistance by DTMR.

DTMR investigated whether Mr Gordon was a fit person to hold a driver's licence, suspended that licence and re-issued it on the basis of medical advice. None of that information was provided in a timely manner. A statement setting out that information was received only on the last day of the inquest and after I directed that it be provided.

DTMR, as the regulator of the NHVAS, conducted an audit of the McAlpine fleet of vehicles, including the vehicle involved in the accident, and issued show cause notices in relation to the company's accreditation. Again, a statement setting out that information was provided on the last day of the inquest and after I directed that it be provided.

One of the main issues for the inquest, known to DTMR in December 2014, was the nature and extent of the investigations into the death by QPS, DTMR and OFSWQ, including the criteria for investigation by each department in relation to such accidents.

Had DTMR at that time or any time prior to the commencement of the inquest provided the information that it held in relation to the audit of McAlpine's fleet and the suspension of Mr Gordon's licence, it may well have resulted in the issues for the inquest being significantly narrowed. The second issue was to be explored because it seemed that neither DTMR nor OFSWQ had conducted any investigations into the accident, in particular, maintenance and/or fatigue issues.

In fact, DTMR had acted appropriately and in a timely manner and conducted thorough investigations in relation to the accident. The failure of DTMR was in cooperating with the coronial processes of investigation and inquest.

OFSWQ followed their policies and procedures and, appropriately, decided not to conduct an investigation.

QPS also carried out appropriate and thorough investigations and Mr Major is to be commended for following up his inspection by reporting the defects he

found to DTMR. Once DTMR were advised of the defects they acted swiftly to ensure that the public safety was safeguarded.

Departments that conduct investigations into reportable deaths routinely provide reports to the appropriate coroner the fact of those investigations and their outcomes. QPS, Qld Health, Department of Communities, Maritime Safety, OFSWQ, to name some of those departments, all report to the coroner, as a matter of course, and without being requested to do so, if they investigate or have any part in investigating a reportable death.

DTMR, as a department which is involved in the investigation of fatal road accidents, should also report its investigations and findings to the coroner as a matter of course and without the need for a request or direction for information. DTMR should have a policy which sets out the procedures to be followed in that regard.

The provision of such information by DTMR would enable coroners to make fully informed decisions and incorporate all relevant material into findings and decide on appropriate issues for inquest.

Most departments which investigate reportable deaths have dedicated coronial liaison officers. Such officers coordinate information for inquests, liaise regularly with coroner's staff and liaise with other coronial liaison officers and departments in relation to investigations of reportable deaths.

The appointment of a coronial liaison officer at DTMR would greatly enhance the provision of information to coroners and also advance the objectives as stated in the MOU between DTMR, QPS and OFSWQ in relation to investigations into fatal traffic accidents.

The presence of transport inspectors at traffic accidents involving heavy vehicles may result in evidence being obtained which may otherwise be lost. Although transport inspectors may inspect heavy vehicles at a later time, their lack of attendance at the scenes of accidents may well result in lost opportunities to obtain evidence of the cause of such accidents.

The evidence given at this inquest is that DTMR has no current policy in relation to attendance of transport inspectors at such accidents. It seems that they may attend if requested to by QPS.

Transport inspectors should attend, as a matter of course, and without a request from QPS or any other department, at the scene of every traffic accident involving a heavy vehicle which results in a fatality. A thorough examination of the vehicles involved and the scene and an investigation of such accidents is necessary to enhance public safety on Queensland roads.

Recommendations

For the reasons set out above in my comments, I make the following recommendations:

1. DTMR appoint a coronial liaison officer

2. DTMR and/or the NHVAS regulator consider mandating the attendance of Transport inspectors at fatal road crashes involving heavy vehicles.

Findings required by s. 45

Identity of the deceased – Geoffrey George Candlin

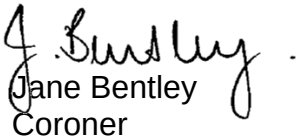
How he died – Mr Candlin died from injuries he sustained when a trailer being towed by a prime mover collided with his car.

Place of death – Bruce Highway JULAGO QLD 4816 AUSTRALIA

Date of death– 29 March 2011

Cause of death – Head injuries

I close the inquest.



Jane Bentley
Coroner
Cairns
23 January 2015