TRANSCRIPT OF PROCEEDINGS

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Date: 20 April, 2006

CORONERS COURT

B L SMITH, Coroner

COR-00002236/04(4)
TOWN-COR-00000083/04

IN THE MATTER OF AN INQUEST INTO THE CAUSE AND CIRCUMSTANCES SURROUNDING THE DEATH OF NICHOLAS SCHUMACHER

TOWNSVILLE

..DATE 16/03/2006

FINDINGS

CORONER: My duties as a Coroner require that I perform certain statutory duties as set out in the Coroners Act 2003, in particular sections 45, 46 and 48. Section 46(2) states that:

> "A Coroner must in investigating a death find:-
>
> (a) who the deceased person is; and
>
> (b) how the person died; and
>
> (c) when the person died; and
>
> (d) where the person died; and
>
> (e) what caused the person to die."

Section 45(5) states:

> "A Coroner must not include in the findings any statement that a person is or may be:
>
> (a) guilty of an offence; or
>
> (b) civilly liable for something."

Section 46 of the Act is headed up, "Coroner's comments", and provides for comments in relation to:

> "(a) public health or safety; or
>
> (b) the administration of justice; or
>
> (c) ways to prevent deaths from happening in similar circumstances in the future."

Section 48 of the Act outlines the correct procedure in relation to the reporting of offences if the Coroner reasonably suspects that such offence have been committed. In

relation to indictable offences such report is to be made to the Director of Public Prosecutions and otherwise the Chief Executive Officer of the relevant Government department. In making these findings I bear those provisions in mind.

I have received written submissions from Mr Fellows, Mr Askin, Mr Honchin and the police officer assisting, Sergeant Beal. These are my findings in this inquest.

Name of the deceased: Nicholas Schumacher.

Date of death: The 12th of September 2004.

Place of death: Bruce Highway, Alligator Creek, via Townsville.

Cause of death: 1.(a) Head injury.

What caused the person to die: At approximately 5.13 p.m. on the 12th of September 2004, the deceased, a young person of 15 years of age, was a passenger in the rear section of a 1983 Toyota LandCruiser Troop Carrier motor vehicle which was travelling west along the Bruce Highway towards Townsville. A total of eight persons were in the vehicle at that time.

The driver of the vehicle was one David John Stubbs, a 42 year old teacher and part-time activity worker and an officer of the cadets in the Australian Navy Cadets at the navy cadet training ship, Pioneer, in Mackay, TS Pioneer Naval Cadet

Unit. The passengers were all naval cadets en route from Mackay to Townsville to partake in a sea exercise, Sea Lion.

The driver was very familiar with the vehicle, having driven it at least once a fortnight over the past year. His private motor vehicle was also a four-wheel drive vehicle. He had in May of 2003, completed a four-wheel driver's course with a private company.

The evidence revealed that the journey up until the incident was event free and normal and that the trip was broken at Bowen at about 3 p.m. for drinks and a toilet stop and that the trip was recommenced at approximately 3.25 p.m. A further short stop was made at Guthalungra just north of Bowen, to secure a flapping curtain.

There is no evidence to suggest that the seatbelts were not properly secured to all occupants of the vehicle. At approximately 5.15 the driver testified to the vehicle veering suddenly and unexpectedly to the left side of the roadway with no warning by way of sound or other noises. The driver estimated the speed of the vehicle at that time to be in the vicinity of 100 kilometres per hour.

The motor vehicle was driven on to the dirt shoulder of the highway with the path being as shown in red on the sketch plan before the Court. In order to avoid a deep water drain in close proximity to the roadway (see photograph number 8) the driver turned the wheel towards the right. As this manoeuvre was attempted the driver has essentially lost all control of the vehicle. The vehicle has more or less continued its forward momentum but in a slightly clockwise manner coming back on to the highway at a point close to where the single lane highway becomes a dual carriageway. The vehicle has shortly thereafter rolled one and a half times landing on its roof on the highway.

As a result, a number of the passengers sustained various injuries. Regrettably in respect of Nicholas the head trauma suffered was fatal and he died at the scene. I find death would have been instantaneous. It seems highly likely in the circumstances, and noting the testimony of Professor Williams, that the head injuries suffered was caused by his head coming into contact with the road surface.

Evidence as to what may have caused the accident was given by the investigating police officer, Senior Constable R S Eggins, together with evidence from the motor vehicle inspection officer, motor mechanic, Mr Stephen Dunbar. A private consultant, Mr Peter Makepeace, also provided testimony and

expressed some opinions based on his examination of the tube and tyre and perusal of some of the photographic material, witness statements and his discussions with persons within the tyre manufacturing industry.

Mr Makepeace I would consider to be in the category of an expert witness notwithstanding an absence of formal qualifications in view of his extensive experience over a long time in all aspects of tyre and tube construction. I take a similar view of the testimony of Mr David Lee.

The age of the tyre in question, a Silverstone Extra Grip Special, the one on the rear left-hand passenger's side, is known precisely, two years and eight months as at September 2004. The age of the Dunlop tube in question has also been ascertained precisely, 12 years and three months as at the date of the accident.

It is unknown when the tube had the patch fitted and the patch itself has not been able to be produced to the Court and its current whereabouts are not known. It is noted though that Mr Dunbar provided in his photograph number 4, attached to his letter dated the 3rd of August '05, Exhibit 22, details of both the patch and the repaired area of the tube with both sections matched together. No scientific evidence has been produced to the Court confirming that the tube failure

actually resulted in the failure of the patch. However, based on the opinions expressed by both Mr Dunbar and Mr Makepeace, in particular, Mr Makepeace, there is a compelling argument that substandard workmanship involved when the patch was applied was a significant factor in the failure of the tube.

The rim itself was not produced to the Court (but the tyre, rim and tube up until today were in the possession of Senior Constable Eggins) but photographs were tendered and it appears to be beyond doubt that the outer portion of that rim has been pitted and affected by rust. See photograph number 14.

The portion of the flap or rust band examined by Mr Makepeace showed some rust on the outside of the flap indicative to some extent of the state of both the rim and the locking device. The locking ring at this time has not been produced to the Court although again photographs of same have been produced to the Court which clearly depict the presence of some rust pitted areas and damage to the ring itself which appears apparently broken. See photographic exhibit photograph number 15.

The overall effect of the testimony given is a strong case that the failure of the tube came about as a direct consequence of the failure of the repair patch that had not been applied correctly (no buffing of the tube) combined with

some other factors as listed by Mr Makepeace in the written material supplied by him and confirmed by him in his testimony to the Court. Two of those factors are: the age of the tube and the other was that aged tube being fitted to a newer tyre contrary to tyre industry recommendations.

There is no question that the failure of the tube caused a sudden deflation of the tyre which resulted in the direct impact of the metal rim upon the hard bitumen road surface at considerable speed and an unknown angle. As a consequence the tyre was forced entirely from the rim. The sudden forceful impact in the manner described, probably partly side on to the roadway, may well have been sufficient by itself to dislodge the tyre locking ring, regardless of its condition, although the possibility exists that the effectiveness of the locking ring may also have been affected to some extent by age and rusted state and that of the rim as stated by Mr Makepeace.

The severe instability thus created with the tyre being removed from the rim placed the occupants of the vehicle in a precarious and dangerous situation from which it would be difficult for them to escape unharmed. The left rear hand passenger side tyre rim has sharply gripped the road surface and noting the direction of travel (see the sketch plan) and mainly forward momentum resulted in the vehicle rolling and ending up as depicted in the photographic exhibits on the

highway upside down. There is apparently nothing inappropriate or wrong in a patching per se of inner tubes and it is still an acceptable practice in the motor vehicle industry provided it is carried out diligently.

The evidence of Mr David Lee in relation to the Bridgestone tube within the Silverstone tyre on the right-hand side of the vehicle indicated that tube was manufactured in July of 1994 making the tube over 10 years of age at the time of the accident. There is no evidence of the motor vehicle being in an unsafe or unroadworthy condition. The comment by the inspection officer is that the vehicle was in "a satisfactory mechanical condition".

There is no evidence whatsoever to suggest any fault on the part of the driver, Mr Stubbs, and his decision to avoid the drainage ditch was entirely reasonable. Prior to this incident I would not have thought it necessary (and neither it seems did the issuers of the safety certificates for registration purposes) that in the interests of safety, that the tubes of the motor vehicle be checked as to age or condition, but if a check had been conducted, the presence of the older tubes, in both the new tyres may have been detected and perhaps replaced.

The Navy cadet unit in Mackay appears essentially to be an innocent bystander in relation to the presence of the used tubes and the tyres on the evidence presented. I am prepared to accept that to be the case.

The sorry saga as it eventually unfolded to this Court appears ultimately to inextricably involve Mr Ian Kennedy as a manager of Transit Tyres, Mackay, and one of the directors of Kenleg Pty Ltd who operate that business. Now it must be conceded that in his preparedness to sponsor the cadet unit he should be commended. Initially though, the statement of Mr Kennedy dated the 4th November '05 portrayed him in a very poor light in that in that statement he makes unequivocal claims as to personally placing two brand new tyres and two new tubes on the said vehicle on the 12th of January 2004 which muddied the waters considerably.

Upon further police investigation and upon his personal testimony before the Court it transpires that Mr Kennedy may have been genuinely mistaken in his recollection, and that the two new tyres were in fact placed on the vehicle on the front not in January 2004 but earlier on the 4th day of September 2003. Whether the one new tyre was purchased, and one donated, or whether a discounted price was made for two new tyres is not known. It is of little consequence. $180, according to Mr Kennedy, would then have been the approximate

retail price of one such tyre. Certainly two new Silverstone Extra Grip tyres were required by the cadet unit in September for an apparently reasonable price of $180 (see receipt number 062455). Tyres were also placed on the vehicle in January although they were second-hand tyres (according to Mr Stubbs originating from Nebo) and those tyres had new tubes placed within them see invoice number 6645.

Mr Kennedy's recollection in relation to the fitting of the tubes to the new tyres in September is now very unclear and in fact he stated he had no specific recollection at all of the vehicle being presented to his place of business in September. He has no recollection of any of his employees approaching him in relation to the fitment of two brand new tyres being part of the sponsorship arrangement in respect of which he had been approached and personally approved. He stated Silverstone tyres usually come with new tubes and rust flap. He also advised the Court of what the usual scenario would be in relation to whether old or new tubes were placed within brand new tyre.

I accept that Mr Rovelli chose to remove the tyres from the front of the vehicle and place them upon the rear. I accept that there is ample evidence to indicate that the motor vehicle was open and available for use by a number of personnel from the cadet unit but there is no evidence to

suggest that any person in any way whatsoever tampered with those tyres in the manner that would be necessary to result in the findings by the two tyre experts. The inescapable conclusion to draw is that either Mr Kennedy or one of his employees for reasons known only to them chose to place old and worn tubes and not new tubes within the two new tyres contrary to soundly based industry practice.

In the case of the left-hand tyre the tube was not only old and worn but also patched. This occurred I find without the tyre fitter or the manager or any other person at Transit Tyres consulting Mr Rovelli or some other person in authority at the cadet unit. Not only that but when the vehicle was collected no information was conveyed to Mr Rovelli as to what had occurred. I note the comments by Mr Honchin in his submission accepted and adopted by Mr Askin in his submission but I would not consider the evidence in relation to the origin of the tubes to be incontrovertible.

While Mr Makepeace's comment on page 2, see note number 4 of his report is noted, I am not certain that the evidence was to the effect that the rims were first painted blue and then later white, in fact I believe the claim may have been denied by one of the witnesses.

I am unable to detect blue overspray under the white of the wheel rim or the wheel hub in photo number 14 of Exhibit Number 4 relied upon to some extent by Mr Honchin. I am unable to make an specific finding in relation to those tubes although it is most likely to be the case as Mr Honchin submits that they were tubes taken from the tyres removed from the vehicle.

My initial view of the cadet unit was that it was one of those voluntary type organisations that was virtually bereft of funds and income and there was an absolute need for the unit to carefully watch the dollars and cents to carefully scrutinize all expenditure of funds and ensure money was wisely spent to ensure the survival of the unit.

However, I note the six figure sum held in interest bearing deposit by the Navy cadet unit, Mackay, and query in the light of that substantial sum why the unit or TS Pioneer Unit Support Group would have risked purchasing the ancient vehicle they did, one in urgent need of new tyres and among other repairs, rather than buying a late model second-hand vehicle if not a brand new one with a view to ensuring the safety and welfare of the young people who would be transported within it together with the added benefit of the longevity of the newer vehicle.

I do note the explanation offered by Mr Rovelli as to the perceived importance and the need to the retain the sum in its current form but I still question the overall wisdom of the strategy adopted in the purchase of such an old vehicle.

Mr Rovelli conceded that the support group would have been entitled to have made submissions to the cadet unit in relation to some access to the term deposit to assist with the acquisition of a vehicle. Perhaps they may see fit to take up that offer at some time in the future. If they do, I am of the belief that their submissions should be given favourable consideration.

I note paragraph 41 of the submissions by Mr Honchin about referring this matter to the Director of Public Prosecutions for consideration of charges against Mr Rovelli and the company Kenleg Pty Ltd possibly in relation to offences under section 286 or 289 of the Criminal Code, manslaughter by breach of duty. In order to do so, as Mr Honchin correctly points out, I have to be reasonably satisfied that a person has committed an indictable offence. I believe I have made it abundantly clear that the conduct of the employees of Transit Tyres operated by Kenleg Pty Ltd left something to be desired, particularly Mr Kennedy as the individual with the overall responsibility for all his employees.

It is virtually impossible to envisage in this particular case any employee taking it upon himself to make the crucial

decision to place the two aged and worn tubes, one patched, within the two new tyres without first consulting his employer. Indeed if he or she did, then it could possibly be inferred that proper instructions, guidelines and supervision by management were lacking in the operation of the business.

Mr Michael Barnes, State Coroner, in the Inquest into the death of Kathryn Marnie Sabadina in Townsville last year stated in his findings,

> "On their face, the words of section 288 are redolent of civil negligence, reasonable care, breach of duty. But the Courts have consistently and understandably held that to be criminally liable the prosecution needs to prove a more blameworthy departure from the expected standards than is required by the plaintiff seeking civil redress. The classic judicial articulation of this difference is found in Regina versus Bateman."

His Honour went on to quote Hewitt LCJ when he used such epithets as "culpable, criminal, gross, wicked, clear and complete".

When the circumstances of this case are considered, I do not think it can be said that the conduct of the company or Mr Kennedy can be equated to those descriptions.

Notwithstanding my comments about Mr Kennedy and his company, I am not satisfied on the whole of the evidence presented to me that this is a case where it is appropriate to invoke the provisions of section 48(2)(a) of the Coroner's Act 2003 and

refer the matter to the Director of Public Prosecutions in respect of the company.

In respect of Mr Rovelli, although he did have the overall responsibility of the cadet unit and was directly involved in taking the vehicle to and collecting the vehicle from Transit Tyres, I again find that this is not a case where the Director of Public Prosecutions should be asked to consider charges against him.

If the business of which Mr Kennedy is the manager, Transit Tyres, was subject to some controlling body or authority I would consider it entirely appropriate to recommend to such body that the circumstances of this case be examined in order to determine if some sanction or other action could be taken against the business of Transit Tyres pursuant to section 48(4) of the Coroner's Act. It does not appear to be the case however that Mr Kennedy belongs to any such organisation as that it seems that no such controlling authority exists, and that in reality any person can walk off the street and decide to open a tyre fitting/retailing business and force themselves upon the unsuspecting public without proper qualifications, experience and without fear of any action by a supervisory body or authority. That is a lamentable state of affairs and worthy of immediate and urgent review and change by the Queensland Government.

In relation to section 46(1)(c) of the Coroner's Act whereby comments are made with a view to preventing deaths from

happening in similar circumstances in the future, I note the various submissions. I make the following remarks.

I am most conscious of the need not to make unnecessary and inappropriate recommendations. They must have a sound evidentiary basis. This incident in an apparently roadworthy albeit older vehicle, 21 years of age, came about on my findings primarily owing to the failure of the repair patch on a comparatively old inner tube. The age and condition of the rim and locking device (which it has been noted was broken in the accident) to some extent may have been a contributing factor to the tyre rolling entirely off the rim resulting in the inevitable capsize of the vehicle. It was not an event or accident I find that could have been reasonably foreseen or predicted by the authorities in charge of the naval cadet unit in all the circumstances.

Now being aware of this incident, it is apparent that there may be some other similar older vehicles in use by other organisations in Queensland or elsewhere. The evidence as given appears also to highlight some deficiencies in the risk management system currently operating within the cadet unit which should be appropriately addressed.

This is so even though in this particular case there is no evidence to the effect that the injury to Nicholas was in fact caused by his being hit with the heavy trolley jack which had been stowed under the seat. I note the submission by Mr Honchin, paragraph 3(a)(b)(c) and (d) in relation to the

overall suitability of the vehicle for which it was used, highway travel, bearing in mind the type of seatbelts and the unenclosed nature of such vehicle. I can certainly understand the reasons why these submissions are made. One might consider that an enclosed vehicle would automatically be a safer means of conveyance in a serious roll over incident. But upon reflection I am not certain that is necessarily so. It is the case that no specific expert evidence was adduced at the Inquest in relation to this issue.

The statistics provided by Mr Askin are enlightening and frightening. I quote from that material, "Passenger car roof crush strength requirement." I quote,

> "Roll over crashes especially in the country are usually very destructive events. Between 15 per cent of passenger cars in fatal crashes in Australia have overturned. Between 13 per cent and 16 per cent of all passenger car occupants killed in Australia died primarily as a result of injuries received in a roll over. Vehicle damage often includes deformation of the roof and its supporting structures. Head and neck injury are common and associated with roof deformation. Strengthening the roof is often suggested as an appropriate counter-measure for such injuries."

Suffice to say that the information provided demonstrates quite significantly the complexity of the dynamics of roll over incidents.

I am certain the parents of the children involved in the incident concerned and other members of the support group have done much soul-searching individually and collectively in relation to the vehicle they purchased and restored to a

reasonable state of repair and as to whether or not that was an appropriate means of conveyance of the navy cadets.

At the end of the day, the support group appears to have the ability, subject of course to some financial considerations, to acquire a vehicle they consider most suitable for the purpose intended. With the wonderful benefit of hindsight a vehicle could have perhaps been hired, but that would have seemed unnecessary no doubt in the light of their possessing their own vehicle.

On my assessment any criticism either of TS Pioneer Naval Cadet Command Structure or the TS Pioneer Unit Support Group Incorporated with regard to the suitability of the troop carrier in question is not justified.

On the material before me, I find the motor vehicle acquired, repaired and modified was a suitable vehicle for use in transporting the cadets along the Bruce Highway to Townsville that day.

I note the submissions in paragraph 3(g) and (h) by Mr Honchin. Bearing in the mind the evidence in this Inquest, those remarks appear reasonable and warranted. As earlier commented upon, recommendations should only be made if a proper evidentiary basis has been established.

I am reluctant to make recommendations that appear awkward or difficult to introduce. I hope these two do not fit into that category. I am prepared to adopt those recommendations as put forward.

I feel compelled then to make the following comments pursuant to section 46 of the Coroners Act 2003.

I recommend:

(1) That wherever possible motor vehicles in use by the naval cadet organisations or other similar bodies in Queensland or other States be limited to vehicles under 12 years of age and that they be regularly serviced by qualified mechanics at least twice a year.

(2) That log books for vehicles used by such organisations be introduced, if already not available and in use, and that they diligently be kept up to date in relation to their usage, servicing, maintenance and repairs.

(3) That in relation to all vehicles currently in use by such organisations, that immediate checks be carried out by qualified tyre fitters/mechanics in order to ascertain the age, general condition of the inner tubes, rims and locking ring, if applicable.

(4) That if necessary an older, damaged, rusted items detected be properly repaired, if that be possible, or replaced immediately with new equipment and that any patched tubes be replaced with new tubes.

(5) That in relation to the vehicles of such organisations when tubes are punctured, that they not be repaired but replaced with new tubes.

(6) That in relation to the vehicles of such organisations, when new tyres are purchased, only new tubes, when applicable, be inserted.

(7) That in relation to troop carriers and like vehicles of such organisations, all luggage and other heavy items such as a tool box or jack, should be securely fastened or enclosed with either individual ties or some type of cargo net or metal cage to ensure that in the event of a serious incident, such as a capsize of a vehicle, that such items do not become potential missiles likely to injure passengers. That risk management plans be altered accordingly.

(8) That the Queensland Government consider the introduction of laws restricting or prohibiting the fitment of old tubes to new tyres.

(9) That the Queensland Government consider that it be made a legal requirement that tyre fitters/ retailers provide a written warning to consumers/customers if a tube shows signs of

deterioration or malfunction that makes it unsuitable or unsafe for fitment into a tyre.

(10) That the Queensland Government review both these Findings and the circumstances surrounding the death of Nicholas, that this be done with a view to implementing, if feasible and practicable, some system of registration, licensing and control of the business of tyre dealing retailing or some other measures to ensure that persons involved within the industry, particularly tyre fitters, possess a certain minimum standard of training, knowledge and expertise to ensure some protection for the members of the public and also so that when examples of bad or unprofessional practices are revealed, appropriate sanctions can be recommended.

I do consider these recommendations entirely reasonable, bearing in mind the tragic events of the 12th day of September 2004. I would urge their immediate adoption by the appropriate naval cadet organisations, both in this State and elsewhere, in relation to items (1) to (7) and by the Queensland Government in relation to items (8) to (10). That completes my Findings and comments.
