QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Emily Jade Payne**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Chinchilla
FILE NO(s):	2014/2395
DELIVERED ON:	3 July 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	11 May 2015, 18 June 2015
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, single motor vehicle crash, seat belts, rural road, apprehension of bias application

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis, Office of the State Coroner
Ms J Littlewood:	Ms C Cuthbert of Counsel I/B Peter G Williams Solicitors

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Introduction

1. Emily Jade Payne was 16 years of age when she died in a car crash on Sunday 6 July 2014. Emily had a twin sister and an older brother and resided with her parents at Roma. She had a partner aged 21. Her parents, family and friends remain distressed at her death at this young age.

2. Emily and her 18 year old cousin, Ms Jessica Littlewood, were travelling in Ms Littlewood's 2001 silver Holden Astra sedan. Ms Littlewood was driving and Emily was in the front passenger seat. They had spent the weekend in Brisbane looking for a dress for Emily's Year 12 formal, and Emily was travelling back home to Roma, a five-and-a-half hour drive from Brisbane.

3. Just outside of Chinchilla, a little over half way along their journey, Ms Littlewood and Emily turned off the Warrego Highway and onto Cameby Road. They were intending to visit Ms Littlewood's father, whose house was further along Cameby Road towards Blackstump.

4. The time was around midday. Ms Littlewood was driving along a straight, unsealed section of Cameby Road, not far from the highway.

5. For reasons that remain unclear Ms Littlewood lost control of the vehicle and struck a large tree located on the left shoulder of the roadway.

6. Ms Littlewood, who was seriously injured in the crash and trapped in the vehicle, managed to call Triple Zero from her mobile phone and spoke to an operator until ambulance officers arrived.

7. During this time and despite her own serious injuries, Ms Littlewood tried to provide medical assistance to Emily, who was unconscious and bleeding from her ears and nose. At some point during this call, it appears Emily stopped breathing. Ms Littlewood could not reach Emily's mouth to provide mouth-to-mouth resuscitation, but was able to perform chest compressions using her elbow on Emily's chest.

8. Unfortunately, when ambulance officers arrived, they were unable to revive Emily and she was declared deceased at the scene.

9. Ms Littlewood had to be cut from the vehicle with the assistance of the Queensland Fire and Rescue Service. She was then transported to Chinchilla Hospital and later airlifted to the Princess Alexandra Hospital in Brisbane for treatment of her injuries.

10. To date, Ms Littlewood has not provided her version of events in relation to the crash. I considered that information held by Ms Littlewood could assist in determining the cause of the crash and understanding the full circumstances of Emily's death.

11. I also considered that hearing these details from Ms Littlewood may also help identify measures for the purpose of comment or recommendations pursuant to section 46 of the *Coroners Act 2003*, for preventing deaths from happening in similar circumstances in the future.

12. In addition, Emily's family wanted to know what caused Ms Littlewood to lose control of the vehicle and why Emily did not have a seatbelt on at the time of the crash, as this behaviour was considered by them to be odd. They also expressed some concerns as to events that occurred in the period after the crash in relation to communication from Ms Littlewood and her family. These concerns were outside of the issues to be determined by me and were passed on to the Littlewood family. This latter event was the subject of an application to recuse myself on the grounds of apprehended bias.

Issues for the inquest

13. Given the above, a decision was made to hold an inquest. At a pre-inquest hearing held on 11 May 2015 the following issues for the inquest were determined:

    a. The findings required by section 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how she died and what caused her death.

    b. The circumstances leading up to the death and the cause of the car crash on 6 July 2014.

    c. To identify measures for the purpose of comment or recommendations pursuant to section 46 of the *Coroners Act 2003*, for preventing deaths from happening in similar circumstances in the future.

14. The following witnesses were called:
    - Ms Jessica Littlewood
    - Senior Constable Michael Parker

15. At the commencement of the inquest, counsel for Ms Littlewood made an application that I recuse myself on the grounds of an apprehension of bias. I dismissed that application and my reasons are attached to this decision.

Autopsy results

16. At autopsy, the forensic pathologist Dr B Terry found Emily's cause of death was due to significant head injuries she sustained in the accident. No drugs or alcohol were detected on toxicology analysis.

17. There were no other significant life threatening injuries. Of note the external examination did not disclose any seatbelt impression injuries. My experience would indicate that in a high force impact as it was here, if Emily was wearing a seat belt there would be such impression or other injuries seen.

The police investigation

18. Senior Constable Michael Parker, currently of the Mackay Forensic Crash Unit, was stationed at Chinchilla at the time of the accident in the position of General Duties Police Officer and part-time crash investigator.

19. Senior Constable Parker was tasked with investigating the crash on behalf of the Queensland Police Service and attended the scene shortly after first response officers had arrived.

20. A mechanical inspection found the vehicle was in a satisfactory mechanical condition and no defects were found which could have contributed to the cause of the incident.

21. Senior Constable Parker's investigation explored several possible causes for the accident; including –

    - excessive speed
    - the layout and condition of the road
    - environmental factors
    - mechanical fault
    - driver distraction
    - driver impairment due to fatigue or drugs and alcohol.

22. So far and despite these extensive investigations, no obvious cause of the crash has been identified.

23. The crash occurred at approximately 12:08pm. The vehicle was travelling north on Cameby Road, Cameby. The road surface was dry and consisted of a dirt road approximately 7 metres wide. The speed limit was 100 km/hour. There was a moderate build-up of loose gravel in the centre of the roadway between the worn track marks. There was also a build-up of loose gravel on the shoulders of either side of the roadway. It is evident the driver lost control of the vehicle and slid for approximately 50 metres across the road surface prior to striking a large tree located on the left western shoulder of the roadway.

24. The sun would have been located high in the sky at the time of the crash and is not believed to have been a visual obstruction.

25. Due to the dirt surface and the fact that a number of emergency service vehicles had already made their way to the site of the crash by the time police arrived there was already some disturbance to the road surface. However, the vehicle's rear tyre marks were readily observed and documented. An inspection did not locate any indication of sudden swerving or braking. A preliminarily analysis by Senior Constable Parker indicated the vehicle was travelling at approximately 71–86 km/hour prior to impact. Excessive speed did not appear to be a contributing factor. In evidence before the inquest, Senior Constable Parker opined that in his experience the damage to the vehicle was consistent with an 80 km/hour collision and not one at 100 km/hour or greater.

26. A comprehensive Collision Analysis was undertaken by Senior Constable Parker and peer reviewed. The location and direction of the tyre friction marks identified at the scene indicated they were created by the crash vehicle prior to impact with the tree. The curved nature of the marks indicate that the vehicle was rotating in an anti-clockwise direction, whilst travelling in a northerly direction. The tyre marks commence on the right

side of the road, which is the incorrect side for this vehicle's intended direction of travel.

27. It was opined that for a vehicle to be rotating in this manner, the driver of the vehicle had to have input excessive steering for the available friction of the road surface, and the intended curve. This is called a critical curve yaw. In this instance it was considered that this was because the vehicle was in an oversteer situation and the driver became aware that the vehicle was rotating, and sliding, and now heading towards the opposite side of the road and as a result input excessive steering to the left in an attempt to correct the direction of travel. The vehicle then continued to rotate anti-clockwise and slide towards the edge of the road. The vehicle then proceeded with the front right corner leading and it is this area of the vehicle that first impacted with the tree.

28. As the impact was offset from the vehicle's centre of mass, this then caused the vehicle to now rotate further, in an anti-clockwise direction, which is how the vehicle came to be facing in the opposite direction and further north of the tree when it came to final rest.

29. At the time of impact the front right corner of the vehicle underwent a rapid deceleration, and the effects of the inertia on the occupants of the vehicle due to that rapid deceleration meant they would both continue in their pre-impact direction of travel, which would be toward the front right corner of the vehicle. It was due to this inertia that the passenger (Emily and probably unrestrained) was thrown to the right, causing her head to impact with the steering vehicle. There was forensic evidence in the form of hairs of the same colour as Emily's on the steering wheel, supportive of contact with the steering wheel and Emily's head.

30. Senior Constable Parker considered there were two possible scenarios to explain how the vehicle came to be in the yaw situation. The first is that for reasons unknown, the driver realised she had started to veer off the carriage way to the left, and at that time attempted to correct her direction of travel, by steering to her right. With the low friction value of the gravel road and the posted speed of 100 km/hour it would not take much steering to cause the vehicle to commence to slide out and rotate. On realising the vehicle was slipping and out of control, the driver has then attempted to redirect the vehicle back onto the correct course, but the position of the wheels then created a further oversteer situation, and the car became out of control.

31. The second scenario is a 'swerve to avoid' situation, in which the driver sees an obstacle or hazard in her path and steers hard to the right to avoid an impact, creating the critical curve speed yaw and the subsequent reaction and result of impact. The inspection of the road surface revealed no such obstacle or hazard, however, a kangaroo or other wildlife could present as such a hazard at the time.

32. Senior Constable Baker stated that in certain circumstances where the commencement of the yaw can be identified through tyre friction marks, and other criteria are met, the speed of the vehicle at the time of

commencing the yaw can be determined. However, that evidence was not available in this instance so no accurate speed calculation could be made.

Fatigue

33. As the vehicle had a Go-via tag police were able to establish some of the movements of the vehicle on 6 July 2014. This established that the vehicle went through two toll detections on the Ipswich motorway with the last occurring at 7:40am. By utilising the RACQ trip planner this would indicate an approximate time of travel of 3 hours and 20 minutes from the last toll detection to Chinchilla. Police were also able to obtain CCTV footage and a receipt from Chinchilla KFC, which indicated a transaction at 11:34am in the drive-thru. Based on these calculations it was considered the vehicle took an extra 34 minutes to complete the journey than would have been ordinarily anticipated, giving an indication the driver was not likely to have been exceeding the speed limit for any extended periods, and that they possibly were delayed or made a stop along the way.

34. The journey of approximately four hours to Chinchilla, especially one with a stop, is not considered to be an excessive driving time, and would tend to suggest that fatigue was not an issue. However, the activities of the driver in the evening and morning prior to commencing this trip had not been ascertained at the time Senior Constable Parker prepared the Collision Analysis Report, so fatigue was not excluded completely by Senior Constable Parker at that time.

Seat belts

35. One significant issue about which Senior Constable Parker gave evidence, is in relation to the possibility that Emily was not wearing a seat belt at the time of the crash.

36. In his report to the coroner, Senior Constable Parker pointed to matters that suggest Emily may have survived the crash had she been wearing a seatbelt at the time.

37. Senior Constable Parker notes that the point of impact between the car and the tree was on the front driver's side corner. Nothing intruded into the front passenger seat compartment where Emily was sitting. That is consistent with my own inspection of the motor vehicle.

38. Emily's airbag successfully deployed, but would not have been as effective in the absence of a seatbelt. Emily's position in the car after the crash suggests she travelled a significant distance within the car at the time of impact, and almost certainly struck her head on the steering wheel.

39. Furthermore, the CCTV footage at the Chinchilla KFC was viewed and in the footage, the passenger in the motor vehicle as it passes through the drive-thru can be seen relatively clearly. It is certainly evident in the footage that the front passenger was either not wearing her seatbelt, or not wearing it correctly as the sash portion of the belt was not visible across her chest.

The evidence of Ms Littlewood

40. A specimen of blood was obtained from Ms Littlewood shortly after the crash and was analysed for drugs and alcohol. No alcohol or illicit drugs were detected. A very small amount of morphine was present, which was consistent with the known medication administration by paramedics at the crash site.

41. Ms Littlewood had a current P1 driver's licence having obtained a licence approximately six and a half months before. She said she had obtained her learner's permit and held it for two and a half years before obtaining her licence. She said most of her driving was city driving. She also was required to wear corrective lenses when driving. There were no traffic offences recorded against her driving history.

42. Ms Littlewood, on legal advice, declined on a number of occasions to provide a statement to the police or to the coroner on the grounds that her evidence may incriminate her. She was entitled to make that claim.

43. Ms Littlewood did not avail herself of the protection offered by section 39 of the *Coroners Act 2003* when giving her evidence.

44. She told the Court that the evening before the trip she and Emily had met at South Bank and had a meal but she was home by 10:30pm and had a good seven or eight hours sleep and felt well rested.

45. After picking up Emily that morning, Ms Littlewood drove to Toowoomba, where they stopped for about 20 minutes trying to find a particular item in a shop. They then proceeded through to Dalby and had a short five to ten minute break and ate lunch at KFC in Dalby.

46. They then pulled into the KFC drive-thru at Chinchilla and picked up some food for the family group that were meeting at Ms Littlewood's father's house. They did not get out of the car.

47. In relation to the wearing of seat belts, Ms Littlewood had a recollection that Emily was wearing her seatbelt during the trip and recalls it being put on when they entered the motor vehicle at Toowoomba and at Dalby. They did not get out of the vehicle at Chinchilla and drove through the drive-thru. She states she was not aware that Emily was not wearing her seatbelt until she was told this by the paramedics when they arrived at the crash site.

48. She recalls Emily called her mother whilst they were in Chinchilla. Ms Littlewood stated she recalls laughing with Emily as they were proceeding towards Cameby Road. Emily was choosing the music they were listening to on an iPod. Ms Littlewood did not access her mobile telephone, which was either in the console or in her hand bag. That is consistent with Senior Constable Parker's investigation of the mobile telephone insofar as text message and telephone calls are concerned.

49. Ms Littlewood then turned into Cameby Road but she says she has no recollection or memory of what then happened and what section of the

road that the crash occurred. She simply has a memory of her driving, Emily changing a song and they were laughing and talking.

50. In the Triple Zero call Ms Littlewood told the operator in response to a question if another vehicle was involved that she "lost control and hit a tree". In her evidence in court she stated this was not a statement of her memory and was an assumption on her part that she had lost control and hit a tree, as she could see there was damage to the vehicle and the tree next to her. It is accepted this was a very distressing moment for her and she did all she could to assist the emergency services to attend and to help her cousin.

51. Significantly however, Ms Littlewood seems to have a good memory of the conversation she had with the paramedics at the scene and the detail about the reference to Emily not wearing a seatbelt. It is also apparent from her evidence that she has a good recollection of what she did immediately after the crash including locating her mobile telephone; endeavouring to contact her father but there was no mobile telephone range and then was able to contact emergency services (through its emergency mobile network). She then had a lengthy and no doubt very distressing 20 minutes where she was on the telephone and making what appeared to be brave efforts to save Emily.

52. Ms Littlewood states that since the accident, understandably she had difficulty controlling some of her emotional responses and had a series of nightmares and panic attacks. She had been prescribed antidepressants and sleeping tablets. In the six months after the incident she had difficulty concentrating and her memory had been fuzzy.

Conclusions

53. In reaching my conclusions it should be kept in mind that 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 for something.[1] 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 with a view to reducing the likelihood of similar deaths.

54. The police forensic crash investigation considered a number of reasons why Ms Littlewood lost control of her motor vehicle. The investigation has concluded, and I accept and can exclude that excessive speed; the condition of the road; visual obstruction by the sun; mechanical condition of the motor vehicle; impairment by alcohol or drugs or fatigue were contributory factors.

55. What is clear is that Ms Littlewood did lose control of her motor vehicle. The police investigation concluded there were two possible reasons for this. Firstly, it was considered possible that Ms Littlewood saw an obstacle or hazard in her path or wildlife and swerved to avoid the obstacle by steering hard to the right to avoid an impact, creating the critical curve

[1] s 45(5) *Coroners Act 2003*

speed yaw and the subsequent reaction and resultant impact. No obstacle or dead wildlife was found at the scene but of course the wildlife may not have been hit. Ms Littlewood's memory of the events immediately before the crash appears to be poor, however she was able to give a reasonable level of detail of her description of events after the crash and there was no mention of wildlife being involved to QAS. In my view, that scenario is less likely to be the cause.

56. The second and more likely scenario is that for unclear reasons she suddenly found herself in a position where she needed to make adjustments to her direction of travel and given the slippery and loose road surface inadvertently input an oversteer with the subsequent loss of control. Other than the important forensic evidence at the scene consistent with a loss of control by oversteer, the other contemporaneous evidence we have is of the Triple Zero statement where Ms Littlewood stated she had 'lost control and hit a tree'. I was not particularly convinced by her explanation now that this statement was simply a reconstruction of events on her part, given she was able to describe in some detail a number of events prior to and immediately after the crash.

57. The reason she lost control was due to the input by her of an oversteer. Why this happened unfortunately still remains unclear. Clearly it was not intentional and there is no evidence suggesting that up until this point she was not otherwise driving safely. I accept Ms Littlewood genuinely may now have no recollection of what caused this loss of control to happen. It would have taken place very quickly and she simply may not be able to now put it all together as a sequence of events given the tragic and distressing outcome. I have no doubt the nature of the gravel rural road would have made it difficult for an experienced driver let alone a relatively novice driver to reverse the yaw once she was in the slide. Emily's family have made mention of their desire that Ms Littlewood consider attending a defensive driving course due to her admitted limited experience of driving on rural roads. Without making any particular finding as to the cause this is a relatively uncontroversial suggestion she may wish to consider.

58. Unfortunately, it is clear that Emily was not wearing her seatbelt at the time. The point of impact between the car and the tree was on the front driver's side corner. Nothing intruded into the front passenger seat compartment where Emily was sitting.

59. Her airbag successfully deployed, but in the absence of a seatbelt this would not have been as effective as a restraint. Her position in the vehicle after the crash suggests she travelled some distance within the vehicle at the time of the impact and struck her head on the driver's steering wheel. It was this impact that caused her fatal head injury. If she had been wearing a seatbelt it is likely she would not have sustained that fatal head injury. She had no other significant internal injuries that were life-threatening.

Findings required by s. 45

Identity of the deceased – Emily Jade Payne

How she died – Emily died when a motor vehicle driven by her cousin, Jessica Littlewood crashed into a tree after the driver lost control on a rural road. The reasons for the driver losing control are somewhat uncertain but it clearly involved the input of an oversteer on the driver's part. Emily was not wearing her seatbelt at the time. It is likely she would have survived the crash if she had been wearing the seatbelt.

Place of death – Cameby Road, Chinchilla Qld

Date of death– 6 July 2014

Cause of death – 1(a) Massive Head Injury due to or as a consequence of
1(b) Motor vehicle accident

Comments and recommendations

These tragic circumstances highlight the continued importance of wearing a seatbelt.

Counsel Assisting, Ms Jarvis noted that figures published by the Department of Transport and Main Roads show that over the past six years 35% of the 1623 lives lost on Queensland roads happened in circumstances where the deceased person was not wearing a seatbelt.

It is clear that not wearing a seatbelt is a significant contributing factor to road fatalities and it is unclear why people are still choosing to not wear seat belts.

I was considering whether I should recommend consideration be given to the development of further strategies to emphasise this message but as a driver I have noted an increase in the dissemination of such road safety messages in various formats. Indeed as I headed east out of Chinchilla after the inquest one such large safety message devoted to the wearing of seat belts could be seen.

With that in mind I make no formal comment or recommendation.

My condolences are expressed to the parents, family and friends of Emily Payne. I close the inquest.

John Lock
Deputy State Coroner
Brisbane
3 July 2015

Decision on Application to Disqualify on Grounds of Apprehended Bias

This is an application made by counsel for Jessica Littlewood that I disqualify myself on the grounds of apprehension of bias.

The substance of the application appears to be based on the fact that an email was sent by counsel assisting on my direction to the solicitors acting on behalf of Ms Littlewood on 14 May 2015. This email copied in concerns that had been received by my office by the family of Ms Emily Payne, the deceased person.

Essentially those concerns related to their expectations that after the tragic incident neither Ms Littlewood nor her family made any attempt to contact them either personally or in some other form of communication. They state that they had a perception that the family were being evasive and protective of themselves, to the exclusion of anyone else's feelings and this added to their sorrow, grief and frustration.

Counsel for Ms Littlewood has expressed concerns that there had been a unilateral communication, outside of Court, with the family of the deceased.

With respect, the role of a coroner and the Coroners Court is quite different to that of judicial officers in the adversarial arena. A coroner is an investigator in an inquisitorial environment, as well as a decision maker but also has a number of administrative responsibilities.[2]

As Freckleton states this combination of roles necessarily entails a coroner to take active measures through his or her staff to make enquiries prior to an inquest, and even during it, in order to obtain relevant information.

The question is whether any actions taken by the coroner or any statements made by him or her are indicative of a fixed view unlikely to be qualified by the evidence formally attended at the inquest.

Certainly a coroner should not reach a decision as to significant matters in an inquest before it opens. And certainly interactions between a witness or potential witness and a coroner should be considered carefully.

In this instance the communication from the family as to their concerns were addressed by me by requesting the concerns be forwarded to the legal representatives for the family on a basis of transparency. No discussions directly with the family relating to these concerns have been made by me.

As to communication with family the *State Coroner's Guidelines* at 2.8 notes that families should always be invited to communicate any concerns they hold about the circumstances of the death to the coroner. It notes that in practice, grief is a very individual process and some families will take the opportunity to express their concerns and some will not. Experience has shown that families can raise a range of issues that may not be relevant to the circumstances of the death. Often there will be aspects of family concerns that are more appropriately referred to someone else and in this case the issues of concern were referred

[2] See Freckleton and Ranson, *Death Investigation and the Coroner's Inquest* 2006 at page 590 – 597 where the issue of bias and appearance of bias is discussed at some length.

to the family of Ms Littlewood for them to take whatever action they felt was appropriate.

The fact that the family were requested to write in with any of their concerns and the fact that they did so and the fact that these have been passed on to the legal representatives of the relevant person for consideration is very much part of the day to day business of the coronial jurisdiction.

Importantly in this case it is noted that the issues raised by the family relate to matters that occurred subsequent to the tragic accident. No member of the deceased's family is being called to give evidence. Furthermore none of the matters of concern raised by the family are in any way related to the issues that I need to determine at this inquest, namely, the identity of the deceased person, what caused her death, how that the death occurred nor do they relate to any potential recommendations that could be made to prevent such deaths occurring in the future.

Freckleton makes reference to a number of cases that have been determined in various jurisdictions on this issue and the matters raised in this particular application come nowhere near meeting the criteria where an application for apprehended or exhibited bias could be substantiated.

In *Leahy v Barnes QSC 13* in the decision of Henry J at para 134 he *cited R v Matterson; Ex parte Moles* (1994) 4 Tas R 87;

"In the circumstances of a coronial inquiry, fair minded people or the hypothetical bystander, would not reasonably apprehend bias from the mere fact that there had been out of court contact between the coroner and a witness who later gave evidence. Indeed, the bystander would not be at all surprised to learn that there had been such contact having regard to the nature of the coronial process. In R v Carter and the Attorney-General; ex p Gray and McQuestin the court held that the apparent bias needs to be considered in the context in which it is claimed, and that the fair minded people referred to in the majority judgment of R v Watson would be aware that a large part of the Commissioner's duty involved investigation and inquiry. So it is in the case of a coronial inquiry."

Mr Leahy alleged bias because of then State Coroner Barnes' pre-existing relationship with a witness, Dr De Leo, and also a breach of the rules of natural justice because he made little attempt to communicate with Mr Leahy, the applicant, but did communicate with other relatives of the deceased and failed to disclose some of those communications. The application was rejected on this issue.

In *R v Matterson* the Court was dealing with an application where the coroner heard and accepted evidence from a police officer, in a case involving the fatal shooting of a civilian by police, when the coroner did not identify or disclose that the officer involved later became a member of his investigative team.

In the British Colombia decision of *Alonzo v Ontario (Coroner)* quoted in Freckleton at page 592 it was held the fact that a coroner spoke in private to an expert witness prior to his testifying at an inquest did not preclude the coroner from continuing to sit on the case.

In *R v Coroner Doogan; ex parte Lucas Smith*[3] the court applied earlier High Court decisions which stated that the governing principle is that, subject to qualifications relating to waiver, a judge is disqualified if a fair minded lay observer might reasonably apprehend that the judge might not bring an impartial mind to the resolution of the question the judge is required to hold.

The Court held that the hypothetical lay observer, in the context of evaluating appearance of bias, must be taken to be aware of the process by which the coroner makes extensive enquiries prior to the inquest. By example it commented it would be absurd to imagine that a coroner could not view the scene of a fatal accident for instance. The court held that it was entirely appropriate for the particular coroner to have conducted a view in the company of experts but in the absence of legal representatives and parties. In addition, it was unnecessary to inform those subsequently given leave to appear of the viewing. However it was incumbent upon the coroner to inform them of any information obtained in the course of the view, which had the potential to be relevant to their interests.

I mention this matter as I should also declare at this point, as is my practice, that I visited the site of the crash incident yesterday afternoon. As noted above it has been held on a number of occasions that it is entirely appropriate for a particular coroner to have conducted a view of the relevant site of an incident in the absence of legal representatives and parties. I have done so on many occasions often in the presence of investigating police. Indeed, often coroners will attend the scene of an incident immediately after it has occurred and whilst forensic examinations are taking place.

The application that I disqualify myself for apprehended bias is dismissed and the inquest will now proceed.

18 June 2015

John Lock

Deputy State Coroner

[3] [2005] ACTSC 74