OFFICE OF THE CORONER
Cunnamulla

FINDING OF INQUEST

CITATION: Inquest into the death of **Waugh, Cappur William Embling**

TITLE OF COURT: Coroner's Court

JURISDICTION: Cunnamulla

FILE NO(s): COR 390/06

DELIVERED ON: 14 September 2007

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FINDINGS OF: O Rinaudo, Coroner

CATCHWORDS: **CORONERS: Inquest, Motor Vehicle Accident;** Single vehicle roll-over, inadvertence, inattention, calculation of speed of vehicle.

REPRESENTATION:

Assisting:	Ms Kim Bryson of Counsel Barrister at Law
Waugh Family:	Mr N E Bouchier Solicitor of Ryan and Bosscher Lawyers
Anna Louise Hall:	Mr F Jongkind Solicitor of Frank Jongkind & Co

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CORONERS FINDING

PLACE INQUEST HELD: Cunnamulla

DATE: 14 September 2007

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons and organisations granted leave to appear at the inquest. These are my findings in relation to the death of Cappur William Embling Waugh. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

Introduction

On 16 January 2006, a Toyota Landcruiser was travelling northbound on the Mitchell Highway towards Cunnamulla when it was involved in a single vehicle accident. The driver of the vehicle was Anna Hall. Also travelling in the vehicle were her two cousins, Courtney Waugh and Cappur Waugh. As a result of the accident, both Courtney Waugh and Anna Hall sustained injuries and were initially transported to the Cunnamulla Hospital before being transferred to the Toowoomba Hospital by the Royal Flying Doctors Service. Cappur Waugh sustained serious injuries and died at the scene.

These findings seek to explain how the accident occurred and whether any recommendations should be made that may reduce the likelihood of similar accidents occurring in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

The accident was reported to the police who recognised the death to be *"violent or unnatural"* within the terms of s 8(3) of the Act. Accordingly, the police reported the matter to me in my capacity as the Cunnamulla Coroner.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case, it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [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. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future if necessary.[2] However, a coroner must not include in the findings

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46

or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* That doesn't 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 provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

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[3] s45(5) and 46(3)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

The inquest

A directions hearing was held in Cunnamulla on 10 May 2007. Following that hearing, Ms Bryson was appointed counsel assisting me. Leave to appear was granted to Anna Hall and the family of Cappur Waugh. The hearing proper commenced at Cunnamulla on Wednesday, 18 July 2007, and proceeded over two days. The following persons gave evidence;

Scott James Reid – Sergeant of Police Charleville – principal investigator of this incident
Andrew Alexander McDonald – vehicle inspection officer for the Queensland police
Dr Doris Terry – Government Medical Officer/Pathologist
Kim Rebecca Bentley – Constable of police – first police officer on the scene
David Claude Tulloch – Sergeant of police – senior collision analyst for Queensland
Trevor Raymond Baker – first person on the scene
Angus John Waugh – father of the deceased
Andrea Vanessa Seeto – Partner of the brother of the deceased, Tadge Waugh
Courtney Louise Waugh – sister of the deceased and occupant of the vehicle
Anna Louise Hall – driver of the vehicle

A list of the exhibits admitted into evidence was produced and forms part of the documents received into evidence as an aid.

The evidence

I turn now to the evidence. I cannot, of course, summarise all of the information contained in the exhibits and transcript, but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Background

Cappur William Embling Waugh was born on 16 January 1989. He sadly passed away on the day of his seventeenth birthday. On the morning of his birthday, he and his cousin

agreed to drive into Cunnamulla for lollies and things for a party.[9] The driver of the vehicle was the cousin of the deceased, Anna Louise Hall, who was seventeen at the time. Also in the vehicle was the deceased's sister, Courtney Waugh, who was thirteen at the time. Cappur Waugh was not originally going but his Mother asked him to go to be with the girls. The vehicle travelled from the property known as "Amenda", at that time managed by Mr Waugh on behalf of the owners, which is about 90 Kilometres south of Cunnamulla. The vehicle was a Toyota Landcruiser utility described to be in good condition. The road was sealed and described as good. The conditions were fine and clear with good visibility.

The vehicle left the road, the driver in attempting to drive the vehicle back on to the road has overcorrected and the vehicle has rolled several times. The deceased ended up under the vehicle and died shortly after of injuries sustained in the single vehicle accident.

To put this investigation into context, the inquest was held after a request from the parents of the deceased in Form 15. The parents of the deceased who are understandable devastated by this untimely tragedy have, for various reasons which will be discussed, come to the conclusion that the police investigation has been inadequate and that there has been a cover-up. This is, on the evidence before me, not justified. However, there concerns have lead to a clarification of a number of issues, which may not have occurred if they had not strenuously agitated for a review of the evidence.

One of the causes of concern by them is that the father of the driver of the vehicle is a police officer. At the Inquest, out of an abundance of caution, Counsel assisting was engaged from the State Coroner's office, thereby relieving the local police prosecutor of being placed in a position of ostensible bias. No inference whatsoever can be drawn from this.

These issues will be discussed further in the consideration of the evidence below.

[9] See transcript page 73 evidence of Anna Hall at line 22

The accident

The police report of 16 January 2007 sets out in some detail the lead up to the accident. It is not necessary to set it out again here, save to say, that the only witnesses to the accident were the surviving occupants of the vehicle.

The issues of concern about the accident relevant to the inquest are as follows:

1. How the vehicle came to be in the dirt on the right hand side of the road.
2. The speed of the vehicle.
3. Whether the deceased was wearing a seatbelt.
4. Whether any other factor contributed to the accident such as alcohol, drugs, the weather conditions or a defective vehicle.

The condition of the vehicle and the road conditions.

It seems clear that the vehicle was in good condition and no mechanical defect contributed to the accident. It is also clear that the weather was not a contributing factor.

There was some suggestion that evidence had been removed from the vehicle, namely a tyre, however, from the evidence of Mr McDonald, the vehicle inspector, this was ordered by him so that he could have a good look at the tyre in his own properly equipped workshop.[10] He says, *Well, as a result of my inspection I found that the vehicle was in a satisfactory mechanical condition and there were no obvious defects which could have contributed to the cause of the accident.*[11]

The police report says, *The incident occurred during daylight hours. During the day there had been a number of short showers of rain moving through the area. At the time of the incident there had been no rain in that area and the road surface was dry. As with most highways in the area the road is slightly elevated and drops away on both sides into a*

[10] See transcript at page 51.
[11] See transcript at page 51, line 13 and following.

table drain. The bend in the road is quite visible. At the time of the incident the road surface appeared to be in good condition. There is no indication that the road surface or configuration of the roadway had any bearing on this incident.[12]

Seatbelts

There is some conflicting evidence about whether the occupants in the vehicle were wearing seat belts.

Miss Waugh gave evidence that her mother told the occupants to put on their seat belts. They did, she said. In particular, she said that her mother said, *Everyone make sure you have your seatbelts on. Put your seat belts on*. Miss Waugh said that she then put her seatbelt on. When asked if she remembered if the others had their seatbelts on she replied, *I'm pretty sure the both did.*[13]

Miss Hall said in her evidence, *I stopped at the end of the driveway and asked, you know, "Everyone put on their seatbelt." And I – I'm pretty sure Courtney did and I asked Cappur to and he - he said, "No." Yeah, and I just said, "All right. It's your choice." So then we left and I don't remember if he actually did put it on without me seeing it.*[14]

The deceased was thrown from the vehicle and it came to rest on him. Mr McDonald, the vehicle inspector, said (after a brief inspection of the seatbelts) that while the driver's side seatbelt was *fully extended at the time of my inspection i.e. that means that the – the belt webbing was stretched. It could be possibly due to the impact as well. And the passenger's seatbelt was intact but it was in a retracted position… that was retracted and you didn't notice any damage consistent with impact? – No noticeable damage; that's correct.*[15]

[12] Exhibit B1.1 page 3.
[13] See transcript at page 51 at about line 30 and following.
[14] See transcript at page 74 line 10 and following.
[15] See pages 50 and 51of the transcript starting at about line 40 and following

Doctor Terry, the pathologist, observed a bruise to the top of the left shoulder and stomach area as set out in the autopsy report and in evidence.[16] He was asked, *There's some suggestion of – there's some possibility that even if a seatbelt was worn in the correct fashion that once the vehicle was crushed the seatbelt mechanism could have malfunctioned at that point. Would that be consistent with the bruise associated on the left shoulder? –It – it's a possibility.*[17]

Mr Tulloch's evidence was of considerable assistance in respect of the path of the vehicle which shall be referred to later in more detail. He also gave evidence on the seatbelt issue. The thrust of his opinion (although he had not specifically studied the point) was that the injuries referred to by the pathologist were consistent with a seatbelt being worn having regard to the way the accident unfolded.[18] He said that while the bruising in this type of accident, *indicates that the belt is worn and worn correctly. However, it – there are other mechanisms in a rollover where the vehicle has rolled probably about three times and quite violently that that injury could have been caused by something else.*[19] He also said that it was possible that the deceased had come out of the seatbelt because the *anchor belt* may have dropped down because of the impact of the roll-over.[20]

On balance it is not possible to conclude that the deceased was not wearing a seatbelt. It is on the evidence more likely than not that he was wearing a seatbelt and came out of the car as a result of one of the mechanisms described to by Mr Tulloch.

The speed of the vehicle and how the accident occurred

Mr Tulloch reviewed all of the evidence of the police investigation. Allying his experience and knowledge, he was able to determine that the speed of the vehicle was between 98 and 101 kph. His scientific approach was most valuable in assisting the court to understand the evidence (in particular the photographic evidence and the sketch plan). Initially evidence had been given by Sergeant Reid who did a thorough and professional job in investigating the accident to the best of his ability. I found that Sergeant Reid had

[16] See particularly page 54 and 55 of the transcript and page one of the autopsy report.
[17] See page 56 of the transcript at line 30 and following.
[18] See page 77 at line 20 and following.
[19] See page 77 of the transcript at line 27 and following.
[20] See page 77 of the transcript at line 40 and following.

done everything that could have been expected of him. In particular, he walked the scene confirming that there were no dead animals in the vicinity or other hazards.

Sergeant Tulloch acknowledged that his conclusions were based on his experience and learning and that Sergeant Reid did not have the experience or expertise to form the same conclusions.

However, as informative as the evidence of Sergeant Tulloch was in establishing the path of the vehicle, the speed of the vehicle and what caused it to roll-over; he was unable to explain what happened in the vehicle to cause it to leave the road. Much technical evidence was presented from which certain assumptions and speculations were able to be made, but none which could adequately explain the cause of the accident. That is, how did the vehicle come to be in the dirt on the right hand side of the road.

For this it is necessary to look to the evidence of the two survivors in the vehicle.

Courtney Waugh said that she could not explain how the vehicle came to leave the road. She said in response to a question about what happened just before the accident, *I just know it was all quiet, like, no-one had been talking for like a little while, and she was just – she was still quiet and she was just driving. Felt like she was driving normally.*[21]

She said, in evidence that she looked down for some reason, although she could not explain why she had looked down at that precise moment. She could not recall any sudden movement but remembered hearing the wheels in the dirt. She started screaming.[22]

Anna Hall made an application pursuant of section 39 of the Act on the basis that she not give evidence that might tend to incriminate her. After consideration and advising her of the provisions of the section of the Act, I ordered that she answer questions in the public interest.

[21] See page 55 of the transcript at line 54 and following
[22] See page 56 of the transcript at line 5 and following

She could not explain how the vehicle came to leave the road on the right hand side of the highway. She said that she had not consumed alcohol or drugs and had had a good nights sleep. She says she did not doze off.[23] She made comment about driving in the middle of the road.[24]

She said she was concentrating on staying on 100 kph. She said she did not go over 110 kph. She said she may have been looking at the speedometer too much, but could not recall.[25]

It seems clear from this evidence that neither of them was able to say that anything out of the ordinary caused the accident. There does not appear to be any sudden swerve to avoid an animal or another car going in the opposite direction. Both say they only became aware that the vehicle was in the dirt when the noise alerted them to it. As for Miss Hall, she says that she braked before hitting the guide post but the evidence of Sergeant Tulloch would suggest that she braked only when she hit the guide post and not before.

The autopsy

In short compass, the findings on autopsy were consistent with the cause of death. That is, injuries sustained in a single vehicle roll-over. The cause of death is set out in the following terms, *The cause of death was due to complications of head injury. The mode of death was cardiorespiratory arrest secondary to combined effects of compromise of airways by blood from upper airway soft tissue trauma, compromise of mechanical ventilation (restricted chest movement by weight of overlaying vehicle) and depression of respiratory drive by head injury.*[26]

[23] See particularly page 76 of the transcript at line 31 and following and the top of page 77 line 1
[24] See page 77 of the transcript at line 10 and following
[25] See page 90 of the transcript at line 15 and following
[26] See Autopsy report dated 27/1/2006 of Dr Terry, Toowoomba.

Toxicology revealed a blood alcohol reading in the urine of the deceased on 12 mg/100mL. Dr Terry deals with this issue as follows, *Well, the consumption of alcohol much prior to the accident because there's no alcohol, you know, within the blood any – any more and, you know, he – he – the urine occurs, you know, several, you know, hours after, you know, alcohol consumption, you know, you sober up but you still might have a bit of urine – alcohol in the urine in - in someone that's, you know, been drinking heavily and sort of thing, but because he didn't have alcohol on the blood and he's got minute amount of alcohol in the urine, it might signify that he just might have had a can of beer or something the day before even.*[27]

He speculated that the beer may have been consumed within the last 12 hours.

In any event, nothing turns on this issue in the context of the cause of the accident. However, it is of concern that the deceased was tested for alcohol and drugs but the driver was not. I refer to this issue again later and in the recommendation section below.

Submissions

I am grateful for the submissions received from the parties' representatives and counsel assisting. They were of great assistance.

In large measure the submission of the Solicitor for the next of kin were directed at whether I should refer this matter to the DPP for consideration of any possible charges against the driver. The submissions of the Solicitor for the driver Miss Hall in my view, correctly summed up the position by saying, *Given that there is a statutory prohibition on the coroner stating that a person is or may be guilty of an offence, or is or may be civilly liable for something*[28]*, it is, in my submission, unnecessary for the Coroner to address the question of responsibility for the death at all.*

The Submission for the next of kin makes reference to statements against interest made by the driver. I say something more about this in the discussion part of this decision.

[27] See page 60 of the transcript at line 35 and following.
[28] Section 45(5) of the coroners Act 2003

I do agree with the issue raised in paragraph 46 of the submission of the Solicitor for the next of kin. I am also concerned to ensure prompt and proper communication by police subject to the exigencies of any particular circumstance.

Discussion

Mr and Mrs Waugh want answers about the death of their son. This is perfectly understandable. An Inquest is a process where answers are sought and often found. What was the cause of the death? Usually an Inquest can answer that question. In this case, the big picture is clear. The vehicle driven by Miss Hall left the right hand side of the road and moved into the dirt. She tried to move the vehicle back onto the road way, lost control and the vehicle rolled. For some reason, probably seatbelt failure, Cappur Waugh (the deceased) was thrown from the vehicle and landed under it. It is possible that, with immediate assistance and treatment, he may have survived. This is not certain. But, in any event, what is certain is that the two girls were not in a position to assist as the deceased was trapped under the vehicle and in any event, they were both injured, most likely confused and in shock.

What is not clear, even now, is why Miss Hall allowed the vehicle to move across the road to the right hand side into the dirt.
Having regard to the evidence of the two survivors it can be established that the following did not have any bearing of the accident;

1. Weather conditions
2. road surface
3. mechanical condition of the vehicle
4. distractions within the vehicle
5. distractions for around the road, such as animals (alive or dead) other cars etc.
6. speed.
7. the accident does not appear to have been caused intentionally.

It is clearly upon for a finding that the accident most likely happened as a result of inadvertence or inattention. Whether that was because the driver was taking too much notice of the speedometer or simply dosed off is not able to be established conclusively.

What is reinforced is that driving on roads out in the west is an inherently dangerous thing. Long distance, straight roads and in some place narrow bitumen all contribute to the danger.

The parents have been completely dissatisfied with the police investigation. They are very concerned about the level of initial communication. However, on the evidence before me whilst there could have been a better level of communication which I will touch on, there is no evidence to suggest a poor investigation or a cover-up. I must note that it was not my responsibility to investigate such allegations. This is properly left to the appropriate bodies (such as the CMC and the ethical standards command of the police). I simply make the comment that I saw nothing that would raise a concern.

The parents have, in my view, taken a lot of information and drawn a conclusion which is not open, in my view, on the evidence before me. In particular, I refer to the statements against interest referred to above. Miss Hall said;
I am glad I killed Cappur because I don't think I could handle it if someone else did.
I wish Cappur didn't come along. I would have driven more responsibly.
I wish Cappur didn't come, he wasn't supposed to be there but Belinda asked him to come at the last minute to keep us safe. I would have been concentrating better if he wasn't there.

These are indeed strange things to say. However, with the benefit of some psychoanalysis of the driver and these comments, it seems to me that they can be explained by a combination of shock and drugs administered in hospital. In my view, the emphasis put on these comments is unsustainable.

In addition, there are the things going on during the journey, inside the vehicle, including the talk of god and heaven, the driving from side to side on the road way and the slapping of knees. There were two seventeen year olds and one thirteen year old in the car. One could not draw any inference from these discussions and driving. It appears that all of

these things happened earlier in the drive and that, at the time of the accident, it was all quiet in the cabin of the vehicle. They may seem strange to a mature adult.

Findings required by s45

I am required to find, so far as has been proved, who the deceased is, when and where he died, what caused his death and how he came by his death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings in relation to the particulars of the death.

Identity of the deceased	The deceased person was Cappur William Embling Waugh.
Place of death	Mitchell Highway, 40 Kilometres south of Cunnamulla
Date of death	16 January 2006
Cause of death	injuries (set out above) sustained in a single vehicle roll-over, most likely caused but inattention or inadvertence.

Concerns, comments and recommendations

Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. After considering all of the evidence, I find that recommendations are required in this case.

1. Every driver of a vehicle involved in a collision which causes serious injury (where someone is hospitalised) to any person must be breathalysed or, if that is not practical, blood taken to determine if the driver had taken alcohol or drug. Blood should always be taken to establish is drugs had been consumed.
2. Police should review this case to ensure that communication is as fulsome as possible with distressed relatives about motor vehicle accidents in which person are seriously injured or killed.

I have great sympathy for the family and friends of the deceased. This death occurred in tragic circumstances and they have left no stone unturned to find answers. Some of their questions will remain unanswered. However, I hope that they will find some degree of closure in these findings.

For the driver and her family, the burden of these tragic events will no doubt be with them forever.

In closing, I would simply say that, it seems to me on the evidence, this was an accident not unlike may other accidents which occur out on country roads. The grief will not go away but the living need to move on.

I sincerely hope that all those touched can move on. I wish you all my sincerest sympathy.

I wish to thank the representatives of the parties in conducting themselves in the professional way they did and for the submissions received. I especially thank Counsel assisting for her substantial assistance to me throughout.

I close the inquest.

Cunnamulla Coroner
Cunnamulla