



OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION: **Inquest into the death of Lee-Anne Gai MCLENNAN**

TITLE OF COURT: Coroner's Court

JURISDICTION: Rockhampton

FILE NO(s): ROCK-COR- 49/2007

DELIVERED ON: 17 July 2009

DELIVERED AT: Rockhampton

HEARING DATE(s): 16 & 17 March 2009

FINDINGS OF: Ms Annette Hennessy, Coroner

CATCHWORDS: Identification of the involvement of a third vehicle in motor vehicle incident; Young driver; Texting while driving; Following too close.

REPRESENTATION:

Queensland Police Service
Officer Assisting: Snr Const S Janes, Police Prosecutor

Family: Mrs E Lumsden (Mother of Deceased)
Mr Stephen McLennan (Brother of Deceased)

Other Appearances:
For Mrs Lumsden and driver: Mr T Arnold, Counsel,
i/by Swanwick Murray Roche
For witness Brett Turner: Mr A Edwards, Counsel
i/by Rsse R & Sydney Jones

These findings seek to explain, as far as possible, how this traffic incident occurred on 4th June 2007 at Gracemere, as a result of which Lee-Anne Gai McLennan died.

THE CORONER'S JURISDICTION

1. The coronial jurisdiction was enlivened in this case due to the death of Mrs McLennan falling within the category of "*a violent or otherwise unnatural death*" under the terms of s8(3)(b) of the Act. The matter was reported to a coroner in Rockhampton pursuant to s7(3) of the Act. The matter was later investigated and an Inquest held. A coroner has jurisdiction to investigate the death under Section 11(2), to inquire into the cause and the circumstances of a reportable death and an inquest can be held pursuant to s28.
2. A coroner is required under s45(2) of the Act when investigating a death, to find, if possible:-
 - the identity of the deceased,
 - how, when and where the death occurred, and
 - what caused the death.
3. An Inquest is an inquiry into the death of a person and findings in relation to each of the matters referred to in section 45 are delivered by the Coroner. The focus of an Inquest is on discovering what happened, informing the family and the public as to how the death occurred, but not on attributing blame or liability to any particular person or entity.
4. The coroner also has a responsibility to examine the evidence with a view to reducing the likelihood of similar deaths. Section 46(1) of the Act, authorises a coroner to "*comment on anything connected with a death investigated at an inquest that relates to – (c) ways to prevent deaths from happening in similar circumstances in the future.*" Further, the Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.
5. Due to the proceedings in a Coroner's court being by way of inquiry rather than trial, and being focused on fact finding rather than attributing guilt, the Act provides that the Court may inform itself in any appropriate way (section 37) and is not bound by the rules of evidence. The civil standard of proof, the balance of probabilities, is applied. All interested parties can be given leave to appear, examine witnesses and be heard in relation to the issues in order to ensure compliance with the rules of natural justice.
6. I will summarise the evidence in this matter. All of the evidence presented during the course of the Inquest, exhibits tendered and submissions made have been considered even though it may not be specifically commented upon.

7. The main issue was the potential involvement of a third vehicle in the incident.

THE EVIDENCE

8. At about 1.25pm on the 4th June 2007, a two vehicle traffic crash occurred on the Capricorn Highway, between the Yeppen roundabout and Gracemere. The incident occurred on the section of road in which overtaking lanes were situated about 1 kilometre west of the roundabout. Two vehicles were involved in the collision which was investigated by Sgt Ray Pimm of the Gracemere Police.
9. Helen Gledhill was driving a white Commodore station sedan. She was travelling towards Gracemere on the Capricorn Highway doing a speed of 100 kilometres per hour. Mrs McLennan was her front seat passenger. Ms Gledhill saw a green sedan approaching from the opposite direction with smoke coming off the wheels. A cloud of smoke surrounded the back of the car. The car was at an angle, heading for her side of the road. He didn't straighten up but kept coming across the lanes. Other vehicles were travelling towards Rockhampton in front and behind this vehicle. Ms Gledhill applied the brake as far as she could and braced for the collision. She was hoping that if she slowed enough then the car would go past her and off the road. The cars collided and her vehicle ended up facing the opposite direction. Both Ms Gledhill and Mrs McLennan were trapped in their seats. Ms Gledhill suffered serious injuries and was transported to hospital. Mrs McLennan died as a result of her injuries.
10. Brett Turner gave evidence following a section 39 direction. He was a young man and was unemployed at the time. On the day in question he had been at his home in Gracemere with his friend Paul Sebbens. They set off in their own vehicles separately from Mr Turner's house about 5 -10 minutes before the incident happened.
11. They were going to Rockhampton to look at items for Turner's new car. The car which Mr Turner was driving had only been owned by him for 3 days. He had held his P plates for a couple of months. Prior to owning this vehicle, he had driven his parents' 6 cylinder Falcon.
12. After leaving the house, Turner and Sebbens stopped at the intersection leading onto the highway. Shortly after turning onto the highway, Turner lost sight of Sebbens car ahead of him.
13. A couple of minutes prior to the accident, Mr Turner sent Mr Sebbens a text message to go to Allenstown. Mr Turner agreed that he could have been sending a text message on his phone around the time of the incident. He was receiving text messages between 1 and 1.30pm that day. One exchange that he can remember is with Paul Sebbens about the destination of their trip.

14. Mr Turner was travelling at about 90 kilometres per hour in a line of traffic towards Rockhampton. About ½ way along the overtaking lane, Mr Turner moved into the overtaking lane and accelerated to 100 kilometres per hour. A car in front of him suddenly moved into the overtaking lane which Mr Turner would have hit if he did not slow down, and he braked. He did not think that he applied the brakes hard.
15. Mr Turner gave evidence that at the time that the vehicle pulled out in front of him, he was about 1 metre or less from it. He had been following the vehicle closely and doing about 90 kilometres per hour at the time. In evidence, he clarified this by stating that the distance between the vehicles narrowed to about a metre when the vehicle moved out. He did not think that the vehicle struck him.
16. The brakes on Turner's vehicle locked up and he slid across the road and was T-boned by another car. It all happened quickly and he said things were a bit of a blur. His car ended up off the road and people came to render assistance to him. Paul Sebbens came to his aid some time after the collision.
17. Mr Sebbens gave evidence that he was driving his white Holden Commodore and was a few cars ahead of Mr Turner. He received a text saying Allenstown. He did not reply to the message. He had his window down and when he was at the end of the overtaking lanes he heard a large sound. He looked back and saw Mr Turner's car going across the lanes. He went further up the road, turned around and came back to discover the accident had occurred.
18. During cross-examination, Mr Sebbens agreed that in the hour surrounding the accident, he had received and sent a total of 35 text messages with his girlfriend, some whilst driving. Some time after receiving the text from Mr Turner about Allenstown, he heard some screeching and looked out his half-open window to see the incident. He was at that time up to 300 metres from the incident and looking back along the road which he said had a curve in it. He returned to the scene and rang 000. However, he did not stay sufficiently long to speak to the Police. He did not mention the incident to his mother later that day or after and the Police did not become aware of his involvement until much later in the investigation.
19. It is doubtful that Mr Sebbens was able to hear and see the collision from the distance he says he was and it is very likely that he was in fact much closer to the incident but how close is not able to be established on the evidence.
20. Owen Murray is a refrigeration mechanic. He was driving 5-6 cars behind the green Commodore. He was doing 90-100 kilometres per hour and the green vehicle was about 40-50 metres ahead of him. He saw the green car in the overtaking lane. Mr Murray was in the left lane when the green car caught his eye. There was a full line of traffic

in the left hand lane at the time. He saw smoke coming from the vehicle and it drifting sideways. He could not see anything that would have caused the green car to move. He slowed right down and heard the collision. He went to the accident site and saw the driver of the green car walking around.

21. Mr Murray presented himself at the Police Station following the incident in order to provide a statement as he was not spoken to by Police at the scene. Mr Murray stated that other cars stopped but left before the Police arrived at the scene.
22. Mr Terry Bridgeman was also a witness to the incident. He gave evidence that he was driving a truck in the course of his employment west along the Capricorn Highway at the time of the incident. He commented that the area is often busy with four lanes of traffic. Mr Bridgeman had come around the Yeppen roundabout and saw a cloud of dust coming off the road up ahead. He could see the cars after the collision. He pulled up at the scene and half blocked the road with his truck for safety of those there. There were a number of people on their phones, he presumed ringing emergency services. He assisted by picking up bits broken off the white car and throwing it off the road so other vehicles would not run over it. Mr Bridgeman then attended to Mrs McLennan and was unable to locate a pulse. Ms Gledhill was trapped in the drivers' seat at the time and had to wait for emergency services to remove her.
23. The driver of the green vehicle was hobbling around holding his knee and swearing. He appeared to be distressed. Mr Bridgeman heard the driver of the green vehicle say to his mate (who arrived shortly after) that he thought he had made it. Mr Bridgeman left his contact details with Police but was not requested to provide a statement until after a year later.
24. An issue had arisen as to which friends attended on Mr Turner immediately following the accident. Mr Bridgeman clearly saw a fellow (presumably Mr Sebbens) and a girl with whom he was very friendly. Police were unable to confirm that another person was with Sebbens.
25. Sgt Pimm is a part time Traffic Accident Investigation Squad officer (TAIS), having completed the Advanced Crash Investigation course. He has attended hundreds of traffic accidents and a number of fatal incidents.
26. Sgt Pimm attended the scene at 2pm. A white Holden Commodore station wagon was situated on the westbound lanes facing Rockhampton with extensive damage to the front section. Mrs McLennan was in the front passenger seat of the vehicle. She was deceased. She was wearing a seat belt. A green Holden Commodore sedan was situated in the grass area off the southern side of the highway with extensive damage to the left side.

27. After ensuring that the injured were attended to, Sgt Pimm investigated the incident and eventually reported to the Coroner.
28. Mr Turner was spoken to by Police. He was closely questioned regarding a description of the vehicle which pulled out in front of him. In the first interview after the accident, he told Police that he could not say what type of vehicle it was. Months later in September, he was again interviewed and stated that a sedan and a van and another vehicle were in front of him at the time. He was able to nominate off-white or beige as the colour of the vehicle. In the insurance form completed by Mr Turner in November regarding the incident, he stated that the vehicle which pulled out was a sedan – a Commodore VN or VR model.
29. Mr Turner was completely unable to give a credible explanation for his inability to inform the Police of the details he provided in the insurance report. His knowledge of car models was shown in court and he was particularly aware of Commodore vehicles. The position he ended up adopting was that he remembered the details of the vehicle after the September interview but didn't think to inform the Police.
30. During evidence, Mr Turner refuted the proposition that the car that pulled out in front of him was Mr Sebbens' car but that he was further up the road at the time. He stated that he "would have remembered" if it was Sebbens' car.
31. In short, I have significant difficulty in giving credit to the version of Mr Turner. It is clear that he has been hedging his bets in relation to the information he has been letting out regarding the other vehicle throughout the investigation and Inquest. The resultant position is that there is no credible evidence as to the description of the other vehicle potentially involved in the incident. I consider that Sgt Pimm has fully investigated every piece of information in this regard, including after the Inquest, unfortunately to no avail.
32. Sgt Tullouch was at the time of the investigation the Senior Collision Analyst for the Police. Sgt Pimm sought his opinion on the cause of the collision. Following the objective analysis of the information gathered by Sgt Pimm, Sgt Tullouch turned his mind to the three scenarios that Sgt Pimm postulated as to the likely cause of the incident in his report.
33. Sgt Tullouch agreed with one of those scenarios which was that a white vehicle had pulled out in front of Mr Turner on the divided highway, collided with the front of Turner's vehicle and then failed to stop. Given the damage with the deposit of white paint on the front passenger side of Turner's vehicle, it was not surprising that no debris was located on the road from that very brief collision or side swipe. It was impossible to say from the evidence whether the collision would

have adversely affected the handling of the white vehicle and if so to what extent. The paint deposits indicated a very quick contact between the two vehicles. It was not possible in Sgt Tullouch's view that the damage spoken of here occurred in the collision with Ms Gledhill's vehicle. Mr Turner confirmed that there was no damage to his vehicle prior to the incident.

34. Further Sgt Tullouch stated that in the circumstances of the collision with the white vehicle (evident from the paint marks on the green vehicle and the skid marks on the road surface), minimal braking would have caused the wheels to lock up and skid. Mr Turner had described a shuddering in the vehicle which he thought was a brake problem but Sgt Tullouch stated that he was describing the actions the car would have undergone during the side swipe with the white vehicle. The skid and brake lock of the green vehicle after the side swipe was unrecoverable given extent of the rotation of the vehicle. The vehicle was, in effect, from that point out of control.

Findings

35. Sgt Pimm conducted a detailed investigation and was very responsive to following through on further information as it came to hand. His work on the matter was thorough and it is a shame that he was not afforded better co-operation and assistance by members of the public in this matter. With more information from other road users on the day the exact circumstances of the incident could have become known, particularly the identity of the other vehicle involved in the side swipe of Turner's car. Sgt Pimm wisely sought opinion from the Senior Collision Analyst in order to ascertain the mechanics of the collision. That evidence was very important in establishing how the incident occurred. However, I am sure that the identification of the third vehicle would have answered outstanding questions for the family of Mrs McLennan.
36. There are a number of causes of the collision in my view which I am satisfied are established on the evidence. They include:
 - (i) Mr Turner's pre-occupation with the outcome of journey including travelling in convoy with his friend;
 - (ii) Mr Turner's texting to his friend about their destination shortly before the incident;
 - (iii) Mr Turner travelling too close to traffic in front of him when on the overtaking section of the roadway, causing the side swipe incident which contributed to him losing control of the vehicle.
37. It has been suggested to me by the family of Mrs McLennan that there should be concerns about Mr Turner, as a young driver, driving the vehicle he was on this day. Whilst I agree with that concern, the evidence suggests that his driving skills as opposed to the vehicle are more of a concern. For instance, there is no suggestion of speed but rather travelling too close is the problem here.

38. I am required to find, so far as has been proved on the evidence, which the deceased person was and when, where and how she came by her death. After consideration of all of the evidence and exhibited material, I make the following findings:

Identity of the deceased person– The deceased person was Lee-Anne Gai McLennan.

Place of death – Mrs McLennan died at the scene of the motor vehicle incident on Capricorn Highway, between Gracemere and Rockhampton.

Date of death –Mrs McLennan died on the afternoon of 4th June 2007.

Cause of death – Mrs McLennan died after the vehicle in which she was a front seat passenger was involved in a collision with a vehicle driven by Brett Turner. The vehicle in which Mrs McLennan was travelling was being driven west by Helen Gledhill when Mr Turner’s vehicle travelled onto the incorrect side of the road, colliding with Mrs Gledhill’s vehicle and forcing it from the road. Mrs McLennan died instantly from multiple injuries as a result of the collision.

There is insufficient evidence for any charge to be laid causing the death of Mrs McLennan but I consider that the Police could have looked at a traffic offence in relation to Mr Turner’s driving on the day but I note that the 12 month time limit has now passed.

I do not propose to make any recommendations in this matter as the dangers of texting while driving and following too close are well known in the public arena and the delivery of these findings will again bring the matter to public notice.

I express my condolences to Mrs Lumsden for her loss and Ms Gledill for her trauma and thank the Prosecutor Assisting, Senior Constable Janes and particularly Sgt Pimm for his assistance in this matter. I close the Inquest.

A M Hennessy
Coroner
17 July 2009