QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Jeffrey Juhas, Virginia Donaldson, Jerome Juhas and Steven McGill**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR 2657/07, 2651/07, 2659/07 & 2645/07
DELIVERED ON:	28 October 2009
DELIVERED AT:	Cairns
HEARING DATE(s):	17/04/2009 (PIC), 28/10/2009 (hearing)
FINDINGS OF:	Kevin Priestly, Northern Coroner
CATCHWORDS:	CORONERS: Inquest – Motor vehicle accident, vehicles approaching from opposite directions, single lane bitumen road – rural setting – head on collision, multiple fatalities
REPRESENTATION:	Counsel Assisting the Coroner: Mr P Edson No other legal representatives

Introduction

At about 9.45 p.m. on 8 June 2007 Jeffrey Juhas, aged 27 years; Virginia Donaldson, aged 21 years; Jerome Juhas, aged one year and nine months - son of Jeffrey Juhas and Virginia Donaldson - and Steven McGill, aged 41 years were the occupants of a silver Ford Corsair sedan travelling south along the Kennedy Highway approximately nine kilometres from Mount Garnet when it came into collision with an oncoming Toyota Hilux towing a trailer.

Jeffrey Juhas was the driver, Steven McGill was the front seat passenger, Virginia Donaldson was seated in the rear next to Jerome, who was seated on a foam booster and secured with a lap sash seatbelt. All four occupants of the Ford sedan were declared deceased at the scene. The occupants of the Toyota Hilux were conveyed by ambulance to Atherton Hospital.

A police investigation was conducted into the circumstances surrounding this collision and a report provided to me to consider in the context of a coronial investigation. That investigation is now complete. These findings seek to explain how the death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future.

Scope and Powers of a Coronial Investigation

The Coroners Act 2003 provides that "When an inquest is held into a death, the Coroners findings may be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The Coroner has jurisdiction to inquire into the cause and circumstances of a reportable death. If possible, he or she is required to find whether death in fact happened, the identity of the deceased; when, where and how the death occurred and what caused the person to die. There is considerable litigation concerning the extent of the Coroners jurisdiction to inquire into the circumstances of a death and it seems to me to be appropriate that I say something about the general nature of inquests for the benefit of the deceased family and for completeness.

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 public interest requires. 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*

preventative recommendations concerning public health or safety in the administration of justice, or way to prevent deaths from happening in similar circumstances in the future. A Coroner must not include in the comments, or findings, or recommendations, a statement that a person is or may be guilty of an offence or civilly liable for something. However, if as a result of considering the information gathered during an inquest a Coroner reasonably suspects that person may be guilty of a criminal offence, the Coroner must refer the information to the appropriate prosecuting authority."

It is important to note the proceedings in the Coroners Court are not bound by rules of evidence pursuant to section 37 of the Act. Because section 37 of the Act provides that a Court may inform itself in anyway it considers appropriate, that does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a Coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its 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 the means of apportioning guilt, an inquiry rather than a trial.

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. 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 is the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to a civil standard.

It's clear that a Coroner is obliged to comply with the rules of natural justice and act judicially. This means no finding adverse to the interests of any party may be made without the party first being given the right to be heard in opposition to that finding. As *Annetts v McCann*[1] 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.

The Road Features

Sergeant McPhail attended the scene of this fatality and, as a qualified Forensic Crash Unit investigator, started an investigation.

At the location of the accident, the Kennedy Highway had a bitumen road surface approximately 3.5 metres wide, with sloping dirt edging or shoulders on either side. For the majority of the length of the shoulders the bitumen surface is slightly raised above the dirt surface with uneven and broken edges. Whilst the road is a dual carriageway, there is only a single lane of bitumen down the centre of the road with dirt edges on both sides. On the north-western side of the road there were large mounds of rock and gravel

[1] (1960) 65 ALJR 167 at 168

being used for road upgrades. These mounds were situated about five metres away from the edge of the bitumen.

The location of the crash is on the plateau of an incline from both directions which dips slightly and levelled out at the scene. The section of road is undulating. Lights from approaching vehicles can be seen when driving in this location. However, vehicles are often not seen until the last minute and may appear further away than first thought. I viewed photographs of the locality as it appears at present and note that the topography has not significantly changed. It is indeed undulating which may restrict lines of sight. There was no street lighting in the area. The signed speed limit for this section is 100 kilometres per hour. It was a cold and clear night. The road was dry. There was no fog along this section of the road, although there may have been some fog on other sections of the road, likely more low lying. There was no rain to impair the driver's vision.

Scene Investigation

Upon arrival at the scene, the police observed the following vehicles.

There was a white Toyota Hilux twin cab utility facing in a south-westerly direction. The rear wheels of the vehicle were on the roadway and the front wheels were on the dirt edging. The vehicle was facing generally at a 45 degree angle to the roadway on the north-northern side and the trailer it had been towing was level with the highway. There was nothing on the trailer. A fabricated metal canopy on the rear of the Toyota Hilux was thrown clear of the vehicle as a result of impact.

The other vehicle was a Ford Corsair sedan, facing a south-westerly direction, and located on the dirt edging at a 45 degree angle to the roadway on the southern side of the road. The vehicle had extensive front end damage which had been totally destroyed and pushed backwards towards the occupants' compartment. The bonnet had been forced up and into the windscreen area. There was a large quantity of alcohol located in the Ford Corsair, including a can of Jim Beam and Cola wedged between the top of the steering wheel and the dashboard area. The can had exploded through the body of the can, although the ring pull on the can was still intact.

Police examined the road surface and identified a number of markings. Firstly, there was a series of four small scrape marks, approximately 1.75 metres west of the driver's door of the Corsair. The marks were approximately .4 metres across. There was also another scrape mark approximately .1 of a metre in length, situated on the roadway, approximately 1.17 metres south of the passenger door of the Toyota.

Secondly, there was a series of four tyre marks on the road surface which were across the entire width of the road, running north-east to south-west, approximately eight metres in overall length. Four of the tyre marks originated from the four, small scrape marks and extended to the location of the Ford Corsair. Another tyre mark was located on the roadway on the western side of the final resting position of the Toyota. This tyre mark was approximately

1.6 metres in length and was situated approximately where the trailer was anchored to the rear of the Toyota.

Thirdly, there was a faint tyre mark initially on the bitumen and subsequently on the western dirt edge. The first part of the tyre mark on the bitumen was very light and extended from the end of the western most tyre mark for approximately 2.6 metres until it passed from the bitumen edge onto the dirt surface. The tyre mark continued in the dirt for approximately 20.1 metres along the dirt edge, just off the western edge of the bitumen surface. These tyre marks on the bitumen and the dirt were made by the Toyota.

The police were unable to find any potholes or objects on the road that might have caused or contributed to the accident.

The location and alignment of the tyre marks and scrapings are depicted in a plan drawn to scale that is before the Court, which gives a much better understanding of the significance of those marks relative to the final resting positions of the vehicles.

Damage to the Vehicles

An inspection was carried out on the Toyota Hilux by a police motor vehicle inspection officer, which revealed it had suffered severe impact damage to the left-hand front of the vehicle, the passenger side, including damage to the front bullbar, radiator and support panels, bonnet, headlights, left-hand side rail, left-hand front wheel, front suspension, front guards, windscreen, roof, left-hand doors, engine, chassis and driveline. The mechanical inspection concluded that notwithstanding the damage identified and attributable to the collision, the vehicle was deemed to have been in satisfactory mechanical condition and no defects were found that would have contributed to the collision.

In relation to the trailer being towed by the Toyota, a full inspection was carried out and the braking system on the trailer was found to be defective and had the potential to be dangerous when the trailer was loaded. The braking system was excessively worn and virtually inoperative when tested. The braking system had been in this condition for some time. The trailer was not loaded at the time of the accident.

The motor vehicle inspection officer who inspected the vehicles provided a supplementary statement at the request of the Coroner's office in relation to a number of questions. He was asked what impact, if any, these defects might have had in the event of a driver over-correcting the steering of the vehicle after pulling off to the side of the road. This officer was informed about the circumstances of this accident and made aware of the nature of the road and the version of events given by Mr Chambers in earlier interviews. In response to that query, he reported that in his opinion the defects mentioned, namely poor trailer brakes, may have made it more difficult for the driver to control the combination of the Hilux and a trailer in an oversteer situation. That witness, Mr Georgis, then says that the position or the handling ability would have been further affected if there had been any sudden application of the brakes.

In relation to the Ford Corsair sedan, the vehicle suffered impact damage to the front with the under body bent and the front section of the vehicle crushed due to impact. All body panels were affected by the accident. As a result of the inspection, the vehicle was found to be in an unsatisfactory mechanical condition due to the condition of the front shock absorbers. However, that defect was of a minor nature and would not have contributed to the cause of the accident.

Witness Accounts

The police attempted to identify witnesses who may have seen either vehicle earlier that evening. A truck driver informed police that he'd been stationary at a truck pad at the southern end of Mount Garnet and left that location around 9.30 p.m. The driver recalled seeing a silver car, possibly a Ford, which had pulled in behind his truck as he left town travelling towards Karumba. The silver sedan overtook the truck as he approached the turnoff to the Mount Garnet racecourse but stated the silver sedan did not appear to be speeding. The truck driver estimated the silver sedan was travelling about 80 kilometres an hour when it overtook his truck. The truck driver came across the traffic accident sometime later and saw the same silver sedan that had overtaken him earlier. No other witnesses to the movements of either vehicle were identified by police.

Mr Chambers, the driver of the Toyota Hilux, participated in a record of interview with police on 29 June 2007 during which he provided to police information about his recollection of the events. Mr Chambers recalled coming up to a crest on the hill and seeing the headlights of an approaching vehicle, either as it came over the hill or as he was cresting the hill. He then pulled off the road a bit and noticed that the other vehicle had not pulled off the road, so he pulled his vehicle further off the road while decelerating. Mr Chambers stated to police that he lost control of the vehicle, it moved sideways and hit the other car. Mr Chambers believed there was a distance of about 100 metres between his vehicle and the Ford Corsair when he first saw the headlights.

He acknowledged that on the night of the accident, when questioned by police officers, he told them he saw the lights of the other car, pulled over to the side of the road and onto the dirt but he skidded on the dirt and went sideways. The other car hit him when his car was sideways across the road.

Mr Chambers estimated that he'd pulled the vehicle off to the left of the road on the dirt shoulder for about two seconds prior to impact. When asked during this interview how far off the bitumen he was, Mr Chambers responded that he'd moved over a bit so the passenger side was on the dirt and as far as he remembered he thought he'd pulled the vehicle mostly off the road but it was actually very hard to tell what was road and what wasn't at that point because the road and the dirt sort of melded together.

Mr Chambers recalls seeing a lot of gravel and mounds of dirt or something on the side of the road. Mr Chambers didn't think he came back onto the

bitumen except after he lost control. Mr Chambers reiterated the Ford Corsair didn't appear to move off the bitumen onto the dirt at all.

Mr Chambers advised he was looking straight ahead watching the road prior to the accident happening. He watched the headlights crest the top of the hill. He was not eating or drinking anything at the time, nor was he on a mobile phone. Mr Chambers stated he did not flash his lights or sound the horn or alert the oncoming vehicle when he saw it wasn't moving over because there wasn't time for that.

In relation to the brakes, Mr Chambers was asked a number of questions to which he responded. When advised that the brakes on the trailer were not working, Mr Chambers advised he did not know that the brakes were in a potentially dangerous condition and said he wouldn't have towed it if he'd known this. He admitted he was familiar with driving a vehicle whilst towing a trailer from his experience in his tree lopping business, and he did not know if the trailer on the day of the incident was equipped with an independent braking system. Mr Chambers agreed it's possible the motion of the trailer may have caused the vehicle to go sideways. Mr Chambers said he had not experienced any problems whilst driving the vehicle prior to the incident, no vibration or shuddering when he was moving over onto the dirt.

Mr Chambers gave evidence in Court and provided an account based on his recollection that is essentially consistent with a version of events that he gave to investigating police during his interview on 29 June 2007. I am assisted in coming to some conclusions about the reliability and honesty of the account given by Mr Chambers by virtue of the fact that I have heard and seen him give evidence.

Police also interviewed other passengers in the Toyota Hilux, including Mr Shane Lobegeiger, who in fact was the owner of the Toyota Hilux. Mr Lobegeiger was seated in the front passenger seat. He provided a statement to police in which he outlined his recollection of the events. He says they were travelling at 70 to 80 kilometres per hour. The traffic was steady with Triple B trucks coming past every 20 minutes or so. They would go off the edge of the road which wasn't a problem, and Mr Lobegeiger said then that he was reasonably familiar with the road, having travelled on it since he was a boy.

He recalls, towards the end of their trip, they came to a rise near the top. He told police he saw some motor vehicle lights that were about a hundred metres away coming towards them. He reports that Mr Chambers noticed the lights as well and moved to the left as far as he could. There were some mounds of road base on their side which prevented Mr Chambers from pulling over any further. The lights of the other car appeared to stay in the middle of the road and kept coming towards them.

Mr Chambers told police that the Toyota kept to the left as far as possible. They travelled about 30 metres or so before the Toyota veered to the right. The front wheels of the Toyota went onto the bitumen surface of the road, the

rear wheels were still on the gravel and the trailer was behind them, although he didn't know what position it was in. The other vehicle did not appear to move from its line of travel and remained in the centre of the sealed section of the road.

Other Evidence

Mr Chambers supplied a blood test which returned a negative blood alcohol result; however, the blood test did detect the presence of tetrahydrocannabinols, consistent with cannabis use. This reading was referred to Dr Geoff Fisher at the Clinical Forensic Medicine Unit for an analysis of likely adverse effects that cannabis might have on a person's capacity to drive. He concluded that the cannabis was not a contributing factor to the accident. It was impossible to determine the recency of the use and the level appeared to be minimal.

Mr Jeffrey Juhas, the driver of the Ford Corsair, was also tested for blood alcohol at the time of his autopsy which occurred on 14 June 2007, six days after the accident. A statement was obtained from Dr Leslie Griffiths in the Clinical Forensic Medicine Unit in Townsville, who calculated that at the time of death, Mr Juhas would have had a blood alcohol reading in the range of 0.049 per cent and 0.052 per cent. Toxicology also detected the presence of tetrahydrocannabinols. Dr Griffiths opined that a driver with the blood alcohol concentration of 0.05 would have twice the crash risk of a driver with a zero blood alcohol concentration. Mr Juhas was also disqualified from holding a driver's licence at the time of the incident.

Post Mortem Findings

Autopsies were performed in relation to each of the four deceased.

In relation to Jeffrey Juhas, the autopsy revealed his cause of death was due to multiple injuries due to a motor vehicle accident. In relation to Jerome Juhas, the autopsy revealed that the cause of death was multiple injuries due to a motor vehicle accident. In relation to Virginia Donaldson, an autopsy revealed that the cause of death was multiple trauma to head, chest and abdomen due to a motor vehicle accident. In relation to Stephen McGill, an autopsy revealed the cause of death was due to haemopericardium due to rupture of the vena cava into the pericardium as a result of a motor vehicle accident.

Forensic Crash Investigators Analysis

Sergeant McPhail concluded his report with an analysis. Predominantly from his investigations at the scene, he concluded the Toyota appears to have crossed over into the path of the Ford Corsair, and the resulting collision caused the Toyota to rotate in a clockwise direction while pushing the Ford Corsair in an easterly direction. The four small scrape marks were made by the front of the Corsair as the Toyota impacted, pushing the front of the Ford Corsair down, leaving marks on the road surface. The four tyre marks were left by the Toyota as it veered across the road surface towards the Ford Corsair. There were no skid marks from the Ford Corsair, and all wheels

remained on the bitumen section of the road prior to impact; however, in evidence, Sergeant McPhail acknowledged that it was possible, notwithstanding the absence of tyre markings, the Ford Corsair may have been positioned partly on the bitumen and partly on the shoulder.

Sgt McPhail reports that the slight crook marks to two of the tyre marks indicated off-centre impact by the Toyota on the Ford Corsair that resulted in the Toyota moving to its left side and rotating away from impact. Sergeant McPhail considered a number of possibilities to explain why the Toyota crossed onto the path of the Ford Corsair. He considered it possible that the slightly raised bitumen edge could have been a factor in causing the inside of the tyre to bounce slightly off the edge of the road causing the driver to over-correct the steering.

Sergeant McPhail observed that on this stretch of road the bitumen surface was only wide enough for one car to travel at a time, and when two vehicles approach each other, at least one, but usually both, vehicles must pull over from the bitumen section onto the dirt shoulders of the road. He further acknowledged that when one side of the vehicle is travelling on dirt and the other side on a bitumen surface, this results in two different friction values operating on the vehicle which could result in over-correction of steering.

Conclusion

I find that:

1. Jeffrey Juhas, Virginia Donaldson, Jerome Juhas and Stephen McGill died at about 9.45 p.m. on 8 June 2007 at a location on the Kennedy Highway, approximately nine kilometres from Mount Garnet;

2. Jerome Juhas died due to multiple injuries due to a motor vehicle accident;

3. Jeffrey Juhas died due to multiple injuries due to a motor vehicle accident;

4. Virginia Donaldson died due to multiple trauma to head, chest and abdomen due to a motor vehicle accident;

5. Stephen McGill died due to haemopericardium due to a rupture of the vena cava into the pericardium as a result of a motor vehicle accident.

I accept the evidence of Mr Chambers and Mr Lobegeiger as to the circumstances leading up to the accident. The evidence from the scene investigation is consistent with their accounts. Mr Chambers saw the oncoming Ford Corsair as its lights came over the crest in the road and, whilst unexpected, he began decelerating immediately and moving the Toyota Hilux to the left. As the vehicles approached, it appeared to Mr Chambers that the oncoming vehicle was not moving from the centre line. Whether or not it moved from the centre line is impossible to determine. There was an absence of tyre tracks attributable to that vehicle, although the scene investigation was

challenging and possibly contaminated such that any movement could not objectively be excluded. However, the perception of both Mr Chambers and Mr Lobegeiger suggest the oncoming vehicle was closing rapidly and remaining in the centre line of the road. Mr Chambers made a split-second assessment that the vehicle was not pulling over and reacted by steering further to the left and decelerating. He was now placed in the more difficult position of becoming concerned about the close proximity of the guide posts. His vehicle started to drift slightly to the left which Mr Chambers corrected, expecting to be able to hold that line of travel until the oncoming vehicle had passed.

It is at this point that I find it likely the trailer impacted on the behaviour of the Hilux by accentuating the drift to the left. Mr Chambers reacted and sought to correct that action and hold the line of his vehicle, but inadvertently perhaps over-corrected causing the Hilux to move towards the centre of the road and impact with the Ford. I find that Mr Chambers took all reasonable actions to avoid the incident. It appears that Mr Juhas failed to move to the left to allow the Toyota Hilux to pass, or at least to move over adequately, or to move at a sufficiently earlier point in time. The evidence does not permit me to determine which one of these possibilities, or a combination of these possibilities came into play.

It is likely that Mr Juhas, as was Mr Chambers, was taken by surprise by the sudden emergence of a vehicle in the opposite direction and that might go some way to explaining the late response on his part in moving from the centre line of the road.

I have evidence before me that this section of road has been subject to a major upgrade to significantly widen it into a sealed dual carriageway, and this morning photographs were tendered showing the present condition of the road. In those circumstances, there are no issues for public health and safety that should be the subject of any recommendations at the conclusion of this inquest.

I extend my sympathy and those of the office of State of Coroner, northern region to the family and friends of the four deceased. Those are my findings.

I close the inquest.

Kevin Priestly
Northern Coroner
28 October 2009