CITATION: *Inquest into the death of Master C*
[2012] NTMC 024

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0032/2011 of 2012
DELIVERED ON:	13 July 2012
DELIVERED AT:	Alice Springs
HEARING DATE(s):	10 and 11 July 2012
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Pedestrian motor vehicle accident, fatal injury, person held in care**

REPRESENTATION:

Counsel Assisting:	Ms Elisabeth Armitage
Counsel for the Department of Children and Families:	Ms Gabrielle Brown

Judgment category classification:	A
Judgement ID number:	[2012] NTMC 024
Number of paragraphs:	52
Number of pages:	14

A suppression order was issued by the Coroner. The name of the Deceased and anything that might identify his name is suppressed.

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0032/11 of 2012

In the matter of an Inquest into the death of
Master C

ON 10 and 11 July 2012
AT Alice Springs

FINDINGS
DELIVERED 13 July 2012

Mr Greg Cavanagh SM:

Introduction

1. The Deceased, Master C, was 5 years old. On 8 July 2011 he died attempting to cross the Stuart Highway near the intersection of Ilparpa Road, Alice Springs.

2. Having considered all the evidence I find that there were no environmental, vehicle, or driver factors contributing to the death. The road conditions were good and visibility was clear. The car and caravan involved in the collision were roadworthy and in good condition. The car towing the caravan was travelling at about 60 kilometres per hour, well below the 80 kilometres per hour posted speed limit. The driver was neither fatigued nor intoxicated. Both the driver and his passenger saw Master C standing still, off to the side of the road, apparently waiting to cross. After the car passed, Master C stepped into the path of the caravan. He was struck by the left front corner of the caravan and did not survive the injuries he sustained. All the evidence before me indicates that Master C did not see or misjudged the position of the caravan and crossed into its path.

3. On 23 May 2011 Master C was placed into the care of the Chief Executive Officer of the Department of Children and Families under a voluntary temporary placement arrangement pursuant to section 46 of the *Care and Protection of Children Act*. The temporary placement arrangement was due to expire on 23 July 2011 but by agreement between Master C's parents and the Department it was terminated early. On 25 June 2011 Master C returned to his parents' care. I find pursuant to section 12 of the *Coroners Act* that Master C was not a person held in care at the time of his death. In those circumstances, an inquest into Master C's death was not mandatory but was none the less appropriate given the uncertainty as to his care status and the close proximity in time between his time in care and his death.

4. Ms Elisabeth Armitage appeared as Counsel Assisting and Ms Gabrielle Brown was granted leave to appear for the Department of Children and Families. A thorough and detailed investigation was conducted by Detective Sergeant Jonathon Beer. I received into evidence his comprehensive investigation brief, and all relevant medical and Department of Children and Families' files. I also heard evidence from Detective Sergeant Jonathon Beer, Mr Dennis Imof, Mrs Margaret Anne Nichol, Mr Christopher Nichol, Mr Mark James, Mr Ivan Petrovic, Ms Sue Edgar, Mr Jefferson Williams and Ms Alice Nelson.

5. Pursuant to section 34 of the *Coroners Act* ("the Act"), I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

6. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

7. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

Relevant circumstances surrounding the death

Family Background

8. Master C was born in Alice Springs on 10 February 2006. He is survived by his mother, Ms Leah Sampson, father, Mr Jefferson Williams, and younger brother, Jaylen Williams, and extended family. Mr Jefferson Williams, and a paternal grandmother, Ms Alice Nelson, told me of the families enduring pain and grief at losing their precious and dearly loved Master C.

9. Master C lived with his family at Yuendumu community, but also regularly visited his extended family in Alice Springs and often stayed with his grandparents at house 4, Old Timers Camp.

10. Although he was a healthy baby, in 2008 Master C contracted pneumococcal meningitis and suffered a stroke (left frontal cerebral infarction). He was left partially paralysed in his right arm and leg (right hemiparesis). He suffered noticeable hearing loss in both ears (chronic supperative otitis media). He was diagnosed with epilepsy and suffered seizures on a regular basis. He also developed speech and behavioural problems and slowed mental development.

11. Despite his medical conditions and physical limitations Master C was a happy child. His family members described him as forthright, adventurous, and said that he loved to explore and play with other children. In their statements family members also described that it was sometimes difficult to supervise Master C as he would "escape" and, due to his hearing loss, would not come back when called. Yuendumu residents anecdotally informed the investigation that Master C was nicknamed Houdini because of his ability to seemingly disappear.

Involvement of the Department of Children and Families

12. As a result of his disabilities, it was difficult for the family to meet his medical needs in a remote community such as Yuendumu. From time to time, the Department of Children and Families (the Department) were notified of concerns about Master C's care and supervision and the Department provided oversight and assistance to his family.

13. On 16 May 2008, for example, the Department was told that Master C was missing regular appointments with specialists at the Alice Springs hospital. Assistance was provided to bring Master C and his mother to Alice Springs where the services of the hospital social worker and the Department were engaged. The matter was resolved without further intervention.

14. Another example occurred on 1 September 2010. The Department received information suggesting Master C was not receiving appropriate care and

medication and was becoming violent. A Department investigation was commenced, and the matter was resolved through meetings with Master C's parents to ensure they understood his special medical needs and could provide adequate supervision.

15. On 24 January 2011 the Department was again notified that Master C was not in receipt of medication or appropriate supervision. The matter was investigated and the Department found that Master C's mother was attentive to Master C's needs and behavioural issues. Discussions among the Department, associated health services, and his parents, resulted in more assistance being provided to the family from supporting agencies and no further intervention was required.

16. On 23 March 2011 the Department was informed that Master C was not receiving his epileptic medication and was suffering regular seizures. Concerns were raised that Master C was not being adequately supervised and that he had been found wandering around the Yuendumu community by himself. An experienced Department case worker, Ms Sue Edgar, was assigned carriage of the matter. Department workers travelled to Yuendumu to assess Master C and his living and care arrangements. In discussions with Master C's parents, and with their agreement, it was decided that Master C would be temporarily removed from Yuendumu by the Department and placed into care for a period of 2 months. It was hoped that during this time his medication could be stabilised and that he could be thoroughly assessed to better determine his future care needs and how best they could be met.

17. On 23 May 2011 Master C was placed into the care of the Chief Executive Officer of the Department under a voluntary Temporary Placement Arrangement in accordance with section 46 of the *Care and Protection of Children Act* 2007. This voluntary arrangement was discussed with Master C's parents and their obligations and rights were explained to them. They were advised that they would have input into Master C's care and access to

family would be facilitated. Pursuant to sub-sections 46 (8) and (9) of the *Care and Protection of Children Act,* Master C's parents could terminate the temporary placement at any time. If the temporary placement was not terminated, the placement was due to expire on 23 July 2011.

18. Under the temporary arrangement Master C was placed with full time rotational carers at unit 3 / 4 Mariae Place, Alice Springs. He found separation from his family, culture, and language difficult and was often distressed. To alleviate some of this distress, it was agreed that Master C would stay with his extended family on weekends. These overnight stays happened without incident throughout the period of the arrangement and Master C appeared happy and content when collected by his carers following these visits.

19. Master C was enrolled at Acacia Hill School for children with special needs so that full cognitive and physiotherapy assessments could be completed. He started school on 24 May 2011. His teacher, Ms Anna Swartz, provided a statement indicating that Master C was progressing well and that he enjoyed playing footy and any game with balls. His possible reintegration into a mainstream school was being considered.

20. Even while in care and with his medication stabilised, Master C experienced a number of seizures. Master C was admitted to the Alice Springs hospital as a result of suffering seizures whilst at Acacia School on 23 June 2011. He was monitored for 2 days and the dosage of his seizure medication, Epilim (sodium valproate), was increased.

21. During his hospitalisation, Ms Edgar, and her immediate supervisor, Mr Petar Kirkles, determined that it was appropriate for Master C to be returned to his parents. They were of the view that Master C's parents had engaged well with the Department and had demonstrated their commitment to attend appointments and to provide appropriate care of Master C. Accordingly, on

25 June 2011 the temporary placement was terminated and Master C was discharged into the care of his mother.

22. In her evidence before me, Ms Edgar confirmed that Master C's parents were loving, caring, capable and committed and that it was best for Master C to be returned to their care. In all the circumstances, I consider that it was reasonable and appropriate to return Master C to his parent's care.

23. An out patient's appointment with Dr Cardine Bushell was booked for 5 July 2011 and Master C's mother agreed to stay in Alice Springs so the appointment could be kept. On review, Dr Bushell noted that Master C was progressing well, his seizures were reduced, and she confirmed there were no problems with him returning with family to Yuendumu. Sadly Master C died before his return to Yuendumu could occur.

24. The Department reported Master C's death to the Coroner's Office as a death in care reportable under section 12 of the *Coroners Act*. However, I accept the submissions of Ms Brown and find that the Temporary Placement Arrangement was terminated on 25 June 2011, when Master C was returned to parental care. I find that at the time of his death Master C was not a person "held in care".

Circumstances surrounding the death

25. During the evening of Thursday 7 July 2011, Master C was left to overnight with his grandparents, Ms Lynette Marshall and Mr Gregory Sampson, at house 4, Old Timers Camp, Alice Springs. This was quite common and Master C was familiar with his grandparents, their house and the surrounds. Extended family members also stayed there, and in neighbouring houses in the camp.

26. No-one could provide accurate times, but at some time during the morning of 8 July 2011 Master C had breakfast on the veranda of house 4. At some time Master C left the residence and went to house 3 to play with other

children. It is not known how long he remained there. At some later time it appears that Master C left house 3 by himself. No adults noticed that Master C had wandered off alone.

27. Just moments before his death, at about 11.10 hours, Master C was seen standing on the western side of the Stuart Highway, directly opposite the Old Timers Camp.

28. There is a well-worn path from the Old Timers Camp to the Stuart Highway. Fencing panels between the Old Timers Camp and the Stuart Highway had been removed to permit direct access to the camp via this path, it was a short cut. Given his location at the time of the collision it can be safely surmised that Master C walked along the path and out of Old Timers Camp through the gap in the fence. He then must have crossed the highway to vacant land on the other side. He was south of the Ilparpa Road intersection.

29. Mr Christopher Nichol was driving a 1999 blue Holden Commodore Sedan Victorian registered PPV-084 and towing a Victorian registered caravan T33-944. Mrs Margaret Anne Nichol was in the front passenger seat. They were driving north along the Stuart Highway into Alice Springs. They were travelling at about 60 kilometres per hour, looking out for the turn off to their intended destination, the MacDonnell Range Caravan Park on Ragonesi Road.

30. As the Nichols' approached the Ilparpa Road intersection they saw Master C standing to the left (inbound) side of the roadway. They also saw workers on the right (outbound) side of the road. According to the Nichols' evidence, Master C was stationery and appeared to be looking across the road, perhaps towards the workers. It appeared to the Nichols that Master C was going to cross the road but had not started to do so. Mr Nichol's believed it was safe to simply continue and pass by. There was no call to apply the brakes nor blow the horn, and neither of the Nichol's heard a horn.

31. I received statements from the road side workers and heard evidence from their team leader, Mr Denis Imhof. The statements and evidence were consistent with each other. Mr Imhof said he heard a horn, looked up, and heard a thump. He then saw Master C propelled in a northerly direction behind the caravan towed by the Nichols.

32. On the conflicting evidence before me I am left uncertain as to whether a horn was sounded, or if it was, by whom.

33. The Nichols told me that as they passed Master C they heard a loud thump. Not knowing what had caused the noise, Mr Nichol pulled off to the left side of the road and stopped. The Nichols exited their vehicle and saw Master C on the roadway. They remained at the scene until Police and other emergency services arrived.

34. Passer's by stopped to provide assistance to Master C and direct traffic. One of the road side workers called triple zero. The 000 call was logged at 11.12 hours. Ambulance services were despatched at 11.13 and arrived at the scene at 11.17 hours. Master C was unconscious when the ambulance officers attended. Road side first aid was provided and Master C was immediately transported to Alice Springs Hospital, arriving there at 11.33 hours.

35. The fire service also attended and provided assistance to the ambulance officers. After Master C was taken to hospital residents from the Old Timers Camp gathered at the scene and were very distressed. A fireman cleaned the scene hoping to minimise their distress, but did so before liaising with attending police. He immediately realised that he should not have interfered with the scene and discussed his mistake with his colleagues in a debrief that followed. I am satisfied that the Alice Springs Fire Service is aware that scene integrity is vital. Indeed, I was referred to the Northern Territory Fire and Rescue Service training manual which instructs that:

Preservation of evidence and scene-integrity are vital to ensure an accurate accident investigation. Therefore, debris is not to be moved without the approval of the Police, OIC, or other responsible agency, unless it is necessary for extrication or personal safety. The smallest piece of wreckage and its location may be vital in any subsequent investigation.

36. Upon arrival at the Alice Springs Hospital, a team of qualified doctors attempted to stabilise Master C. However a CT scan revealed that Master C had suffered an unsurviveable traumatic brain injury and the medical notes record multi organ failure. After family members arrived, life support was terminated, and Master C was pronounced deceased at 14.27 hours.

Autopsy

37. Dr Eric Barclay Donaldson performed an autopsy on 15 July 2011. He found the cause of death to be extensive skull fracturing and traumatic brain injury caused by blunt force trauma from impact by a caravan. I agree with and accept those findings.

Crash analysis

38. A comprehensive crash analysis considering all facets of the collision was conducted by Senior Constable Ivan Petrovic of the Major Crash Unit, Alice Springs. I received his report and heard evidence from him in the Inquest.

39. The fatal collision occurred on the western side of the Stuart Highway 34 metres south of the Ilparpa Road intersection.

40. Master C was struck by the front left corner of the caravan towed by the Nichols.

41. At the scene of the collision, the road was straight, flat, and clear, and consisted of two marked lanes travelling north and south. There was nothing obstructing the driver's view of the roadway or of persons standing next to

the road. The speed limit was 80 kilometres per hour. There was nothing to indicate that road conditions contributed to the collision.

42. The crash occurred during daylight hours. The sun was high in the sky and did not interfere with driver visibility. There were no adverse weather conditions. There was nothing to indicate that environmental conditions contributed to the collision.

43. The vehicle and caravan were inspected and found roadworthy. There was nothing to indicate that any vehicle fault or defect contributed to the collision.

44. Mr Nichol was an experienced driver who had held a licence for 25 years. There was no evidence that Mr Nichol was fatigued and his road side breath test returned a zero blood alcohol reading.

45. The length of the crash scene was measured at 26 metres from the estimated point of impact to the point where Master C came to rest. There was no tyre friction marks identified, consistent with Mr Nichol's evidence that brakes had not been applied. Speed calculations indicated that the vehicle and caravan were travelling between 51-60 kilometres per hour on impact which was also consistent with Mr Nichol's evidence.

46. Senior Constable Petrovic considered the research which accords with common-sense, that developmentally children of 5 years of age lack the cognition, attention, perception, and visual skills to safely cross roadways. It is also probable that Master C's hearing impairment increased his likelihood of error.

47. Following his analysis of the collision, Senior Constable Petrovic concluded:

There is no evidence to suggest any wrong doing by Nichol. He was not under the influence of alcohol, he maintained his vehicle within his lane, he

was travelling below the gazetted speed limit, he observed the deceased stationary on the side of the road, and he believed he was not going to run out into his path. It is the member's opinion that Master C failed to observe the vehicle approach and moved out into its path outside (behind) Nichol's field of vision. Nichol was not able to detect Master C running out or employ any evasive manoeuvre to avoid the collision.

48. I concur with those conclusions. I find that Master C misjudged the traffic conditions and entered the roadway between the Nichols' car and caravan resulting in the impact which caused his death.

Conclusions

49. This death was the result of a tragic accident. Master C wandered off from family, and failed to safely cross the road.

50. He is sorely missed by his family. Mr and Mrs Nichols have expressed their deep sorrow and anguish at his death. Ms Edgar has experienced significant and ongoing grief and distress.

51. There are no recommendations arising from this Inquest.

Formal Findings

52. Pursuant to section 34 of the *Coroner's Act* I find, as a result of evidence adduced at the public inquest, as follows:

    (i) The identity of the Deceased was Master C born in Alice Springs on 10 February 2006. The Deceased resided at Yuendumu Community, in the Northern Territory of Australia.

    (ii) The time and place of death was 14.27 hours on 8 July 2011 at Alice Springs Hospital.

    (iii) The cause of death was extensive skull fracturing and traumatic brain injury from pedestrian strike by a caravan.

(iv) Particulars required to register the death:

1. The Deceased was Master C.

2. The Deceased was of Aboriginal descent.

3. The Deceased was a school student.

4. The death was reported to the coroner by the Department of Children and Families.

5. The cause of death was confirmed by post mortem examination carried out by Dr Eric Barclay Donaldson.

6. The Deceased's parents are Leah Nampijinmpa Sampson and Jefferson Williams.

Dated this 13th day of July 2012.

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GREG CAVANAGH
TERRITORY CORONER