CITATION: *Inquest into the death of Nicholas Konedaris* [2007] NTMC 042

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FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Motor vehicle accident, quality of police investigation, police registration of motor vehicles

REPRESENTATION:

Counsel:

Assisting:	Dr Celia Kemp
Commissioner of Police:	Mr John Stirk

Judgment category classification:	B
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0060/2006

In the matter of an Inquest into the death of

NICHOLAS KONEDARIS
ON 26 AUGUST 2006
AT COLYER CREEK BRIDGE,
STUART HIGHWAY,
ALICE SPRINGS

FINDINGS

(13 June 2008)

Mr Greg Cavanagh SM:

1. This inquest inquired into the death of Nicholas Konedaris (the deceased) who was fatally injured in a motor vehicle accident that occurred on the Colyer Creek Bridge on Saturday 26 August 2006. The collision involved two vehicles; the deceased was driving north from Alice Springs with his fiancée, Jolene Wright in the passenger seat. Suzanne Harbour was driving south towards Alice Springs with her husband, Justin Harbour in the passenger seat and they were towing a trailer. Suzanne lost control of her car and it crossed the median strip and hit the car driven by the deceased, resulting in his death.

2. His death was investigated and reported to the Coroner as it fell within the definition of a reportable death pursuant to s 12 of the *Coroner's Act.* The holding of a public inquest was at my discretion pursuant to s 15 of the *Act*. Section 34 of the *Coroners Act* sets out the matters that a Coroner investigating a death shall find, if possible:

   "(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*; and

(v) any relevant circumstances concerning the death

3. 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."

4. The Commissioner of Police was represented by Mr John Stirk. The material tendered before me consisted of the initial investigation brief prepared by Senior Constable Steven Salvia as well as additional statements, letters, reports, photographs, and original documents, totalling 16 exhibits. Suzanne Harbour was charged with driving a motor vehicle (the trailer) that was unsafe to drive and driving without due care. The particulars for the latter charge were that she did not keep a proper lookout in permitting her vehicle (the car and the trailer) to leave the road, that she permitted to the vehicle to go to the wrong side of the road and that she failed to accelerate to straighten out the trailer. The matter went to hearing before Magistrate Greg Borchers on 8- 9 May 2007 at the Alice Springs Court of Summary Jurisdiction. His Honour heard from numerous witnesses and he found that all of them were honest and gave their evidence frankly. In the end both counts were dismissed. I have before me the transcript of the evidence given at that hearing which forms part of my brief. His Honour, on the evidence before him, commented that one hypothesis for why the car was suddenly unable to be controlled was that it was a result of vehicle failure, the vehicle being the trailer.

5. Subsequent to the hearing an internal investigation into the conduct of the police investigation and into the events surrounding the registration of the Harbour's trailer was conducted by Superintendent Don Fry. Statements and interviews from this investigation were before me however its conclusions and the covering memorandum in relation to it do not form part of my brief.

6. I heard evidence over the three days of the inquest from Senior Constable Steven Salvia, Constable Csaba Boja, Constable Mark Ashton, Constable First Class Mark Casey, Brian Wingrove, Stuart Davis, Ben Falzon, Senior Sergeant Michael Potts, Grant Johnston, Commander Bert Hofer, May Taylor, Senior Constable Justin Harbour (by video link), Suzanne Harbour (by video link) and Constable Ivan Petrovic.

7. The deceased was the eldest son of George and Pauline Konedaris. They ran a building business in Tennant Creek and he worked for the business. His parents tell me that he was an extremely hard worker and he was also very dedicated to his family. He had been in a relationship with Jolene Wright since January 2004 and just before his death they had become engaged. They were planning to have children together. It is clear that the deceased was a gentle man with a good heart who was very much loved and that his death has caused and continues to cause great pain to those who loved him.

8. The deceased's parents were present throughout the inquest. They had significant concerns about the death and Mr Konedaris, on behalf of himself and his wife, wrote to me during the investigation and also wrote two letters which were tendered during the course of the inquest. Jolene Wright was also present throughout the inquest and sat through descriptions of the accident which she had lived through and which had killed her fiancé. I would like to commend all three people for the significant assistance they gave this office and for sitting through an inquest that was deeply upsetting for them.

9. I would also like to particularly commend Ben Falzon and Stuart Davis, the paramedics from St John Ambulance who treated the deceased. It was a very difficult situation and they both performed with competence and compassion. Stuart Davis was a student paramedic at the time and spent a considerable period of time in a small hole in the deceased's vehicle so as to be closer to both people trapped in the car.

FORMAL FINDINGS

10. Pursuant to s. 34 of the *Act*, I find, as a result of evidence adduced at the public Inquest as follows:

    (a) The identity of the deceased person was Nicholas Konedaris born on 4 December 1979 at Tennant Creek in the Northern Territory of Australia.

    (b) The time and place of death was at the Colyer Creek Bridge on the Stuart Highway at 2 pm on 26 August 2006.

    (c) The cause of death was multiple injuries sustained in a motor vehicle accident caused by another vehicle losing control and crashing into the vehicle driven by the deceased.

    (d) Particulars required to register death:

        1. The deceased was a male.

        2. The deceased's name was Nicholas Konedaris.

        3. The deceased was Caucasian Australian.

        4. The death was reported to the Coroner

        5. The cause of death was confirmed by post-mortem examination and was multiple injuries sustained in a motor vehicle accident.

6. The pathologist was Dr Paull Botterill.

7. The deceased’s mother is Pauline Konedaris and his father is George Konedaris.

8. The deceased lived at Lot 293, Stuart Highway, Tennant Creek.

9. The deceased was a painter who worked for GK Painting Contractors.

10. The deceased was born on 4 December 1979.

CIRCUMSTANCES OF THE DEATH AND INITIAL INVESTIGATION

11. The deceased had travelled down to Alice Springs from Tennant Creek on the morning of 26 August 2006 to meet his fiancé’s flight arriving at Alice Springs from Brisbane at 10:10 am. The two did some shopping and then had lunch. They filled up with fuel, visited Jolene’s brother, and then set off for Tennant Creek. The deceased was driving a blue 1999 Ford Falcon XR6 Sedan NT GK0001 that was registered to his employer. It was a large passenger sedan fitted with a 6-cylinder 4.0 litre fuel injected petrol engine with a four speed automatic transmission delivered in a rear wheel drive configuration. He had a current Northern Territory driver’s licence. As he approached the Colyer Creek Bridge he was driving at about 90- 100 km/hr.

12. Ti Tree Police station had two officers at that time; Senior Constable Justin Harbour was in charge and Constable Ivan Petrovic was the second member. On 26 August 2006 Senior Constable Harbour and his wife Suzanne were travelling from Ti Tree to Alice Springs on a personal trip. Suzanne was driving their blue 2005 Nissan Murano Station Wagon NTJUSUZ. It was an all wheel drive sports sedan fitted with a 6-cylinder 3.5 Litre fuel injected petrol engine with a continuously variable automatic transmission with sports shift manual mode delivered in an all wheel drive configuration. It

was towing an empty brown 1975 dual axle box trailer NT TB 0610. Suzanne had a current Northern Territory drivers' licence. As she approached the Colyer Creek Bridge she was travelling at about 110 km/hr, the posted speed limit.

13. The Colyer Creek Bridge is on the Stuart Highway about 10 km north of Alice Springs. It has two through lanes, one in each direction, separated by a centre line to separate opposing traffic flows. The eastern edge at the approach to the Colyer Creek Bridge from the north has a 100 mm vertical step within about 200 mm of the edge line.

14. As she approached the bridge, Suzanne's car veered to the left. She corrected by steering to the right. The trailer was 'fish tailing' behind her car. She continued to attempt to control the car but was not able to do so and her car went into a yaw (that is it began to spin) and crossed onto the wrong side of the road and collided head on with the front right hand side of the deceased's vehicle. The trailer hitch snapped and the trailer broke away. Suzanne's car continued to spin in a clockwise direction for a further 180 degrees and then came to rest head first into the eastern guard rail. The deceased's car continued north for a few metres and then came to rest.

15. The deceased and his fiancé were alive but trapped in the car after the accident. However the deceased was very severely injured and despite the attentions of St John Ambulance officers he passed away at about 2 pm while still trapped inside his vehicle. His death was due to the multiple injuries he had sustained in the collision. He was removed from the vehicle after he had passed away.

16. I have considered closely the cause of this accident. At the time of impact Nicholas's vehicle was in its correct lane, and the crash occurred because Suzanne Harbour's vehicle travelled into that lane. It is clear that there was no fault whatsoever on the part of Nicholas. The two cars were

subsequently examined and found to have been roadworthy at the time of the accident.

17. The trailer was examined and was found not to have been roadworthy at the time of the accident. This is of particular concern as the trailer was registered as being roadworthy four days before the accident by Constable Ivan Petrovic, Mr Harbour's subordinate. I heard detailed evidence in relation to the trailer from Mr Brian Wingrove, a Transport Inspector with the Motor Vehicle Registry in Alice Springs who examined the trailer after the accident. I find that the trailer had a number of serious defects, as described by Mr Wingrove. I also heard from Mr Grant Johnston, a consultant engineer who was engaged by my office to provide an expert opinion on the cause of the accident and, as part of his review, examined the trailer. I found his evidence extremely helpful. Mr Johnston gave evidence that those defects in the trailer did not initiate the accident, that is they did not cause the Nissan Murano to go left which led to the subsequent loss of control. I will discuss the issues surrounding the registration of an unsafe trailer later on in this judgment.

18. I have formed an opinion on the totality of the evidence before me, and in particular the evidence from Mr Johnston, that the accident was initiated when Suzanne Harbour's car drifted left onto the dirt verge. This is supported by the evidence of eyewitnesses who saw a puff of orange dirt and one eyewitness saw the wheels of the trailer leave the road and go onto the dirt verge. Mr Grant Johnston, the expert witness, informed me that given the comparative widths of the trailer and the car, this would mean that the cars wheels had also left the edge of the road. Although neither Senior Constable Harbour nor Suzanne Harbour gave evidence that the car had left the road, the descriptions given by Senior Constable Harbour and Suzanne Harbour in court show that the car was far over on the left hand side of the road. In addition I heard evidence from Constable Boja that directly after the accident Senior Constable Harbour told him that 'basically [Suzanne's]

realised that she's actually drifted onto the dirt verge on the left hand side heading into town and overcorrected, immediately she's pulled the steering wheel hard to the right and overcorrected'. Senior Constable Harbour did not recall saying this and I accept that his lack of recall was honest and not surprising given that he had just been in a high speed collision. However I find that he did say this immediately after the accident and that it was an accurate description of what occurred.

19. I have carefully considered the cause of this leftward drift. Senior Constable Salvia looked into whether a cross wind could have caused this drift and found that there was not sufficient wind speed at that time. There were no faults in the car which would have caused the drift and I have found that the faults in the trailer did not cause it. Suzanne Harbour says she did not fall asleep, or cough, or feel unwell and her evidence is that she does not know what caused the car to move to the left. I accept the evidence that Suzanne Harbour was an experienced driver who normally drove very safely and cautiously but even so I find that the likely cause of the drift is momentary inattention on the part of Suzanne Harbour. I note that the car was on cruise control set at 110 km/h. Mr Johnston told me that to keep a car in the correct position in the lane constant minor corrections are required. He said that cruise control removes the need to make corrections as to speed, but the need to make corrections as to the direction of the car remains, and sometimes it can be difficult to remember to do this if there is no need to do it in relation to speed. It is possible that this contributed to the momentary loss of attention.

20. I find that the drift to the left caused the two left tyres of the Nissan Murano and the two left tyres of the trailer to drop off the road onto the dirt verge. The road at that point has a vertical step of 100 mm. It is likely that the tyres 'tram tracked', that is they got caught up against the step. In response to this Suzanne overcorrected by turning her steering wheel hard to the

right. This initiated a loss of control of both the Nissan Murano and the trailer, which resulted in the car colliding with Nicholas's vehicle.

21. It was particularly unfortunate and unlucky that this occurred near the Colyer Creek Bridge, had it occurred on an unbounded stretch of road the situation would have seemed much less urgent to Suzanne Harbour and she may not have overcorrected, initiating the loss of control. Mr Konedaris would have had a chance to steer off the road to avoid the oncoming vehicle. However as it was he was on the bridge and unable to avoid the oncoming car.

22. I have carefully considered whether the defects of the trailer contributed to the accident once the Nissan Murano had drifted to the left. I heard evidence that the presence of a trailer would make a car harder to control than had a trailer not been present and that the lack of functioning brakes on this particular trailer would have made the car harder to control than had the brakes been present. However Mr Johnston could not say that had the brakes been present the accident would not have happened. He said that functioning brakes may have prevented the accident but they may not have. He said that it was unlikely that the other defects contributed to the accident.

23. On all of the evidence in my view the trailer defects did not contribute to the accident.

THE INVESTIGATION OF THE ACCIDENT

24. I have some concerns about the overall conduct of the investigation. I expect all investigations where someone has lost their life to be of a high standard, and I would expect particular care when a local police officer and his wife are, in effect, being investigated. On the day the accident happened Senior Constable Anthony Barry was in charge of the investigation. Senior Sergeant Michael Potts was the watch commander for a later period of that

day and attended the scene. Sergeant Ruehland from the Darwin Accident Investigation Unit tasked members from Darwin to fly down the day after the accident to take charge of the investigation to try to minimise the appearance of bias that could occur if local police investigate their own members. The evidence is that it was anticipated that two police would be sent but for reasons unclear only Senior Constable Steve Salvia was sent.

25. I find that the evidence collection on the first day was not as good as it could have been. The marks on the road weren't photographed in the best way to capture information for future purposes (for instance no photographs were taken close up of the tyre marks and there were not enough photographs taken of the marks) and a mark that may have been crucial as it may have indicated where the Nissan went off the road, was not recorded at all although Senior Constable Barry saw it and pointed it out to Senior Sergeant Potts. There was some uncertainty as to whether it was from the accident, or made subsequently due to the cars being banked up. Mr Johnston said that if there was such uncertainty it was even more important to record the marks so that someone could subsequently make the decision as to whether they were relevant or not. The police were under particular difficulties because at about 4 pm on the same day, while police were still collecting evidence in relation to this accident, a runaway truck driven by Daniel Koop passed through the scene, striking a vehicle which contained two women and causing it to move off the embankment and land on its roof, and then striking the two vehicles involved in the accident. Some of the investigating police had to run out of the way to avoid being hit by the truck. Mr Koop subsequently pleaded guilty to having committed a dangerous act causing serious actual danger to people's health. I accept that in the context of the difficulties caused by this second incident, the investigating police did what they could on the day.

26. The subsequent investigation by Senior Constable Salvia was not of a high standard. Suzanne Harbour was interviewed but neither Justin Harbour,

clearly a vital witness, or Jolene Wright were interviewed. The investigation seemed to proceed by way of written requests for statements to be provided. When statements were received there is no evidence that the investigating officer turned his mind to what they said and whether further clarification or further evidence was required. He did not do any follow up questioning in relation to any statements. This was seen most starkly in relation to Constable Boja's statement that Senior Constable Harbour had 'briefly given me a rundown of the circumstances of the accident as to what happened' and the failure to go back and find out what Constable Boja remembered Senior Constable Harbour saying.

27. Insufficient consideration was given to the question of the trailer as a possible cause of the accident. It was clear from looking at it that it was very old and in poor condition and the Motor Vehicle Registry Inspection conducted soon after the accident revealed significant defects. There was no testing done on the trailer until the expert secured by the Coroner's Office did so for the purposes of his expert report.

28. There was no attempt to look at the file from a coronial point of view. The investigation of the circumstances surrounding the registration of the clearly unroadworthy trailer received only cursory attention and the original file provided to the Coroner did not have copies of all the relevant registration documentation, let alone a proper investigation in relation to what had occurred. Senior Constable Harbour was not asked about past use of the trailer or the temporary registration. After the flaws in the trailer were revealed Senior Constable Petrovic was not interviewed about his registration process. There was no investigation at all into the training either member had received in relation to the registration of motor vehicles. There was no investigation into the history of the registration of the trailer.

29. This is particularly concerning because Sergeant Ruehland, the head of the Accident Investigation Unit (AIU), sent an e-mail to various members including Senior Constable Salvia on September 14 2006 which stated

> "The Coroner will ask the following question: how did the trailer obtain registration when it was found to have numerous major and obvious defects deeming it to be unsafe four days after being registered. This question is likely to lead to further questions such as training received by remote station police in registration procedures, what training courses are available and who conducts them etcetera. The purpose of this correspondence is to advise the department of this situation."

However despite this the AIU investigation did not attempt to answer any of these questions.

30. Furthermore, the investigation seems to have been marred by a lack of a clear understanding about the division of responsibility between the Darwin and Alice Springs investigative members. In a case involving a current police member it is vital that not only the investigation is unbiased but that it is seen to be so. I have particular concerns about the role of Senior Sergeant Potts who, as an Alice Springs member, should have had very limited involvement after the first day after the directive was made to send a Darwin member down. However he subsequently asked for, and was given, the drawings made from the scene and he did his own calculations from them. He was not, however, privy to the subsequent investigation. He was called at the criminal proceedings, qualified in detail as an expert in road accidents by the defence lawyer, and then asked questions by the defence about the vehicle dynamics in the accident and he gave evidence about this issue without qualifying it in any way in relation to his limited involvement or knowledge of the evidence. The result was a failure to remove a perception of bias, which was the purpose of taking the bulk of the investigation away from Alice Springs members and, not surprisingly, the family of the deceased were left with a strong impression of police bias. I have closely looked at the evidence Senior Sergeant Potts gave in court and

do not consider that it was untruthful but I find that it was unwise for him to continue to be involved with the matter beyond the first day of the accident.

31. The multiple deficiencies in this investigation are of particular concern because this is one more in a series of poorly investigated files in relation to deaths in motor vehicle accidents conducted by the Accident Investigation Unit, now called Northern Traffic Operations and Southern Traffic Operations.

32. In the Inquest into the death of Clifford Brown [2006] NTMC 059, I commented on the investigation of the motor vehicle accident as follows:

> "I pause to note this is not the first matter which I have had cause to comment adversely on the standard of investigations by police into fatal motor vehicle accidents over the past few years. My comments have included failure by police to properly consider criminality with respect to deaths in motor vehicle accidents, as well as a failure to advert to surrounding coronial issues such as medical treatment at the scene….I am informed through the affidavit of Superintendent Michael White (exhibit 5) that serious consideration has been given to the review of this particular investigation and coronial investigations into motor vehicle deaths generally. Superintendent White properly concedes that the first investigation was not adequate, and informs me of the following:
>
> (1) Where it is apparent that a serious criminal offence may have been committed, detectives are involved [in the investigation] due to their expertise in obtaining evidence in relation to criminal charges.
>
> (2) Continuing efforts have been occurring in the southern division to increase the investigative capabilities of members.
>
> (3) Given the developments of education which have occurred within Northern Territory Police since December 2004, including in Southern Division, he is confident that investigations of future fatal motor vehicle accidents will be of an appropriate standard.
>
> Given what has been put to me about the changes to General Orders and the other action that has taken place with respect to improving the investigation of fatal motor vehicle accidents, I do not propose to

> make any formal recommendations in this regard. However, I do expect to see an improvement in future in the quality and scope of such investigations.

33. In the Inquest into the death of Louisa May Turner [2007] NTMC 007, I found, in relation to the investigation which was conducted by the Accident Investigation Unit:

> "In my view the overall coronial investigation was not of a good standard. Deficiencies included the quality of the record of interview, the presence of another witness (Mr Eibofner's wife) in the interview prior to that witness providing a statement, and the failure to obtain adequate (or any) statements from other potential eyewitnesses prior to making a decision as to charges."

34. Senior Constable Salvia gave evidence that he was transferred to the Accident Investigation Unit in mid 2004. He did a two week basic crash investigation course by correspondence in his own time and in March 2006 he did a two week advanced crash investigation course at Berrimah College. He also has done a two week operation investigator's course in 2005. He has not done a Detectives Training Course. He gave evidence that he had investigated no more than 10 fatalities. I was concerned by Senior Constable Salvia's evidence that apart from one member who went to Canberra to do a heavy vehicle and pedestrian course, there is nobody in the Accident Investigation Unit in Darwin with a higher level of training.

35. I found Senior Constable Salvia to be an honest witness who did as well as he could given his experience and training. I consider that the problem is a systemic one; there appears to be a developing pattern of poor investigation in relation to deaths in motor vehicle accidents. I am aware through my office that the standard of files coming in from Northern Traffic Operations remains poor. This affects the Coronial process and also, presumably, criminal prosecutions. The solution that has been put forward in the past is the participation of a major crime member in all investigations into motor vehicle accidents involving a death. I did not hear detailed evidence about

why this was not working, but it clearly is not, and the promised increased standard of investigation into these deaths has not eventuated.

THE REGISTRATION OF THE TRAILER

36. I have found that the defects of the trailer did not cause nor contribute to the accident. However my power to 'comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated' allows me to examine and comment on the situation where a trailer that was clearly unsafe was allowed on the road.

37. Mr Brian Wingrove is a transport inspector for the Motor Vehicle Registry for the Northern Territory Government. He had considerable experience and expertise. I found his evidence impressive and completely accept it. He examined the trailer TVO-610 on 28 August 2006 and found that it was unroadworthy because of a list of five defects that would have been present prior to the accident. Each defect by itself would have been sufficient to render the trailer unroadworthy.

38. The defects were as follows. The brakes weren't operational; parts of the brake line were missing and there was no fluid in the brake reservoir. There was advanced rust, including rust holes in the metalwork in the draw bar next to the tow coupling. There was an incorrect right spring rocker, which is an important part of the load bearing suspension. There was a broken right rear spring main leaf; the spring is part of the suspension and holds the axles parallel and it is an important part of the structural integrity of the vehicle. A broken spring is a serious problem that can result in instability in towing the trailer. There was a cracked mudguard and there were no mudflaps.

39. Mr Wingrove said that although each of the five defects would have been enough to render the trailer unroadworthy, only the first three as listed above made the trailer unsafe.

40. The trailer was manufactured in 1975. It was listed as having an ATM (Aggregate Trailer Mass, the combined weight of the trailer and maximum load) of 2000 kg and a tare weight (the empty weight of the trailer) as 460 kg. Its' registration had expired on 11 January 2002. It was unregistered until Senior Constable Harbour obtained a seven day temporary permit for it on 14 August 2006.

41. Senior Constable Harbour had purchased the trailer in early 2004. He had driven the trailer around while it was unregistered. The evidence before me was that he had mostly driven it from his property in Alice Springs or Hermannsburg to the local tip, but that he had also driven the road between Hermannsburg and Alice Springs three times and the road from Hermannsburg to Ti Tree three times, that is had driven it a substantial distance while unregistered. In court he said he should have had it registered and it was unacceptable not to have done so.

42. In order to temporarily register the trailer Senior Constable Harbour had to sign an application saying that he believed the trailer was roadworthy and presented no danger to the public. Senior Constable Harbour was aware that the brakes were not working and told Constable Petrovic. Together they looked at the 'Outstation Manual' and decided that this particular trailer fell into the category of trailer that did not require brakes. This was incorrect. A trailer with an ATM over 750 requires brakes; this trailer had an ATM of 2000. However the Tare Weight of the trailer was 450 and the error appears to have stemmed from confusing the Tare Weight with the ATM.

43. A more experienced person would have not confused the ATM and Tare Weight and would have known that a trailer that had a brake system attached and that had two axles was likely legally to require brakes. In addition a more experienced person would not have confused surface rust with advanced rust, as it actually was, and would have looked under the trailer and picked up the broken spring.

44. A Motor Vehicle Inspector would have been expected to pick up all five defects. Neither police officer picked up any of them. Senior Constable Harbour gave evidence that at the time he didn't know rust holes meant advanced rust. Senior Constable Harbour gave evidence that he had examined over 100 vehicles for roadworthy status. He had received no formal training whatsoever in relation to roadworthiness. He said that when he took up a relief position at Hermannsburg police station in 2002 the police there talked him through it. The instruction would have lasted five minutes. Constable Petrovic's evidence was very similar; he had received no formal training and his only training was five minutes from his Sergeant when he was first placed at a bush station. Neither officer came to the police force with any formal mechanical training or any particular automotive skills or knowledge. It is therefore not surprising that they were unable to pick up defects in a vehicle. I also have a statement from Sergeant Johnsson which indicates that he also had no formal training and demonstrates he also misunderstood how to determine whether brakes are required. Bert Hofer, the Commander of the Southern and Regional Command for the Northern Territory Police, gave evidence that there is a one week small station management course, the last one was in Darwin in 2006. The component to do with motor vehicle registration covers the administrative side. There is no formal training in basic automotive knowledge and how to conduct a roadworthy. He gave evidence that police in remote localities are operating at a commonsense level. Police also have power to defect vehicles on the roadway. The evidence before me seems to indicate that the lack of mechanical knowledge resulting in the registration of unroadworthy vehicles is likely to be a widespread issue.

45. As well as the mechanical errors, there were administrative deficiencies with the registration process. The temporary permit form gave it as being for 8 days not seven. No proof of ownership was provided, as required, which meant that when MVR eventually received the registration they cancelled it.

The confusion of ATM and Tare Weight demonstrates a lack of the general knowledge sufficient to use the Outstations Manual meaningfully.

46. I found that Senior Constable Harbour and Constable Petrovic were honest witnesses and that their registration of the unroadworthy trailer was a result of ignorance. I find that they conducted the registration process in the ordinary way it is currently done out bush; that is it was done in a perfunctory way with no examination underneath the trailer and without having undergone any proper training about what they were looking for. This registration exemplifies the risk of having roadworthy inspections done by people who are essentially completely untrained and unqualified to do them. It is not surprising that the result of this system is the presence of unsafe vehicles on Territory roads.

BUSH POLICE DOING MOTOR VEHICLE REGISTRATIONS

47. The Commissioner has submitted to me that the police are not empowered legislatively to do inspections for motor vehicle registration purposes. Mr Richard Hancock, the CEO of the Department of Planning and Infrastructure (DPI) has provided me with a statement saying that police do have power. I cannot resolve this issue as part of this coronial process. In my view, this issue needs to be addressed urgently by Mr Hancock and the Commissioner of Police.

48. The Commissioner also submitted to me that NT Police Officers are not trained to perform motor vehicle registry functions and that their continued engagement in these responsibilities poses significant risk. The Commissioner has informed me that NT Police are working towards establishing a Memorandum of Understanding with DPI to clearly establish that continued performance of limited MVR functions by members in remote locations is not seen as a permanent arrangement and to establish a framework to transfer the function over time to DPI personnel or outsourced private providers.

49. Mr Hancock submitted that road safety is a joint responsibility and core business of both the Department of Planning and Infrastructure and police, that police have historically provided inspection, registration and licensing services and that 'the provision of MVR services by NT Police Outstations offers the most benefits to remote Territorians whilst placing the least cost on the general community. The reality is that making a qualified MVR Transport Inspector available at each remote community is administratively and financially unviable given the relatively small number of remote transactions actioned annually'.

50. I accept that the vast geographic areas and sparse population distribution in the Northern Territory presents particular challenges for motor vehicle registration. I find that the current situation may be dangerous and poses real risk. This inquest has demonstrated significant deficiencies in the training provided to NT Police in relation to roadworthy inspections and administrative registration processes, and this needs to be rectified. It is more appropriate for the details of how this is done to be addressed by the Commissioner and the CEO of the Department of Planning and Infrastructure.

RECOMMENDATIONS

51. (1) There needs to be a greatly increased standard of crash investigations by police in the Northern Territory which includes increased training in the mechanical side of crash investigation but also, and even more importantly, a significant increase in general investigation skills. I recommend that the Police Commissioner provide increased training and resourcing to AIU members in both these areas.

52. (2) I recommend that the Police Commissioner puts in place improved mechanisms to ensure that there is no perception of bias when an investigation involves the conduct of a police officer or their immediate family.

53. (3) I recommend that both the Commissioner of Police and the CEO of the Department of Planning and Infrastructure review the situation where bush police are conducting roadworthy inspections with no formal mechanical training whatsoever and extremely limited training administratively. The review needs to include a resolution of the issue of the legality of police conducting registration inspections at all. If police are to continue doing such inspections there needs to be proper training provided.

Dated this 13th day of June 2008.

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GREG CAVANAGH
TERRITORY CORONER