CITATION: *Inquest into the deaths of Barbara Malthouse, Nigel Inkamala, Daryl Inkamala, Dion Ngalken, Gordon Murray and Antonia Meneri* [2009] NTMC 066

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0074/2007 A0075/2007 A0076/2007 A0077/2007 A0078/2007 A0079/2007
DELIVERED ON:	17 December 2009
DELIVERED AT:	Alice Springs
HEARING DATE(s):	3-4 November 2009
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Motor vehicle accident, police pursuit, pursuit policy and training, adequacy and timeliness of police investigation

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
Police Commissioner	Mr John Stirk

Judgment category classification:	A
Judgement ID number:	[2009] NTMC 066
Number of paragraphs:	39
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0074/2007
A0075/2007
A0076/2007
A0077/2007
A0078/2007
A0079/2007

In the matter of an Inquest into the deaths of

BARBARA MALTHOUSE,
NIGEL INKAMALA,
DARYL INKAMALA (aka DARYL NGALKIN),
DION JAMES NGALKEN (aka DION NGALKIN & DION INKAMALA),
GORDON NAPTHALI MURRAY AND
ANTONIA MENERI
ON 7 DECEMBER 2007
AT LARAPINTA DRIVE
APPROXIMATELY 50KM WEST OF
ALICE SPRINGS

FINDINGS

17 December 2009

Mr Greg Cavanagh SM:

INTRODUCTION and OUTLINE OF EVENTS

1. On the evening of Friday 7 December 2007 members of NT police were conducting a random breath testing station at the corner of Larapinta Drive and Namatjira Drive. They were stopping every vehicle which passed them for the purpose of checking licences and registrations, breath testing the drivers, and searching the vehicles for alcohol being illegally carried into the desert communities west of Alice Springs which are designated dry communities. During that day the six deceased had come into Alice Springs

from Hermannsburg to celebrate the birthday of Daryl Inkamala (one of the deceased). They spent the afternoon drinking alcohol with friends and family at town camps. In the evening, when all were intoxicated, they decided to travel back to Hermannsburg, with Edgar Inkamala driving the car.

2. Edgar Inkamala was the least intoxicated of the group. He was, however, an unlicensed and inexperienced driver. Seven people were travelling in a white Ford Falcon sedan intended to carry a total of five passengers including the driver. Only Edgar Inkamala was wearing a seatbelt. Before leaving Alice Springs the group purchased a further carton of beer and were carrying this in the car on the way back to Hermannsburg. Hermannsburg has been a dry community at the voluntary election of community members since well before the "Commonwealth intervention" (when a number of additional communities had alcohol restrictions imposed), and the group well knew that bringing grog into Hermannsburg was illegal. The previous evening police had conducted a larger scale traffic operation at the same location and apprehended three drunk drivers and seized 161 litres of alcohol.

3. Edgar Inkamala drove along Larapinta Drive. At about 10:15pm he saw the police car parked on the right hand side of the road just before the intersection with Namatjira Drive with its emergency lights activated as a signal for him to stop. Constable Luke Dalgliesh was in the driver's seat and (then) Probationary Constable Hayden Pearce was the passenger. The police were seated in the vehicle rather than standing on the roadway due to an incident the previous evening when a car had driven directly at Constable Pearce as he stood signalling it to stop.

4. Edgar Inkamala did not stop but accelerated away from the area and continued west along Larapinta drive, now travelling at an excessive speed. In an interview with police conducted on 17 December 2007 he said that he did not stop because he was "drunk and frightened". When he reached the

Hugh River causeway area, he failed to negotiate an approaching right hand bend and skidded off the southern side of the road into the dry river bed. The car rolled three times and all six passengers were ejected from the car. They all suffered multiple significant head, neck and chest injuries which caused their deaths almost immediately or within a short period of time thereafter. Edgar Inkamala remained restrained in the vehicle by his seatbelt, conscious, and was assisted out by Constable Pearce and later treated at Alice Springs hospital.

5. Meanwhile, after the car passed without stopping as directed, Constable Dalgliesh did a u-turn. By the time he had completed the turn, the white sedan was out of sight over a rise. The police car (a 4WD vehicle with a cage) followed in a westerly direction, reaching an estimated top speed of 120km/hr. After about 2.5km, they saw a large cloud of dust. They stopped, got out of their vehicle and saw the white sedan on its roof on the side of the road. The officers approached the area and ascertained that there were a number of very seriously injured people. They immediately sought to radio for medical and police assistance but were unable to do so, due to being in a UHF radio "blackspot". Constable Dalgleish (as the senior officer and driver) decided it was safer at that stage for both officers to remain together. They drove back to the area where they had been earlier parked and radioed Alice Springs communications for assistance, then immediately returned to the incident scene.

6. It took some time for assistance to arrive. During this period the two police constables assessed each of the people at the scene and found them all (with the exception of Edgar Inkamala) to be unconscious; either already deceased or with obvious breathing difficulties. Ambulance members assessed all six as deceased by midnight. Edgar Inkamala, who admitted to being the driver, was provided with medical assistance and a blood test was taken for forensic analysis. He had a BAC of 0.086%.

7. Superintendent Lance Godwin took overall charge of the investigation, which was fairly shortly afterward classified as a "death in custody" investigation, due to the police pursuit aspect of the fatal motor vehicle accident. That meant that the investigation was to be carried out in accordance with Police General Order D2. Senior Sergeant Potts attended the scene to carry out the collision/crash analysis. Detective Sergeant Leith Phillips was tasked as the officer in charge of the criminal investigation, and the following morning, Sergeant Conan Robertson was allocated the "coronial investigation".

8. Edgar Inkamala pleaded guilty in the NT Supreme Court to the offence of dangerous driving causing the deaths, and was sentenced to six years imprisonment with a three year non parole period.

9. Unfortunately, a completed and satisfactory coronial file was not submitted to my office until 18 months after the deaths. I address this issue below.

10. Constables Dalgleish and Pearce remained at the scene until they were directed by their Sergeant (Keith Bridgeman) to return to Hermannsburg to collect personal effects and then go straight to Alice Springs. This was to avoid reprisals from the Hermannsburg community: indeed there had already been angry intoxicated persons attending the accident scene accusing police of being at fault in the deaths. The two Constables drove from Hermannsburg together in Constable Dalgleish's private car and reported to Superintendent Godwin at about 5am at Alice Springs police station. He explained to them what the process of the investigation would be, and advised them they would be contacted to be interviewed later in the day. Having assumed (incorrectly) that they would retire to separate residences, he did not advise them that they should separate and that they were not to discuss the matter with one another. Both young men were exhausted and shocked by their experience, and Probationary Constable Pearce was at that time living alone in Alice Springs. He therefore returned with Constable

Dalgliesh to his family home where they had a couple of hours sleep. They were interviewed that evening (8th) and participated in videotaped re-enactments at the scene on Sunday 9th December 2007.

11. Superintendent Godwin has previously been stationed at Hermannsburg and knows members of the community well. He and Superintendent White travelled to Hermannsburg on Monday 10th December 2007 to express condolences and answer questions from families about the incident and the investigation process.

JURISDICTION TO HOLD AN INQUEST

12. My jurisdiction to investigate these deaths and to hold a public inquest arises from sections 12, 14 and 15 of the *Coroners Act* ("Act"). The deaths of these six people have been referred to many times as "deaths in custody". This is pursuant to the extended definition of "custody" which includes the death of a person who is escaping from police attempts to apprehend him or her. However, in this particular case the evidence establishes that the only person whom police sought to apprehend was Edgar Inkamala, the surviving driver of the vehicle which had failed to stop as directed. The deaths are therefore *not* deaths in custody for formal or statistical purposes. However, it was appropriate that the police investigation carried out on my behalf be conducted as if it were a death in custody investigation. Whether a particular death falls within the statutory definition in the *Act* may be a matter that is not finally decided until the hearing of evidence at an inquest. As a matter of principle, all deaths where there is police involvement with the deaths should be investigated rigorously and thoroughly for the same reasons as deaths in custody are so investigated (or should be). So much is reflected in NT Police General Order D2 entitled Deaths in Custody and Investigation of Serious and/or Fatal Incidents resulting from Police contact with the Public. In this case, the deaths were investigated and the inquest was conducted in the same way as it would have been had the formal definition been satisfied.

13. Counsel assisting me at the inquest was Ms Helen Roberts, I thank her for her excellent work. Mr John Stirk instructed by Ms Gabrielle Martin of the NT Department of Justice, appeared on behalf of the Commissioner of Police and the police witnesses. A large number of relatives of the deceased attended the inquest over the two days and asked questions of the witnesses through Counsel Assisting. They were encouraged to attend by the efforts of Sergeant Robertson, and Ms Roberts visiting them in the days prior to the inquest to ensure they had received the written communication from my Office advising them of the inquest dates, and were aware of their right to attend and participate. The questions they wished to ask were for the most part relevant, and otherwise very understandable matters of concern to them. As is the usual practice, my Office sent a letter advising the Central Australian Aboriginal Legal Aid Service of the upcoming inquest, but there was no appearance by any CAALAS solicitor on behalf of the family. Fortunately, this particular family included a number of members who are literate in English as well as Aboriginal languages and were well able to understand and participate in the inquest process with the assistance of my counsel assisting.

14. Pursuant to section 34 of the *Coroners 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*;

15. 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.

16. 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.

FINDINGS

17. In order to make the findings required under the *Act* I had before me a brief of evidence prepared by Sergeant Conan Robertson which contained several folders of statements and documents (Exhibit 3) as well as additional statements and documents tendered throughout the inquest. I heard oral evidence from the following witnesses: Sergeant Conan Robertson, Constable Luke Dalgliesh, Constable Hayden Pearce, Superintendent Lance Godwin, Detective Sergeant Leith Phillips, Dr Terry Sinton, and Superintendent Robert Rennie.

18. I have set out the formal findings relating to each of the six deceased people individually at the conclusion of these remarks. The discussion above and below of the circumstances surrounding the deaths, my comments and recommendations apply to all of the six.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATHS

The Police Pursuit

19. I find that the six deceased died immediately or shortly after being thrown from the motor vehicle and sustaining multiple, severe fatal injuries. The six persons were travelling unrestrained in a motor vehicle intended to carry four passengers. The cause of the motor vehicle roll over was the manner of driving of the driver: contributed to by inadequate lighting (his headlights on low beam), excessive speed for the darkness and his lack of driving expertise, his intoxication, and his unfamiliarity with that vehicle and with driving at all.

20. At the time of the motor vehicle roll over, the vehicle was being pursued by police within the meaning of the NT Police Urgent Duty Driving ("UDD") and Pursuit Policy. The driver of the white sedan, Edgar Inkamala, made a decision to accelerate past a police vehicle which was signalling him to stop. The police vehicle driven by Constable Luke Dalgliesh had executed a u-turn and followed the sedan, with its lights on and reaching a speed above the posted speed limit. There was no physical proximity between the two vehicles – in fact neither could see the other – and I find that at the time of the roll over the police vehicle was at least 400 metres behind the white sedan.

21. The two police members did not carry out the risk assessment required by the UDD and Pursuit Policy. This was due to the fact that the driver in particular did not appreciate that he was engaging in a pursuit. He expressed the view when interviewed on 8 and 9 December 2007 that there is some material distinction between "following" and "pursuing" a vehicle based either on speed or physical proximity between the vehicles. That this misapprehension exists among junior officers is not surprising given that a similar distinction was drawn by Superintendent Rennie, who held the

position of Superintendent, Road Safety Division, for five years (Exhibit 8, paragraph 13).

22. As much as many police may wish it so, there is no such distinction in the policy as it stands. This was properly acknowledged by the police witnesses, and by Mr Stirk on behalf of the Commissioner. Constable Dalgliesh readily volunteered in evidence the fact that he knew that his original position was wrong, and with further consideration of the policy in the months after the interview, he understood that he had engaged in a pursuit.

23. Despite this error, I find that on the night Constable Dalgleish did assess the risk-taking into account road conditions and the like-in terms of his past experience and 'on the job' training and made a bona fide, not reckless, decision to pursue the vehicle. The driver, Edgar Inkamala, had assumed that he was being followed by police due to having grog on board (and I make this inference due to his past experience whether as a passenger or driver). The police decision to pursue therefore had very little impact upon his manner of driving. His acceleration to an excessive speed commenced at the point at which he first saw the police vehicle signalling him to stop.

Absence of Adequate Radio Communication

24. I heard evidence that were UHF radio 'blackspots' in the area where the incident took place. These can be remedied to some extent by the use of HF radio and/or satellite phones but neither is a perfect solution, and it is a reality of remote area policing which has to be acknowledged. The absence of adequate radio communication in an area should be a matter taken into account in a risk assessment. Superintendent Godwin referred to this (transcript p 68):

> "So there are inherent risks [of pursuits] and you know experience teaches you certain things but you know basically under the policy it provides for many different layers and one of the things I see quite often now is if that radio communication …once the pursuit is

initiated, if its not of good quality the pursuit will be terminated very quickly."

25. In this particular case, the police officers came upon the crash scene very quickly and located a number of dead or dying people. The difficulty with radio communication in the area meant that they had to leave those people in order to call for help. Once they returned, they carried out first aid as best they could while awaiting the arrival of assistance. Dr Sinton (the forensic pathologist) gave evidence that the efforts they made were entirely appropriate. The severity and nature of injuries suffered by all six people were such that, as explained by Dr Sinton, "they would have died shortly after, some minutes after receiving those injuries just by the nature of the injuries". His evidence was that the delay in obtaining help would have made "no difference" to their ability to survive their injuries (transcript p.89). Further, all were exceedingly likely to have been unconscious from the moment of impact. This evidence was I hope some comfort to the family who had harboured concerns that delayed medical treatment had compounded their relatives' suffering.

26. However, it is not at all difficult to imagine a different scenario in which the radio 'blackspot' at the crash site may have made a difference to the outcome. Of course the absence of radio communication removes the safety aspect of having a supervisor or senior officer in the communications room able to assess and call off the pursuit, but there are other matters of safety to consider. As but one example, a police officer himself could have been injured and unable to easily drive to another location to call for assistance. The presence or absence of effective radio communication should always be a factor in the forefront of the risk assessment carried out in relation to pursuits in remote areas.

Pursuit Policy and Pursuit Training

27. When asked to consider the whole pursuit with the benefit of hindsight, Constable Dalgliesh said (transcript p.38):

> "I'm - personally I'm very hesitant to engage in any form of pursuit however policing by its nature and doing highway work, which is what I do at Ali Curung … doing this all the time, pulling cars over etcetera so I'd do the risk assessment a bit more critically I think and make that a more automatic part of pulling a car over. If the car did take off I'm not sure that I would you know pursue it just, just because the risks as we found far outweigh the benefits of catching the person …"

28. This seemed to me to be a completely understandable perspective given the significant personal impact this distressing incident has had upon this officer. However, from the point of view of the public and the police force in general, it is important that the pursuit policy and training adequately equips officers to make these decisions without having first to have experienced the deaths of members of the public in such a way. I have made comments and recommendations in this regard in the past. In my *Inquest into the Death of Damien Wayne [2005] NTMC 072*, having heard evidence about the benefits of practical (rather than simply classroom based) pursuit driver training I made the following recommendation:

> "I recommend that practical mock pursuit training be reinstated in the police recruit driver training module, or alternatively, that it be taught as an advanced driver training module which is regularly available to members who are likely to engage in driving duties as part of their general or specialist duties."

29. Since that recommendation made on 11 November 2005, <u>one</u> such practical course has been conducted. The Advanced Driving Level 2 course was attended by eight NT police members in October 2009. Constable Hayden Pearce, having joined the Traffic Unit, had the benefit of participating in that course. With respect to pursuit driving, it involved three or four scenarios, the opportunity for each member to be both the driver and the

radio operator, and a detailed de-briefing with instructors after each scenario. Constable Pearce gave evidence that he found the learning experience very valuable because (transcript p.48):

> "I think you would have a better understanding of [the risk assessment] and you'd have a lot greater, I guess having a better understanding of pursuit policy and how you implemented it in that training would make you make different choices, you know, in a real scenario."

30. The Police Commissioner through his witnesses and counsel at this inquest was unable to give me any definitive answer as to when or whether any further similar practical pursuit training courses were to be offered to NT police members. I am aware that such courses are resource intensive. However, having heard evidence from both involved drivers, and from driving instructors at a number of inquests involving deaths in police pursuits, I remain convinced of the necessity for and benefit of such practical courses in the prevention of similar deaths, and I intend to make a recommendation accordingly.

Compliance with General Order D2

31. The Introduction to General Order D2 Deaths in Custody and Investigation of Serious and/or Fatal Incidents resulting from Police contact with the Public provides at paragraph 1.4:

> "The aim of this General Order is to ensure the investigation into all incidents defined by this General Order is impartial, thorough, and completed in an objective and timely manner."

32. The quality of the investigation into this matter was of a high standard. The collision analysis carried out by Senior Sergeant Potts is thorough and was of great assistance in providing an objective analysis of any variation in the accounts given by the police officers and by Edgar Inkamala. As it turned out, their accounts were substantially similar and consistent with the expert opinions provided by Senior Sergeant Potts. The re-enactment interviews

carried out by Detective Sergeant Phillips (videotaped by Senior Constable Fiona Sutherland) were comprehensive, rigorous and of good quality. I am pleased that my comments in earlier inquests about the need for good quality re-enactments to be conducted by investigators have been heeded. The investigation into the movements of the deceased people and the driver, and the police officers, leading up to the crash carried out by Sergeant Robertson was thorough and he provided detailed and useful memorandums summarising the evidence in the brief. Sergeant Robertson efficiently carried out the requests made by my counsel assisting for further work to be done in the lead up to the inquest.

33. Having considered all of the evidence in the brief and the oral evidence given at the inquest, I do not criticise the actions of the involved police officers. As discussed above, Constable Dalgliesh made a decision to follow the vehicle in a bona fide effort to carry out his police duties, and his decision to do so had little to no impact on the driving of Edgar Inkamala and the resulting crash which caused the deaths. The two young officers then found themselves confronted with a horrific scene, and an incident which has had an ongoing substantial psychological impact upon them both, but on Constable Dalgleish in particular. I am pleased that both officers have engaged in mature reflection upon the events of that night and have incorporated any lessons learnt into their subsequent policing practice. I find that Constables Dalgliesh and Pearce participated willingly in the investigation process, and gave frank and truthful accounts of their actions, both in their interviews and when questioned further at the inquest. I am sure that the opportunity to hear honest evidence directly from the two officers was of great benefit to the relatives who attended the inquest.

34. It is extremely unfortunate then, that in these circumstances, I must again criticise NT police for an unacceptably delayed submission of a completed coronial investigation brief in a significant matter. It closely follows my criticism and recommendations in the *Inquest into the death of Kunmanara*

Forbes [2009] NTMC 024. That inquest was held in April 2009 in Alice Springs and the criticisms I made of the delay during the hearing received substantial publicity. Despite this negative publicity for NT police, and repeated requests from my Office, I did not receive a completed coronial file in the present matter until September 2009.

35. It is disappointing that the senior police responsible for oversight of this investigation yet again failed to heed the fact that delayed investigations lead to increased distress for bereaved families, unnecessarily extended stress for involved police members awaiting the inquest, and invariably (as occurred in this case) give inaccurate rumours and suspicion about police conduct the opportunity to spread amongst community members. Regardless of the quality of interviews or reports, a delayed investigation affects the integrity of the coronial investigation. This is always unfortunate but is particularly unacceptable when the incident being investigated involves police conduct. The bereaved family in this case stated clearly that they really wanted to hear the whole story about what took place, as they are most certainly entitled to, and that they would have liked to hear it much sooner. The involved members suffered significant stress over the incident, and no doubt anxiety about the necessity to give evidence at an inquest which was unnecessarily prolonged.

36. I quote from the Police Commissioner's response in September 2009 to my recommendations in the *Forbes* matter :

> "This report is made in accordance with the requirement of Section 46B of the *Coroners Act* and in response to recommendations made by the Coroner as a result of a Coronial Inquest into the death of Veronica Forbes. The Coroner made the following recommendations which I have responded to in turn:
>
> (i) I recommend that the Police Commissioner ensure that the Coronial Investigation Unit in Alice Springs is appropriately staffed and resourced in order that the members of that Unit are able to, and do, exercise investigative, oversight and liaison functions in relation to deaths reported to the Coroner in the Southern Command in a

similar way to the operation of the Coronial Investigation Unit in Darwin.

I concur with the Coroner that adequate staffing levels within the Coronial Investigation Unit (CIU) in Alice Springs must be maintained in order for the Unit to be able to fulfil all its required functions. The Commander, Alice Springs and Southern Region undertook a review of staffing levels and will ensure that the CIU is adequately staffed in future.

(ii) **I recommend that the Police Commissioner put specific strategies in place to ensure that reportable deaths are investigated by police officers in the Northern Territory in a timely way, with the expectation being that a coronial investigation file of satisfactory quality will be submitted to the coroner within 6 months from the date of death**.

All investigations into reportable deaths undertaken by Northern Territory Police on behalf of the Coroner are now oversighted by the Divisional Officer of the Investigation section tasked with the investigation. **This oversight will address previous quality control issues and ensure the timely submission of coronial files to the Coroner's Office**." [my emphasis]

37. A number of explanations, reasons and excuses were proffered to me during the inquest for the delay in this matter. I received evidence from Superintendent Lance Godwin. He was the officer in overall charge of this investigation, and is presently the Superintendent, Regional Investigations Division of the Alice Springs Regional Command. In that capacity he is responsible in a supervisory capacity for the large majority of coronial investigations (although this would not include matters to be investigated by the newly created "Major Crash" section). Superintendent Godwin provided evidence of some of the details of changed procedures intended to prevent a repeat of the situations which occurred in *Forbes* and in this matter. I told him, and John Stirk on behalf of the Commissioner, in a direct manner that I do not want to come back to Alice Springs in the next 12 months for an inquest which revisits the same issues of unacceptable delay in the completion of a coronial investigation. I will not repeat the

recommendations I made in *Forbes* but I trust that those recommendations and the responses referred to above will be heeded in practice in the future.

RECOMMENDATIONS

38. I recommend to the Commissioner of Police that practical mock pursuit training be taught as part of either recruit driving training or an advanced driver training module which is **regularly** available to NT police members.

FORMAL FINDINGS

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

Barbara Malthouse

(i) The identity of the deceased person is Barbara Malthouse.

(ii) The time and place of death was approximately 10:40pm on 7 December 2007 at Larapinta Drive 2.9km west of the intersection with Namatjira Drive, Alice Springs.

(iii) The cause of death was multiple injuries arising from an unintentional motor vehicle rollover where she was a passenger. Another significant condition contributing to death but not related to the condition causing death was acute alcohol toxicity.

(iv) Particulars required to register the death:

1. The deceased was Barbara Malthouse.

2. The deceased was of Aboriginal descent.

3. The death was reported to the Coroner.

4. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton on 13 December 2007.

5. The deceased's mother was Ivy Pareroultja and her father was Harold Malthouse.

6. The deceased lived at Hermannsburg.

7. The deceased was unemployed

Nigel Max Inkamala

(i) The identity of the deceased person is Nigel Max Inkamala.

(ii) The time and place of death was approximately 10:40pm on 7 December 2007 at Larapinta Drive 2.9km west of the intersection with Namatjira Drive, Alice Springs.

(iii) The cause of death was multiple injuries arising from an unintentional motor vehicle rollover where he was a passenger. Another significant condition contributing to death but not related to the condition causing death was acute alcohol toxicity.

(iv) Particulars required to register the death:

a. The deceased was Nigel Max Inkamala.

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton on 12 December 2007.

e. The deceased's mother was Dena also known as Edna Julie Kantawara and his father was Mark Inkamala.

f. The deceased lived at Hermannsburg.

g. The deceased was unemployed.

Daryl Inkamala

(i) The identity of the deceased person is Daryl Inkamala also known as Daryl Ngalkin.

(ii) The time and place of death was approximately 10:40pm on 7 December 2007 at Larapinta Drive 2.9km west of the intersection with Namatjira Drive, Alice Springs.

(iii) The cause of death was multiple injuries arising from an unintentional motor vehicle rollover. Another significant condition contributing to death but not related to the condition causing death was acute alcohol toxicity.

(iv) Particulars required to register the death:

a. The deceased was Daryl Inkamala aka Daryl Ngalkin.

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton on 12 December 2007.

e. The deceased's mother was Elsa Inkamala / Kantawara.

f. The deceased lived at Hermannsburg.

g. The deceased was unemployed.

Dion James Ngalken

(i) The identity of the deceased person is Dion James Ngalken also known as Dion Ngalkin and Dion Inkamala.

(ii) The time and place of death was approximately 10:40pm on 7 December 2007 at Larapinta Drive 2.9km west of the intersection with Namatjira Drive, Alice Springs.

(iii) The cause of death was multiple injuries arising from an unintentional motor vehicle rollover where he was a passenger. Another significant condition contributing to death but not related to the condition causing death was acute alcohol toxicity.

(iv) Particulars required to register the death:

a. The deceased was Dion James Ngalken also known as Dion Ngalkin and Dion Inkamala.

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton on 12 December 2007.

e. The deceased's mother Elsa Kantawarra was and his father was Frank Ngalken.

f. The deceased lived at Hermannsburg.

g. The deceased was employed with Tjuwanpa Rangers.

Gordon Napthali Murray

(i) The identity of the deceased person is Gordon Napthali Murray.

(ii) The time and place of death was approximately 10:40pm on 7 December 2007 at Larapinta Drive 2.9km west of the intersection with Namatjira Drive, Alice Springs.

(iii) The cause of death was multiple injuries arising from an unintentional motor vehicle rollover where he was a passenger. Another significant condition contributing to death but not related to the condition causing death was acute alcohol toxicity.

(iv) Particulars required to register the death:

a. The deceased was Gordon Napthali Murray

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton 10 December 2007.

e. The deceased's mother was Erna Ebatarinja and his father was Jonothon Murray.

f. The deceased lived at Hermannsburg.

g. The deceased was employed by Tjuwanpa Rangers.

Antonia Meneri

(i) The identity of the deceased person is Antonia Meneri.

(ii) The time and place of death was approximately 10:40pm on 7 December 2007 at Larapinta Drive 2.9km west of the intersection with Namatjira Drive, Alice Springs.

(iii) The cause of death was multiple injuries arising from an unintentional motor vehicle rollover where she was a passenger. Another significant condition contributing to death but not related to the condition causing death was acute alcohol toxicity.

(iv) Particulars required to register the death:

a. The deceased was Antonia Meneri.

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton 10 December 2007.

e. The deceased's mother was Ivy Pareroultja and his father was Matthew Meneri.

f. The deceased lived at Hermannsburg.

g. The deceased was unemployed.

Dated this 17th day of December 2009.

_____

GREG CAVANAGH
TERRITORY CORONER