




**CORONERS COURT  
OF NEW SOUTH WALES**

<b>Inquest:</b>	Inquest into the deaths of Susana Estevez Castillo, Liam Milne and Darren Milne
<b>Hearing dates:</b>	6 May 2016
<b>Date of findings:</b>	15 July 2016
<b>Place of findings:</b>	WYONG 
<b>Findings of:</b>	<b>Coroner David Day</b>
<b>Catchwords:</b>	CORONIAL LAW – Manner of death  Deliberate act
<b>File numbers:</b>	2015/ 00031540 2015/ 00031518 2015/ 00031516
<b>Representation:</b>	<b>Sgt G. HUNT, Police Advocate Assisting</b> <b>Nil other</b>

<b>Findings:</b>	<p><b>Identity of deceased:</b> The deceased persons were Susana Estevez Castillo, Liam Milne and Darren Milne</p> <p><b>Date of death:</b> The deceased died on 1 February 2015.</p> <p><b>Place of death:</b> The deceased died at Foutaindale in NSW</p> <p><b>Manner of death:</b> The deaths were intentionally caused.</p> <p><b>Cause of death:</b> The medical cause of the deaths was multiple injuries (road crash).</p>
------------------	--

## Table of Contents

Introduction: .....	1
The Inquest: .....	2
The Evidence: .....	2
Background: .....	2
The Fatal Incident: .....	2
Autopsy Report .....	2
Hearing and Consideration of the oral and documentary evidence. ....	3
Findings required by s81(1).....	9
The identity of the deceased.....	10
Date of death .....	10
Place of death.....	10
Cause of death .....	10
Manner of death.....	10

*These are the findings of an inquest into the deaths of Susana Estevez Castillo, Liam Milne and Darren Milne.*

## **Introduction:**

This is an inquiry into the deaths of Susana Estevez Castillo (39 years old), Liam Milne 11years old and Darren Milne ( 42years old), who died when the car in which they were travelling collided with a tree at Fountaindale on 1 February 2015.

An Inquest is an independent judicial inquiry by a Coroner. A Coroner investigates sudden and unexpected deaths to establish, where possible, the identity of the deceased person, the date and place of the person's death; and the manner and cause of that death.

Inquests are one way in which our society shows respect for human lives, the lives of those whose deaths it investigates, and also for those who love and care for the ones they have lost. If a member of our society dies unnaturally it affects not only the deceased but also many others. They are lost to their loved ones, and they are lost to the wider community.

We need to find out what happened to the deceased reduce recurrence where possible.

In this Inquest there is no controversy as to the identities, date and causes of death.

This Inquest concerns the manner of the deaths.

The three deceased were three members of one family. One child survives. One child died in utero with the mother.

The Court received no word picture of the deceased other than that contained in the Statements obtained by investigating Police and some of those observations appear below.

## **The Inquest:**

Evidence was given and tendered on 6 May 2016.

The Investigator's Brief became Exhibit 1. The Statement (with attached photographs) of Leading Senior Constable Mason became Exhibit 2 and a cardboard box containing wiring, batteries and 2 fuel canisters became Exhibit 3.

Oral evidence was called from Detective Senior Constable Kennedy, Mr Cooper, Mr. Winkle and Leading Senior Constable Mason.

## **The Evidence:**

### **OUTLINE**

At about 12.40 pm a Corolla wagon driven by Darren Milne collided with a roadside tree on Enterprise Drive, Fountaindale.

The collision was observed by a number of witnesses, the closest being Mr Cooper. Mr Cooper was the following vehicle. The stretch of road was straight and level. Trees were close to the road. He estimated the speed just before collision to be 90 kilometres an hour. There was no swerving and no brake lights were seen.

The vehicle sustained massive structural damage to the front end.

Darren Milne, Susana Estevez Castillo and Liam Milne died at the scene. Benjamin Milne survived the collision and was evacuated to Westmead Children's Hospital

### **ISSUES**

Any traffic incident such as this throws up matters for consideration.

In this matter the following issues arose:

- Whether mechanical fault caused the collision.
- Was it an accidental collision or otherwise, and if an accident did it arise from driver error, inattention, falling asleep or sudden unconsciousness?
- Were the roadside trees a contributing factor?

### ***Autopsy Reports***

Dr Beer from the Department of Forensic Medicine (Newcastle) performed the autopsies on the deceased.

Autopsy findings (summary) with respect to:

**Susana Estevez Castillo**

Complete translocation of lower cervical spine at C6 level.

Multiple rib, clavicular, pelvic and limb fractures.

Thoracic haemothorax.

29 weeks pregnant.

No evidence of sedation.

**Liam Milne.**

Multiple skull fractures

Possible subluxation C1-C2

Multiple limb fractures

Haemothorax indicative of significant internal chest trauma (blunt force trauma)

No evidence of sedation

**Darren Milne**

Skull fractures

Multiple rib and clavicle fractures

2 Right ventricular (heart) lacerations

Partial tear of descending thoracic aorta near the arch

Lung contusions

Liver and spleen lacerations

Multiple limb and pelvic fractures.

## **Hearing and Consideration of the Evidence.**

**Hearing** 6 May 2016

Detective Senior Constable Kennedy, Colin Cooper, Matthew Winkle and Leading Senior Constable Mason (vehicle engineer-expert) were called as witnesses.

**Detective Senior Constable Karen KENNEDY.**

The eight volume Brief was tendered through her, [Exhibit 1] and she was stood down to allow eyewitness and expert evidence to be taken.

**Colin Kevin COOPER.**

Mr. Cooper made a Statement to Police on 2 February 2015. He had held a driver's license for over thirty years and currently held a combination license permitting him to drive cars through to semi-trailers. He had driven truck for a living for a time.

Findings in the Inquest into the deaths of Susana Estevez Castillo, Liam Milne and Darren Milne.

He lives at Ourimbah and has a business in premises at Berkeley Vale. It was his custom to visit the premises each day over a weekend to check security. He had been travelling Enterprise Drive for about ten years on that basis.

At around midday on 1 February 2015 he was driving to the business along Enterprise Drive. He described the traffic at that time as “nil” to “light”. He said as he departed the vicinity of the University (sic. of Newcastle, Ourimbah Campus) he observed a small silver (grey) vehicle in front of him in the 60 kilometre per hour zone.

The road passes through a short section which he described as hilly, with bends, which then as he said “opens up”, becomes straight and then the speed limit increases to 90 kilometres per hour. There is one lane in each direction. The road was sealed, with a narrow shoulder beyond a fog line, with narrow gravel verges to vegetation or fences.

He said the vehicle in front of him was, for most of the time, 200-300 metres in front of him. It was travelling normally through the bends onto the open area. There was no erratic driving. In the 90 speed zone he had closed up on the lead vehicle and was about 100-150- metres behind it. From his evidence I inferred that there was nothing remarkable about the driving of the lead vehicle.

He was watching the lead vehicle and the road ahead of it. He attributed this to his experience as a truck driver. He was approaching a place where the vegetation comes close to the shoulder, near “Follyfoot Farm”, Foutaindale. He described it as a “treed area”. It was a straight stretch of road. Ahead of the lead vehicle there was no debris on the road. He saw no animals on the road

He said “things went slower”: Watching the lead vehicle he said he saw no brake lights, there was no sharp turn or erratic swerve. He said there was a deviation to the left “like an exit from the Freeway or something”[T: p 8.27]. He said he thought to himself “What’s this FW doing”, “What’s he doing like”[T:p8.31]

The grey/ silver vehicle struck a large roadside tree.

He said when that happened he thought “He’s done this on purpose”[T:p8.32].

He saw the car’s battery slide along the roadway.

He was already braking when he saw the deviation and he stopped just beyond the crash site and put his hazard lights on. Other cars stopped. Emergency services attended.

### **Matthew John WINKLE**

He said he was driving from Ourimbah to Chittaway on Enterprise Drive on 30 January 2015 at about 9.30 am.

He knows the road well and drives it every day and had done so for about ten to fourteen years.

He came up to the vicinity of "Follyfoot Farm", in the treed area. On his side of the road he saw a man standing near a tree close to the road. He said the man was not wearing any reflective clothing, such as would a road worker or surveyor, but was wearing a red button up shirt. He had brown hair. He said he did not see a car nearby, but said that there are places either side of the narrow section where cars often park. He did not notice any cars as he approached but he was not making that observation until he saw the man and by that time he had passed the Ourimbah side areas where cars could park.

This evidence assumed considerable importance when Detective Kennedy was recalled.

**Leading Senior Constable MASON**, from the Police Engineering Section gave evidence.

He gave oral evidence on aspects of his Report in Exhibit 1, and explained his observations of the vehicle in the photographs. His Report and attached photographs were tendered separately as Exhibit 2.

The subject motor vehicle was a Toyota Corolla four door station wagon. The Corolla had only one SRS airbag which was fitted to the steering wheel. The airbag had not deployed. The airbag control module within the cabin could not be tested due to impact damage. He said it was easy to disable that module by unplugging it. He observed that from his experience in a high speed crash such as this, airbags sometimes did not deploy. He did not elaborate.

He gave evidence in explanation of photographs he took of items found in the Corolla's engine bay. They were not standard fittings. A metal canister was located behind the off-side headlight housing. It was wrapped with parallel wiring of insulated and uninsulated heavy electrical cable, sleeved in part of a tyre inner tube and linked to an electrical cable which he removed from the engine bay. He said the cable had been placed so as not to catch or connect with any moving parts of the engine. It wound around to the near-side head lamp. A second fuel canister had been collected at the scene and placed on the back seat of the vehicle. That fuel canister was also wound in the same parallel coil as the other canister. The cable had numerous joints. Wired into the cable were three small 12 volt batteries, similar to those used in motorcycles. The cable also had a link to the active terminal ("Positive") of the car (main) battery (although that had detached). He opined that the second fuel canister was placed behind the near side headlight but had been ejected. The basis for this opinion was the placement of the cable to that location and a separated wire joint.

The fuel canisters contained about half a litre of fuel each. They were produced in Court (empty) and became part of Exhibit 3, along with the cable and small batteries.

From my observation they were aluminium fuel bottles; of about 600ml capacity commonly used for small light weight petroleum fuelled pressure hiking stoves,

noting that I have such equipment and I am more than familiar with these types of bottles.

The fuel canisters, cabling and additional batteries were not part of the vehicle operating system. The only connection to the car was to its active battery terminal. A piece of that type of wiring he observed was attached to that terminal, but had broken away.

He did not observe any connection to the negative terminal of the car battery or to the (steel) chassis (which would be connected to that terminal).

In my view the fuel canisters were set in such a way as to ignite upon creation of a short circuit which would have loaded the wiring with to an Amp load sufficient to melt those canisters and cause ignition.

The car battery was not in the engine bay. It was seen by Mr. Cooper ejected from the car on impact and was located on the road way some distance from the site.

The seating for the boys was that Liam was in a “booster” type seat, whereas the younger and smaller child, Benjamin, was in a five point type harness.

There was no obvious defect in the vehicle in respect of tyre tread, brake pad thickness or other (observable) mechanical defect taking into account the massive front end damage.

Detective KENNEDY was re-called.

She gave additional oral evidence in explanation of her 40 page Statement in Exhibit 1.

She said that Police recovered an iPad from the rear of the vehicle. Observations of it were made at the scene, screens were photographed and it was taken as an exhibit.

A “Dash Cam” (small dashboard mountable video camera) was also taken as an exhibit.

In the Notes folder of the iPad there was an entry captured by photograph at page 23 of her Statement. It was dated 20 September 2014. It reads [T:26.17]

“It’s not worth it, neither of us have the skills to make it work. We have both given it our best shot over a long period of time. There is too much conspiring against us. G got the calculation wrong, it’s that simple. L and B are both happy, B doesn’t know it yet, it is a good time to go. It is only going to get tougher as time goes on. We have been completely S’d over, maybe we can stop it from happening to someone else. They are going to have to manage ADD and diabetes, it is going to be too much. They need to exercise and manage their health, it is going to be hard to see this fail. Things are going to get progressively harder for Ben, he hasn’t seen any malice or bullying yet but it is coming. From this point on I need to be



totally focussed, forget everything else, need to source comfort from the fact. See if A bags can be disabled. Finalise medical records, disks and leave copies. Letter to HGA, correspondence. Start cleaning stuff up.” [T:26.35]

There was a second document.

“Take DVR out of car as to not raise suspicion. Carry out recon after daylight savings, full day on RDO. Look at Old Pacific Highway to Central Coast. Stay until dark. Practise at least ten times. Memorise all markers, learn the road backwards. Copy all work, personal stuff to portable disk. Start taking personal stuff home. Leave credit cards well in credit. Leave enough money to pay next phone.” [T:26.39]

Other items were taken as exhibits.

She said there were numerous photographs in the iPad. They were examined and they disclosed GPS co-ordinates of where the photographs were taken. There was a photograph dated 30 January 2015 taken at the crash scene, of the tree with which the vehicle collided. It was taken around the time that Mr. Winkle observed the man beside the road. The seized iPad was subject to technical inspection and disclosed the GPS coordinates of the crash scene. [T.28.14 ff]

The only conclusion available is that the operator of the iPad camera was the person Mr. Winkle observed. That person was Darren Milne.

A Search Warrant was obtained to search the Milne residence at Ryde.

In that search SD cards were seized. They were subsequently viewed and were found to contain video imagery of Enterprise Drive from out of Ourimbah to past the crash scene in Fountaindale. Other road scene were viewed showing video material relating to the Old Pacific Highway, South Maroota, The Northern Road (north of Penrith) Wiseman’s Ferry Road between Spencer and Mangrove Mountain, and Sackville Ferry Road.

All scenes are of relatively straight sections of narrow rural road with heavily timbered roadsides.

Also seized at the home was an A4 notepad. Written on it was:

*“Enterprise Drive, after Berkley, 90 zone, multiple after railway bridge green pole RIP dead straight and easy video scout Enterprise full speed after bridge.*

The house was orderly, if a little untidy, consistent with a family home. The boys’ medical records were orderly and organised.

Witnesses were interviewed by Police disclosing:

- The family had recently been on a six week holiday. Darren had taken some long service leave to extend his normal leave entitlement.
- On the preceding working day, 30 January 2015, Darren Milne had dressed for work and left at his usual time, but his employer reported he had arranged a day off.
- Darren and Susana had been undergoing IVF therapy to conceive a third child. After the boys were diagnosed with Fragile X Syndrome they had the embryos genetically tested to avoid having a third child with the syndrome.
- Susana was about thirty weeks pregnant with a child clear of the syndrome at the time of her death. She had diabetes.
- One person suggested from their discussions with Darren and Susana the third child was a potential carer for the boys when the parents were no longer capable.
- Other persons interviewed said Darren was a loving father and was very good with the boys. The boys clearly loved him. The boys were on the Autism Spectrum and in 2014 were diagnosed with Fragile X Syndrome. They could feed and bathe themselves. Liam's condition was more severe than Benjamin's.
- Darren was an electrical engineer, managing a section at AusGrid. His work colleagues said he was a good manager and very organised and tidy.
- Darren's treating psychologist Dr. Pace was interviewed. He had been treating Darren for some years for depression with both medication and cognitive therapies. He reported no suicidal or homicidal ideation. He last saw Darren in August 2014. It appears that Darren decided not to continue in treatment.
- Search warrants directed to relevant financial institutions showed the couple had no financial difficulties and had already paid for seven IVF cycles at about \$10,000.00 each. Susana had a significant investment in Australia of slightly under \$200,000.00.
- Susana was from Mexico. Her family are quite wealthy. She struggled at times with the different way of life in Australia and, along with Darren, was concerned with the boy's diagnosis.

At the close of evidence Mr. Milne (the deceased's father) and his sister Ms. Richards (aunt) were invited to speak about the deceased but both declined.

The Court adjourned to consider the contents of Exhibit 1 in Chambers and the 15<sup>th</sup> of July 2016 was fixed for making Findings.

## **BRIEF MATERIAL**

There is nothing in the Brief not covered by oral evidence as to manner of death.

There was extensive "dash cam" video material of other locations about which Detective Kennedy gave oral evidence. It was copied onto a computer compatible "Cellbrite" device for my viewing in Chambers.

There were a number of statements from others at the scene. None had as good a view of the collision as Mr. Cooper.

Susana Estevez Castillo suffered from diabetes.

Dr. Pace's statement amplified the evidence given by Detective Kennedy as to Darren's treatment, and its cessation.

## **CONSIDERATIONS**

The Corolla wagon sustained massive damage to its centre front with the engine and transmission entering the cabin. In considering Leading Senior Constable Mason's report and Mr. Cooper's observations I discounted mechanical defect as a cause.

The trees were close to the roadway. That created the opportunity for collision. It is not the cause. I discounted the trees from further consideration.

The additional photographs and video material downloaded onto the Cellbrite device as part of Exhibit 1 showed other reconnaissance style activities employing the dash mounted video camera.

The first responders and the medical evidence disclosed deaths of the adults were instantaneous. Liam died at the scene.

Police inquiries revealed that although Benjamin was seriously injured, he survived and despite permanent injury he lives with members of his mother's family in London (UK).

## **CONCLUSION.**

Based on the evidence of Mr. Cooper as to manner of driving, the "dash cam" videos of the particular site and the other similar stretches of road elsewhere, the iPad note ( stage 2 plan), the A4 note, the on-site reconnaissance on 30 January 2015 with the photograph taken on what can only be Darren Milne's iPad, the evidence of and observations of the wired fuel canisters and the absence of any contradictory evidence, I can only conclude that the collision with the tree was not accidental.

It was a deliberate and planned act. Darren Milne took his own life and in so doing took the lives of Susana and Liam.

## ***Findings***

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the deaths occurred and make the following findings in relation to it.

***The deceased persons were*** Susana Estevez Castillo, Liam Milne and Darren Milne

***Date of death*** 1 February 2015

***Place of death*** Fountaindale NSW

***Cause of death*** The deaths were caused by multiple injuries

***Manner of death*** The deaths were caused by a deliberate act of Darren Milne.

### ***Finally***

I extend the sympathy of the Court to the families.

I praise the efforts of the other motorists and emergency services in rescuing Benjamin. I understand he is doing well in his new home.

I thank the investigating Police and in particular Detective Senior Constable Kennedy for their comprehensive investigation of this tragic event.

It is unusual for a Coroner to comment on the conduct of a person who has taken their own life. Two other lives were taken by him and the actions of Darren Milne should attract more than the usual disapproval attached to murder and suicide. He made assumptions about the quality of the boys' lives. He disregarded the boys' fundamental human rights. He disregarded potential advances in medical science potentially beneficial to the boys. He assumed successful execution of his plan without regard to the possibility that the front seat occupants, he and Susana may not survive, but that one or both the rear seat passengers would survive, terribly injured, severely disabled or otherwise, or worse, be conscious, trapped inside the cabin when the car caught fire.

He disregarded the excellent services available to persons contemplating self-harm. He had a psychologist. He dropped out of treatment. The telephone directory book lists many registered psychologists in practice who could assist him and others contemplating suicide. Medical General Practitioners are trained with respect to depression and suicidal ideation.

Lifeline, Beyond Blue and The Black Dog Institute, Mens Line, Salvo Crisis Line, (and locally, the Central Coast Mental Health Services) are organisations with outreach services for persons contemplating suicide. Their contact details are easily obtained. A search engine on-line search will yield many others.

Further the National Fragile X Chromosome Association of Australia offers support for parents and those with the condition. I thank the Association for their interest in this matter and commend their efforts in the field.

These persons and organisations can and do help. Their efforts are recommended to the public.

Suicide is a preventable death, and in this case, the deaths of Liam and Susana were preventable.

I close this inquest.

David Day  
Coroner  
Wyong  
15 July 2016