



**CORONERS COURT  
OF NEW SOUTH WALES**

<b>Inquest:</b>	Inquest into the death of James Hughes
<b>Hearing dates:</b>	30 November -2 December 2016 at Goulburn
<b>Date of findings:</b>	21 February 2017
<b>Place of findings:</b>	State Coroners Court, Glebe
<b>Findings of:</b>	<b>Magistrate Teresa O’Sullivan, Deputy State Coroner</b>
<b>Catchwords:</b>	CORONIAL LAW – Cause and manner of death Motorcycle accident Pothole in road Goulburn Mulwaree Council Council response to public complaints about condition of road –
<b>File number:</b>	2015/292379
<b>Representation:</b>	<b>Sergeant Timothy O’Donnell, Sergeant Assisting</b>  <b>Mr Ian Bradfield for the family</b> <b>Mr Mark Cahill for Goulburn Mulwaree Council</b> <b>Mr David Lloyd for Mr Matthew O’Rourke</b> <b>Mr Phillip Gibson for Mr Chris Brassel</b> <b>Ms Wendy Thompson for Mr Andrew Palmer</b>

<p><b>Findings:</b></p>	<p><b>Identity of deceased:</b> The deceased person was James Hughes</p> <p><b>Date of death:</b> 4 October 2015</p> <p><b>Place of death:</b> Oallen Ford Road, Oallen</p> <p><b>Manner of death:</b> Mr Hughes died when he was thrown from his motor cycle after it hit a pothole in the road.</p> <p><b>Cause of death:</b> 1 (a) Multiple injuries (b) Single vehicle motor cycle fatality</p>
<p><b>Non-publication order</b></p>	<p><b>A non-publication order is made on all phone numbers and emails in evidence. <i>Section 74(10(b) Coroners Act 2009 NSW</i></b></p>

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*The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

*These are the findings of an inquest into the disappearance and suspected death of James Hughes.*

## **REASONS FOR DECISION**

### ***Introduction:***

This inquest concerns the death of James Hughes who died as a result of a single vehicle motor cycle accident on 4 October 2015.

### ***The Inquest:***

This inquest examined the manner of Mr Hughes' death and the relevant contributing circumstances. The inquest placed particular focus on whether the Goulburn Mulwaree Council's response to the issues with the road's surface on the Oallen Ford Rd Bridge and its approaches was appropriate. The inquest also looked at whether the Goulburn Mulwaree Council responded appropriately to its own internal notifications and to the complaints made by members of the public about the condition of the road's surface.

This investigation was carried out by Officer in Charge, Constable Jessica Walsh, and Second in Charge, Senior Constable Kelli Moller. The brief of evidence that was tendered at inquest contains over 30 statements from Police Officers, members of the public and employees at the Goulburn Mulwaree Council. Thirteen of these witnesses gave evidence at the inquest.

Section 81 (1) of the Coroners Act 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings. These are my reasons and findings.

### ***Background:***

James Hughes was born on the 14th of March 1965 to Carol and Colin Hughes and spent most of his younger life living in Canberra. He had two younger brothers, Allan and Peter Hughes.

James left home at age 17 and joined the Royal Australian Air Force (RAAF) where he completed his training as an aircraft engine fitter. He remained with the Royal Australian Air Force until 1989. James then worked for a company called SnapOn tools, selling tools to tradesmen around the Canberra region. After a number of years with SnapOn tools he opened a bakery in Queanbeyan with his then-wife Karin. A few years later their marriage ended and they sold the business. James moved to Melbourne and recommenced working with SnapOn tools as an Area Manager. In

2005 he left SnapOn tools and became self employed as a franchisee for Colortech doing vehicle paint repairs. He remained in this occupation until he died.

James had no children of his own, but had a number of step children. His first wife Karin, had two children from a previous marriage, Shannon and Melissa, who James stayed in close contact with. His second wife, Cathy, also had two daughters, Laura and Megan, from a previous marriage.

In June 2012, James met Melissa Pearce. James and Melissa were both residing in Canberra at the time. They began a relationship and by August 2012, were spending almost every weekend together, either at James' or Melissa's house, or at James' family holiday house on the south coast.

In late 2013, Melissa and James sold their individual homes and by March 2014 had moved into their new home together in Jerrabomberra, just outside of Canberra. They lived there with Melissa's two children, Sarah and Cai.

For the majority of his life, James had been fascinated and passionate about motorcycles. He began riding them on his Grandfather's farm when he was about 9 or 10 years old. By the time he was old enough to get a motorcycle license, he was already familiar with riding motorcycles, as well as fixing and rebuilding them. He was an accomplished rider and would often go on riding trips for a number of days with a group of about 15 friends that included his brother, Allan and best mate Tony Martin. He owned a number of motorcycles over the years. He had a particular passion for Ducati motorcycles, as well as fixing and restoring old vintage bikes. He still owned the BMW bike that he bought as his first ever bike at the age of 18. The Ducati 900S2 that he was riding on the day of the accident, was his pride and joy. He had spent many hours with his friend Tony rebuilding the engine and ensuring that the bike was mechanically immaculate. On the 3 October 2015, the day before the accident, James had entered the Bungendore Car and Bike show and won two trophies with his Ducati 900S2.

### ***The incident:***

At approximately 11:30am on Sunday 4th October 2015, James Hughes was riding his Ducati motorcycle in an easterly direction along Oallen Ford Rd, approximately 20kms outside the town of Windellama. As Mr Hughes approached the newly constructed Oallen Ford Rd Bridge, witness, Brendan Lindsay, saw him and observed the motorbike to be travelling about 40-50kms/hr and slowing down. Mr Lindsay saw him brake before the pothole located on the northern approach to the bridge. Mr Lindsay states that Mr Hughes braced himself against the handlebars just before the bike hit the pothole and he was thrown forwards when the rear wheel hit the pothole. The bike began to wobble and hit the barriers on the left hand side of the bridge. Mr Hughes was thrown off his motorbike and over the edge of the bridge.<sup>1</sup>

Bystanders attempted to render aid to Mr Hughes, but he was unconscious and not breathing. Mr Hughes was covered with a tarp and police were notified.

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<sup>1</sup> Exhibit 1, Tab 7

An autopsy was completed by Dr John Docker on 9 October 2015 which concluded that the direct cause of death was 'multiple injuries' with the antecedent cause of death being 'single vehicle motor cycle fatality'.<sup>2</sup>

### ***The Road:***

The evidence before this inquest revealed that failures to the surface of the Oallen Ford Rd Bridge approaches became evident only days after the newly constructed bridge opened to the public on the 10th of September 2015.

On 15 September 2015, Chris Brassel, the Contractor Supervision and Inspection Officer, sent Andrew Palmer, the Manager of Works, an email titled '*good the bad and the ugly*' with photos taken of the approaches to the bridge showing potholes and uneven gravel appearing on the road.<sup>3</sup> Michael Dodson, the Works Supervisor, was contacted about the road failure and he organised a road maintenance crew with a Pave Line truck to attend the site on 16th September 2015 to carry out the repairs. The team leader for this repair job was Christopher Wayne Bartlett from Road Maintenance.

On 16 September 2015, Mr Bartlett completed the repairs to the road but communicated to Michael Dodson that he felt movement under the surface and believed that the repair would not hold.

A Goulburn Mulwaree Council Works Meeting was held at 9am on Thursday 17 September 2015. At the meeting the issue of the road failure and the repair was raised, and a decision was made that the Oallen Ford Rd Bridge approaches would be asphalted.

On 18 September 2015, an email was sent from David Ellison, the Works Co-ordinator, to Pat Quinn from 'ROADWORX' detailing the additional works required to repair the approaches.

It was anticipated that the work would be completed in conjunction with other asphaltting works that ROADWORX were completing for the Council.

At 12:21pm on Tuesday 22 September 2015, Chris Brassel sent another email to Andrew Palmer titled 'OAF approaches' where he attached three photographs showing the northern and southern approaches. He states in the email "*It needs addressing again this week to make it safe. I think we need to look at this ASAP*".<sup>4</sup>

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<sup>2</sup> Exhibit 1, Tab 2

<sup>3</sup> Exhibit 5

<sup>4</sup> Exhibit 6

On 25 September 2015, Andrew Palmer went on leave and was not due to return to work until Tuesday 6 October. His absence during this period was noted in the Works Meetings that were held on 17 September 2015 and 1 October 2015.

***Public complaints about the road:***

At 5:24pm on Monday 28th September 2015, a complaint was made via email by a member of the public, Fred Kroesche, stating that *'the bitumen on both approaches has failed and is seriously unsafe'*. This was forwarded to a generic email address for customers to contact the Council, council@goulburn.nsw.gov.au. There was no evidence produced that this complaint was followed up on. Mr Kroesche gave evidence that he never received any acknowledgement or reply from the council.<sup>5</sup>

On the 28 September 2015, Chris Brassel went on leave and was not due to return until 5 October 2015.

A Goulburn Mulwaree Council Works Meeting was held at 9am on Thursday 1 October 2015. The Oallen Ford Rd Bridge approaches were flagged as an *'urgent matter'*. At 2:14pm the same day, Craig Johnson, the Customer Service Manager, sent an email to Matt O'Rourke informing him of a complaint made by a member of the public (Peter Dwyer) regarding the quality of the road approaches. At 2:25pm, Matt O'Rourke forwarded the email to Andrew Palmer stating *"FYI and action"*. Andrew Palmer was still on leave at this time.

Following the accident on Sunday 4 October 2015, a repair crew was dispatched at the request of attending police. Christopher Bartlett attended that day and sealed both approaches.

The scheduled asphaltting works on the bridge approaches were carried out by ROADWORX on 8 October 2015. They were completed the next day on 9 October 2015.

***The condition of the road as a contributing factor:***

This inquest had the benefit of hearing from witnesses who saw and drove over the Oallen Ford Road and were able to take photos and describe what it was like. It has also had the benefit of hearing evidence from an eyewitness, Mr Baty, who saw Mr Hughes hit the pothole.<sup>6</sup>

The road's surface should never have been allowed to deteriorate to the extent that it did. On the basis of the evidence before this inquest, I also find that the condition of

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<sup>5</sup> Exhibit 1, Tab 18

<sup>6</sup> Exhibit 1, Tab 8

the surface of the northern approach to Oallen Ford Bridge Road on 4 October 2015 substantially contributed to the death of Mr James Hughes.

**Expert report:**

Mr Greg Wright provided a report.<sup>7</sup> He was not required for cross-examination by any interested party.

In his report Mr Wright concludes:

1. Goulburn Mulwaree Council (GMC) and/or its employees did not maintain Oallen Ford Rd in a safe condition or, alternatively, warn motorists about the damaged road pavement.
2. GMC did not record in the Customer Request Management System and/or promptly investigate the safety concerns expressed by Mr Kroesche on 28th September 2015 or the quality concerns expressed by Mr Dwyer on the 1st of October 2015.
3. GMC did not record in the Customer Request Management System and act upon the advice received from Mr Chris Brassel, who recommended to his manager, Mr Palmer, on the 22nd of September that the approaches to the new bridge at Oallen Ford Rd should be made safe as soon as practicable.
4. That on the 22nd of September 2015, GMC did not use an appropriate method of repairing the road pavement failure in the southbound lane of the northern approach, or alternatively install appropriate signage to warn southbound motorists about the damaged road pavement.
5. GMC did not ensure that Oallen Ford Rd was safe to travel on the day of the incident
6. GMC did not promptly investigate or conscientiously act upon the complaints received from Mr Kroesche on the 28th of September or Mr Dwyer on the 1st of October, or from Mr Chris Brassel, who advised his manager on the 22nd of September that the approaches were unsafe and need to be repaired as soon as practicable.
7. And when responding to the question put to him in his instructions, "*what else could the Council have done in the interim to make the road surface safer to the public?*", Mr Wright concluded, that it could have installed warning signs or monitored the performance of the repairs that it did on 16 September 2015 and re-patched the failure using the same method repeating same until it arranged Roadworx to permanently repair the road.

This is not a situation where any one person is to blame or where one particular mistake or failure was made; there were a number of failures as described by Mr

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<sup>7</sup> Exhibit 42

Wright and by witnesses in this inquest. It is the accumulation of these failures that ultimately let Mr Hughes down.

To its credit, the Goulburn Mulwaree Council, from the very beginning of these proceedings, recognised a number of systemic failures. Through Mr Cahill they conceded:

1. There was a failure of the Council's fault reporting and monitoring systems in relation to the recording of the pavement failure that was identified and reported by Mr Brassel on the 15th of September 2015.
2. There was a failure of the Council's fault reporting and monitoring systems in relation to the recording and monitoring of the pavement failure identified by Mr Brassel on the 22nd of September 2015.
3. There was a failure in the Council's Higher Duty Delegating System in that no person was delegated to act in Mr Palmer's position as the Manager of Works while the Manager of Works was on leave from 25th September 2015 until the 6th October 2015.

To a large extent the witnesses from the Council conceded their shortcomings. Mr Palmer made the comment during his evidence that in hindsight he regrets not putting up a "*loose gravel*" sign.<sup>8</sup>

There were some factual disputes between the evidence given by Council employees. Mr Palmer and Mr O'Rourke had differing recollections about whether a conversation took place between them on 22 September 2015 after Mr Palmer received an email and photos from Mr Brassell regarding the condition of the road.

On Mr Palmer's evidence, after receiving the email from Mr Brassel, sometime between 12:31pm and 3pm that same day, he showed Mr O'Rourke the email and images on his office computer monitor. He was then instructed by Mr O'Rourke to have Mr Brassel "monitor" the surface. Mr Palmer stated that he then informed Mr Brassel verbally over the phone on 22 September and then again in person on 23 September, to "*keep an eye on it*".

Mr Brassel gave evidence at the inquest that he has no recollection of receiving these instructions from Mr Palmer. Mr O'Rourke also gave evidence that he had no recollection of having that conversation with Mr Palmer on 22 September, or being shown the email from Mr Brassel on Mr Palmer's computer monitor. On either version the action taken was inadequate.

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<sup>8</sup> Evidence at inquest on 1 December 2016

On Mr Palmer's version there was a failure to take appropriate steps to ensure that the road remained effectively monitored, especially when he approved Mr Brassel's leave. If no conversation took place then Mr Brassel's concerns were left completely unanswered.

### ***The Council's response to complaints:***

Mr Fred Kroesche, a member of the public, made a complaint by email on 28 September 2015 regarding the condition of the approaches. This complaint was sent to Mr Palmer via an internal program called InfoXpert while Mr Palmer was on leave. No one had been appointed to act in his position while he was away and his InfoXpert emails were not re-directed, leaving the complaint to go unanswered until after the incident. This demonstrates a systemic breakdown in Council's communication system and the Council's higher duty delegating system.

Another member of the public, Mr Dwyer, made a complaint on 1 October 2015. Mr O'Rourke gave evidence that he forwarded the email to Mr Palmer knowing that he was on leave at the time, as he was of the belief that the complaint was in relation to "*a construction matter on the Nerriga side of the bridge rather than on the northern side of the bridge*". Mr O'Rourke largely accepted that he should have taken a different course with it by calling Mr Dwyer back and arranging for someone inspect the site.

### ***Improvements by Council:***

Since the incident, GMC has implemented changes to improve their systems. This is again to their credit. Mr Warwick Bennett's statement sets out the changes and proposed changes that GMC has made and intends to make to try and ensure that an incident such as this does not happen again.<sup>9</sup>

Of note are the improvements to the Customer Request Management System (CRM) to ensure that all requests received from the public or from a Council officer must be recorded within the system and directed to the appropriate service. A significant improvement to the procedures regarding this system is an increase in the amount of information it can capture, as well as a more accurate reflection of priority levels that that jobs should be given. As Mr O'Rourke explained when giving evidence, the old system would categorize all potholes with a '*medium*' priority level. Under the improved system, the size and depth of the pothole will be taken into account when categorizing the priority level of the response. Jobs that are given 'high' or 'urgent' priority now have the added requirement that a phone call must be made to the person whose responsibility it is to respond.<sup>10</sup>

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<sup>9</sup> Exhibit 8

<sup>10</sup> Evidence at inquest 2 December 2016

Increased training for their staff and management has taken place, with Mr Bennett informing the Court through his statement that fifteen Council staff have completed a two day course focused on bituminous surfacing maintenance and rehabilitation, allowing them to “*fully evaluate and implement road maintenance and rehabilitation options*”.<sup>11</sup>

The Operations Division has been restructured to ensure that small, routine construction and maintenance works are done well in-house. The role of Manager Works is now separated into three new positions, a Construction Superintendent, a Maintenance Superintendent, and a Business Manager Operations, to whom the Construction and Maintenance Superintendent’s report.

Higher Grade Duties procedures have changed to ensure that an officer is selected to act in the role when that usual officer goes on leave.

There is also the foreseen improvement of combining their four depots throughout Goulburn into one depot to improve communication between workers. Any improvements that can be made regarding communication between workers should certainly be encouraged. Given that these changes are new, ideally they would be regularly reviewed to ensure their effectiveness and that they are being appropriately complied with.

In closing, I would like to thank Sergeant Timothy O’Donnell for his excellent assistance in this inquest.

I would also like to thank the officer in charge, Constable Jessica Walsh and the second in charge, Senior Constable Kelli Moller for their excellent investigation.

Finally, I offer my sincere condolences to the family of Mr Hughes; his partner, Melissa, his father, brothers and friends who attended throughout the inquest.

## **Findings required by s81(1)**

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 death occurred and make the following findings in relation to it:

### ***The identity of the deceased:***

James Hughes

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<sup>11</sup> Exhibit 8

***Date of death:***

4 October 2015

***Place of death:***

Oallen Ford Road, Oallen

***Cause of death***

- 1 (a) Multiple injuries
- (b) Single vehicle motor cycle fatality

***Manner of death***

Mr Hughes died when he was thrown from his motor cycle after it hit a pothole in the road.

I close this inquest.

Magistrate Teresa O'Sullivan  
**Deputy State Coroner**

**Date 21 February 2017**