STATE CORONER'S COURT

OF NEW SOUTH WALES

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| **Inquest:** | Inquest into the deaths of Eliza Wannan and William Dalton-Brown |
| **Hearing dates:** | 23 - 27 May 2011 and 23 & 24 September 2013 |
| **Date of findings:** | 9 October 2013 |
| **Place of findings:** | State Coroner's Court, Glebe |
| **Findings of:** | Magistrate Sharon Freund, Deputy State Coroner |
| **Findings:** | I find that Eliza Wannan and William Dalton-Brown both died on 27 January 2010 at Orange Base Hospital from hypoxic brain injury following a cardiac arrest as a result of injuries sustained as a result of being run over and crushed by a vehicle. |
| **File number:** | 1013/10 and 1024/10 |

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| **Representation:** | Mr W. Hunt instructed by Ms L. Molloy and Ms S Christian, Crown Solicitor's Office, Counsel Assisting;<br><br>Mr P. Saidi, instructed by Mr S. Robinson, for the Commissioner of Police;<br><br>Mr M. Schwab, solicitor for the Family of Eliza Wannan;<br><br>Mr A. Johnson, instructed by Mr S. Makenzie for Ms L. Dalton, the mother of William Dalton-Brown;<br><br>Mr M. Manwarring, solicitor for Rhys Colefax; |

## FINDINGS

It was the Australia Day long weekend 2010, and a group of between 60 and 100 friends and acquaintances from the local area, the majority of whom were between 17 and 19 years of age, many of which had returned to town after completing their first year at University, gathered at the shearing sheds of the property at Belgravia Road, Molong known as "Ridgeview" to catch up, socialise and party. Many drove and parked their cars at the property and intended to spend the night. Alcohol was available and food was provided by Mrs. Christopherson during the evening. But for Eliza Wannan and William Dalton-Brown and their respective families this evening of joy was to become a tragedy, when the swag which they shared that night was run over and they were crushed by a vehicle driven by Rhys Colefax.

On the final day of the inquest, the parents of Eliza and William provided emotional personal statements to this inquest, permitted me to peak into the window of their torment, loss and grief at losing their children on 27 January 2010.

Mr. Wannan gave a personal statement about his daughter Eliza, and also read out a statement prepared by his wife. Both Mr. and Mrs. Wannan's statements spoke of their

grief at the loss of Eliza, particularly for Eliza's younger brother Nicholas, who has lost his only sibling. They each recalled Eliza's vivacious and fun-loving personality, her passion for all things French, and her eye for fashion. Eliza was the girl whose smile "lit up a room", was caring and inclusive and, as such, had many friends.

Similarly, Mrs. Dalton spoke movingly of her grief at having lost her only son, and her daughter Sophie's loss of her brother. William who was also just 19 was a young man who embraced life and adventure and had a personality that allowed him to engage with others and make many friends. William had planned to enroll in science in university over the ensuing days after this incident but that was not to be. William's father, Mr. Brown, indicated that he continued to honour his son in death as he did in life and spoke of his anger in relation to the circumstances surrounding William's death and of his feelings of injustice.

It was abundantly clear that both Eliza and William were very much loved and will be and continue to be much missed by their parents, siblings and friends but their short lives have made an indelible impact on all who had the privilege to know them.

A Coroner's function pursuant to s. 81 of the *Coroners Act 2009* is to seek to answer five questions namely, who died, when they died, where they died and the manner and cause of their death. The cause of death refers to the direct physical cause, where the manner of death relates to the surrounding circumstances. A coroner, pursuant to s. 82 of the *Coroners Act 2009* has the power to make recommendations, not in attempt to lay blame, but to look forward in attempt to prevent future similar deaths and the pain and suffering that has been experienced by the families of Eliza and William being experienced by others in the future.

The uncontroversial facts surrounding the deaths of both Eliza and William are the following:

1. Rhys Colefax was the owner and driver of motor vehicle registration number XRZ-611 (NSW) that ran over and crushed both Eliza and William at about 5:00am on 26 January 2010;

2. at the time he was the holder of a Learners' licence and was unaccompanied when driving the vehicle when the vehicle ran over Eliza and William;

3. he is the son of Brett Colefax, a police officer who at one time was stationed at Orange police station;

4. he had been drinking the night of the party to some unknown extent;

5. he was subject to a breathalyser test by the first responding police officers who attended the scene and that alcolizer registered zero alcohol on his breath;[1]

6. approximately, one week later that alcolizer did not calibrate properly and was found to be faulty and sent to be repaired;[2]

7. at the time of the incident, Rhys Colefax was arrested under the *Road Transport (Safety and Traffic Management) Act 1999* and conveyed to Orange Base Hospital for the purpose of blood and urine testing and his blood and alcohol was extracted at 7:40am on 26 January 2010;

8. the samples of blood and urine obtained from Rhys Colefax were eventually tested his blood was found to contain 0.039g/100mL of alcohol[3]; and

9. Rhys Colefax never provided a statement to investigating police as to his version as to what occurred that fateful evening and he was never charged with any offences under the *Road Transport* legislation.

On the final day of the first fixture of this inquest, having heard most of the evidence, I suspended this inquest having had formed the view pursuant to s. 78(1)(b) of the *Coroners Act 2009* inter-alia that the evidence I had heard was capable of satisfying a

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[1] Exhibit 3, Volume 1, Tab 17 & Exhibit 3, Volume 2, Tab 1(b)
[2] Exhibit 3, Volume 1, Tab 10
[3] Exhibit 3, Volume 1, Tab 30;

jury beyond reasonable doubt that the driver of the motor vehicle that ran over and crushed both Eliza and William was guilty of the indictable offence of drive in a manner dangerous cause death.

The Director of Public Prosecutions, despite additional submissions from the families of both Eliza and William, declined to prosecute.

Accordingly, I made the decision to reopen the inquest in order to finalise the outstanding matters that were not dealt with during the course of the first fixture. These included:

1. determining the exact cause of death in relation to both Eliza and William;
2. whether there was a proper investigation into their deaths; and
3. whether any recommendations can be made pursuant to s. 82 of the *Coroners Act 2009*.

I will deal with each of these issues in turn.

**WHAT WAS THE DIRECT CAUSE OF DEATH OF BOTH ELIZA AND WILLIAM?**

No autopsy was conducted on the bodies of Eliza and William.

Accordingly, in order to formulate a cause of death, an expert report was obtained from Dr. A. Cala dated 29 March 2011, the senior staff specialist in Forensic Medicine at the

Newcastle Department of Forensic Medicine.[4] Dr Cala also provided oral evidence to the inquest on 23 September 2013. His evidence can be summarised as follows:

1. he agreed with the recorded cause of death in the Report of Death of a Patient to the Coroner as being hypoxic brain injury due to a cardiac arrest. However, he was unable to identify the underlying cause of the cardiac arrest;

2. that if the tyre of the vehicle became caught on the fabric of the swag, it may have caused the fabric to pull, causing, in turn, a "smothering" or "strangulation" effect by blocking the deceased's airways and neck. This impairment of the airways would mean that the length of time between inspiration and expiration would be longer, and would cause the levels of oxygen in the blood to drop, eventually triggering a cardiac arrest;

3. the length of time that the vehicles rested on the bodies of William and Eliza was important. He gave evidence that both deceased seemed to suffer cyanosis which in his view was indicative of a cardiac arrest or asphyxiation, or both. However, Dr Cala stated that, in the absence of an autopsy, there was no pathological way of determining how long the vehicle rested on both Eliza and William but said that based on the evidence, he would estimate that the time range would be anywhere from 30 seconds to several minutes; and

4. that while it is not possible to determine what the outcome would have been if the vehicle was rapidly removed from the bodies of Eliza and William, Dr Cala indicated that the earlier that the vehicle was removed, the greater the likelihood of a successful outcome.

Accordingly I am satisfied on the balance of probabilities that the cause of death of both Eliza and William is hypoxic brain injury due to cardiac arrest.

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[4] Exhibit 3, Volume 2, Tab 52

**WAS THERE A PROPER INVESTIGATION INTO THE DEATH'S OF BOTH ELIZA AND WILLIAM?**

The central theme of the submissions of Mr Schwab solicitor for the Wannan family and Mr Johnson of Counsel for Mrs Dalton revolved around the perception of a conflict of interest held by Detective Senior Constable Gannon in relation to his investigation of the deaths of Eliza and William. They argued, in effect, that there were number of coincidences in relation to this matter including that:

1. the driver of the vehicle that ran over and crushed Eliza and William was a son of a police officer who at one time served at Orange Police Station;

2. the breathalizer used to test Rhys Colefax after the accident was found to be faulty;

3. Rhys Colefax was never charged with any road related offences even though there was evidence that became available to police that he had driven to the party without being accompanied by a licensed driver;

4. the OIC, Detective Senior Constable Gannon, knew the father of Rhys Colefax and as such should have been aware of and advised his superiors of a "conflict of interest" in investigating the deaths of Eliza and William;

5. Rhys Colefax was not interviewed by the OIC the morning after the incident nor did he ever provide a statement to police accordingly any opportunity to obtain his version of what occurred that night was lost;

6. that statements given to the press by the NSW Police, shortly after the incident, had indicated that alcohol had not been a factor;

Many of the matters described in submissions by the respective representatives of the family as coincidences in the circumstances surroundings the deaths of Eliza and William were, in my view, uncontested matters of fact. In particular, that:

1. Rhys Colefax was the son of Brett Colefax who was at the time of the incident a serving member of the NSW Police Force and had previously been stationed at Orange;

2. at the time of the incident Rhys Colefax only had his L plates and was not licensed to drive unaccompanied;

3. the first responding police officers had subjected Rhys Colefax to a breath analysis at the scene and the breath alcolizer had shown a reading of 0.00 alcohol in his system;

4. approximately ten days later, Senior Constable Gannon was advised that the alcolizer used to test the presence of alcohol on Rhys Colefax was found not to calibrate properly and was sent in for repairs (Senior Constable Gannon reported and logged the fault in his statement);

5. at the time of the incident Rhys Colefax was himself 17 years old;

These circumstances as they unfolded however, did not occur in a vacuum. If they had, in my view the investigation conducted into the deaths of Eliza and William would have been quite open to criticism. However, this inquest has revealed that steps were taken, many of them against the interest of Rhys Colefax, to ensure that the investigation was open, transparent and thorough. These steps included firstly, having Rhys Colefax arrested for the purpose of transporting him to hospital to obtain samples of the blood and urine for testing and secondly, the reporting of the alcolizer to be faulty.

Rhys Colefax at the time of the incident was 17 years old. He therefore was a juvenile. As such he could not be interviewed by police without the presence of a guardian or a support person pursuant to s.13 of the *Children (Criminal Proceedings) Act 1987*. Detective Senior Constable Gannon made a number of requests to interview Rhys Colefax, however on his third attempt it became clear that he would not be providing an interview based on legal advice. It is trite law in this state that a person of interest is entitled to evoke their right to silence. It would have been improper for Senior Constable Gannon to have pursued the matter further at this stage.

Moreover, the carriage and direction of the investigation proceeded under the guidance of this Court and indirectly thereafter through the Crown Solicitors Office from as early

as June 2010, when it became clear that the deaths of Eliza and William were suspicious, that an inquest was required and there were issues in relation to the surrounding circumstances of their deaths that warranted investigation.

The thoroughness of the investigation was highlighted as a potential issue by the family at an early point in the preparation for these proceedings. Accordingly, those assisting me thought it prudent that a report be obtaining from Superintendent David Driver from Canobolas Local Area Command[5] to comment on the thoroughness investigation. The report was not critical of the investigation excepting that Superintendent Driver identified that Rhys Colefax may have committed some traffic offences prior to the incident occurring in that he drove to and from the party without a fully licensed driver accompanying him and the possibility of his purchase of alcohol as a juvenile in breach of licensing laws.

It was the evidence of Detective Senior Constable Gannon that he was aware that summary offences were available however he was focused on the "bigger picture" which was the deaths of Eliza and Willliam and made a conscious decision not to charge Rhys Colefax summarily. Much was made of this by the various representatives of the family. I note that if Rhys Colefax had been charged under c. 15 of the *Road Transport (Driver Licensing) Regulation 2008* of driving a motor vehicle on a road or road related area unaccompanied by a supervising driver, he would have faced the following maximum penalties:

- a fine of 20 penalty units (cl. 15(1)(a) of the *Road Transport (Driver Licensing) Regulation 2008*); and
- suspension of licence (cl. 15(3) of the *Road Transport (Driver Licensing) Regulation 2008*).

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[5] Exhibit 19

Accordingly, I am satisfied on the balance of probabilities that the investigation in the circumstances was thorough and adequate and was not compromised by the fact that Rhys Colefax is the son of a police officer who was formerly stationed at Orange.

**POSSIBLE RECOMMENDATIONS?**

For someone to be charged with an offence of negligent, furious or reckless driving causing death pursuant to s. 42 of the *Road Transport (Safety and Traffic Management) Act 1999* (as it was at the relevant time), the offence had to occur on a road or road related area. A "road related area" is defined as:

> *"(a) an area that divides a road, or*
>
> *(b) a footpath or nature strip adjacent to a road, or*
>
> *(c) an area that is open to the public and is designated for use by cyclists or animals, or*
>
> *(d) an area that is not a road and that is open to or used by the public for driving, riding or parking vehicles, or*
>
> *(e) a shoulder of a road, or*
>
> *(f) any other area that is open to or used by the public and that has been declared under section 15 of the Road Transport (General) Act 2005 to be an area to which specified provisions of this Act or the regulations apply."*

(see s. 4 *Road Transport (Safety and Traffic Management) Act 1999* and Dictionary)

As the incident that took the lives of Eliza and William occurred on a paddock on private property, it did not occur on a road or road related area. Accordingly, Rhys Colefax could not face such charges, and as the DPP declined to prosecute him under s. 52A(1) of the *Crimes Act 1900* for dangerous driving occasioning death, it is likely he will not face a legal penalty in relation to the incident.

Mr Schwab, solicitor for the Wannan Family, made detailed submissions regarding the inconsistencies between the various states as to whether a person can be charged with driving under the influence of alcohol or drugs irrespective of whether the driving occurs on a road or road related area.

In 2010 (and currently under the *Road Transport Act 2013*), ss. 9, and 12 of the *Road Transport (Safety and Traffic Management) Act 1999* stated:

> *"s. 9 Presence of prescribed concentration of alcohol in person's breath or blood*
>
> *(1A) Offence—novice range prescribed concentration of alcohol*
>
> *If a person is the holder of a learner licence or a provisional licence in respect of a motor vehicle, the person must not, while there is present in his or her breath or blood the novice range prescribed concentration of alcohol:*
>
> *(a) drive the motor vehicle, or*
>
> *(b) occupy the driving seat of the motor vehicle and attempt to put the motor vehicle in motion.*
>
> *Maximum penalty: 10 penalty units (in the case of a first offence) or 20 penalty units (in the case of a second or subsequent offence).*
>
> *s. 12 Use or attempted use of a vehicle under the influence of alcohol or any other drug*
>
> *(1) A person must not, while under the influence of alcohol or any other drug:*
>
> *(a) drive a vehicle, or*
>
> *(b) occupy the driving seat of a vehicle and attempt to put the vehicle in motion, or*
>
> *(c) being the holder of a driver licence (other than a provisional licence or a learner licence), occupy the seat in or on a motor vehicle next to a holder of a learner licence who is driving the motor vehicle.*
>
> *Maximum penalty:*
>
> *(a) in the case of a first offence to which paragraph (a) or (b) relates—20 penalty units or imprisonment for 9 months, or both, or*
>
> *(b) in the case of a second or subsequent offence to which paragraph (a) or (b) relates—30 penalty units or imprisonment for 12 months, or both, or*
>
> *(c) in the case of an offence to which paragraph (c) relates—20 penalty units.*
>
> *(2) If a person is charged with an offence under subsection (1):*
>
> *(a) the information may allege the person was under the influence of more than one drug and is not liable to be*

*dismissed on the ground of uncertainty or duplicity if each of those drugs is described in the information, and*

*(b) the offence is proved if the court is satisfied beyond reasonable doubt that the defendant was under the influence of:*

*(i) a drug described in the information, or*

*(ii) a combination of drugs any one or more of which was or were described in the information.*

*Note. Division 3 of Part 3 of the Road Transport (General) Act 1999 provides for the disqualification of persons from holding driver licences for certain offences (including offences under this section).*

Those offences, on first, reading do not have a requirement that the offence take place on a road or a road related area. However, section 13 of the *Road Transport (Safety and Traffic Management) Act 1999* (NSW) (as was the relevant legislation as at 2010) states:

*"s. 13 Power to conduct random breath testing*

*(1) A police officer may require a person to undergo a breath test in accordance with the officer's directions if the officer has reasonable cause to believe that the person:*

*(a) is or was driving a motor vehicle on a road or road related area, or*

*(b) is or was occupying the driving seat of a motor vehicle on a road or road related area and attempting to put the motor vehicle in motion, or*

*(c) being the holder of a driver licence, is or was occupying the seat in a motor vehicle next to a holder of a learner licence while the holder of the learner licence is or was driving the vehicle on a road or road related area.*

*(2) A person must not, when required by a police officer to undergo a breath test under subsection (1), refuse or fail to undergo the breath test in accordance with the directions of the officer.*

*Maximum penalty: 10 penalty units.*

*(3) It is a defence to a prosecution for an offence under subsection (2) if the defendant satisfies the court that the defendant was unable on medical grounds, at the time the defendant was required to do so, to undergo a breath test.*

> *(3A) Before requiring a person to undergo a breath test under subsection (1), and for the purpose of determining whether to conduct such a test, a police officer may conduct a preliminary assessment to determine if alcohol is present in the person's breath by requiring the person to talk into a device that indicates the presence of alcohol.*
>
> *(4) Without limiting any other power or authority, a police officer may, for the purposes of this section, request or signal the driver of a motor vehicle to stop the vehicle.*
>
> *(5) A person must comply with any request or signal made or given to the person by a police officer under subsection (4).*
>
> *Maximum penalty: 10 penalty units.*

Accordingly, the police only have the power to conduct a breath test if the officer has reasonable cause to believe that the person was driving a motor vehicle or occupying the seat of a motor vehicle on a road or road related area. So without the power to test somebody driving a motor vehicle or occupying a seat of a motor vehicle on a private property for the presence of alcohol, it follows that charges are unlikely to arise.

I observe that other States, like Queensland and Victoria, are not so constrained. Sections 49 to 50AA of the *Road Safety Act 1986 (Vic)* creates offences for drink or drug driving irrespective of whether the driving occurs on a road or on private property. Sections 79, 79A and 80 of the *Transport Operations (Road Use Management) Act 1995 (QLD)* create offences irrespective of whether the driving occurs on a road or "elsewhere".

I have no doubt that the fact that Rhys Colefax is unlikely to be charged and face a legal ramification for what occurred that early morning on 26 January 2010 adds to the torment of both the families of Eliza and William. However the legislation is what it is. There is no provision currently in NSW for a person who has driven negligently (if the driving is not deemed to be in a manner dangerous) and caused death or grievous bodily harm, to be charged with an offence if the driving did not occur on a road or road related area. This anomaly can only be addressed by a review and rewording of the legislation to broaden the definition of road related area, or alternatively to adopt the

course taken by other states to create offences in relation to driving a vehicle on a road or "elsewhere".

As previously indicated, my role as a Coroner is confined to issues in relation to cause and manner of death. The anomalies with respect to *Road Transport Act 2013* (and its predecessor the *Road Transport (Safety and Management Act) 1999*) falls outside the ambit of my jurisdiction, and for that reason alone I decline to make any formal recommendations regarding the drafting of the legislation and the fact that it does not currently create an offence for negligent driving that occurs in an area that is neither a road nor a road related area. This however, should not be read as an endorsement of the legislation as it is currently drafted but rather as an observation that there is an anomaly which can result in a negligent driver who has caused harm or death to another, not facing a possible legal penalty as the driving occurred on private land/property.

Mr. Brown, William's father, in his emotion-charged statement to the court on the final day of the inquest said the following "that Rhys Colefax is the luckiest boy in the world". I do not agree. Rhys will have to carry with him for the rest of his days the knowledge that his actions on the 26 January 2010 took the lives of two beautiful souls. He may have escaped legal penalty but to describe him as lucky would be wrong. This was a terrible accident with terrible irreversible consequences for all directly and indirectly involved.

I now turn to the formal findings I am required to make pursuant to s. 81 of the *Coroners Act 2009*.

**I find that Eliza Wannan and William Dalton-Brown both died on 27 January 2010 at Orange Base Hospital from hypoxic brain injury following a cardiac arrest as a result of injuries sustained as a result of being run over and crushed by a vehicle.**

For the reasons set out in these findings I decline to make recommendations pursuant to s. 82 of the *Coroners Act 2009*.

9 October 2013

**Magistrate Sharon Freund**
Deputy State Coroner

**Addendum to finding on 6 December 2013:**
Having had access to both the transcripts and recording of the inquest, it has been brought to my attention that the quotation attributed to Mr Brown in my findings dated 9 October 2013 was not accurate. It is now clear that he never said the words that I attributed to him. I apologise unreservedly for any hurt caused by this error.

**Magistrate Sharon Freund**
Deputy State Coroner