OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of** Samantha Anne MASLEN
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Goondiwindi
FILE NO(s):	COR 1356/05(4)
DELIVERED ON:	28 August 2008
DELIVERED AT:	Goondiwindi
HEARING DATE(s):	28 July 2008, 26 & 27 August 2008
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Police pursuits, tyre deflation devices

REPRESENTATION:

Counsel Assisting: PCSC Dane Sheraton, Sergeant William Kearney, Senior Constable Jonathon Colquhoun:	Mr Justin Harper
RACQ Pty Ltd:	Mr Adrian Braithwaite (Gilshenan & Luton Lawyers)
Queensland Police Service Commissioner:	Mr Guy Hampson (instructed by Quinlan, Miller & Treston Lawyers)
	Mr Wayne Kelly (QPS Solicitors Office)

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The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organizations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system including the Attorney-General and the Minister for Police and Corrective Services. These are my findings in relation to the death of Samantha Anne Maslen. They will be distributed in accordance with the requirements of the Act.

Introduction

On 5 June 2005, Samantha Maslen was the front seat passenger in a car that drove away from a petrol station in Yelarbon in South Western Queensland without anyone paying for petrol that had been pumped into the car. The vehicle was seen heading towards Goondiwindi, some 56 kms away.

The theft of the petrol was reported to the Warwick Police Station where the officer who received the call discovered the vehicle had been reported stolen. That information was conveyed to a police officer at Goondiwindi and two vehicles from there set out to intercept the stolen car.

Both police cars headed towards Yelarbon. One only went 5 kms before stopping to set up an interception point; the other continued on until it came across the car in which Ms Maslen was riding. That police car turned and chased. After travelling 7 to 10 kms, the stolen car came upon the other police vehicle. The officer in that car was standing on the road directing the car to stop. He also had ready to deploy a tyre deflation device. When he ascertained that the driver of the stolen car was not going to stop, he moved off the road and pulled the deflation device into the path of the car. Just before it ran over the device, the stolen car swerved to the right; apparently trying to avoid the device. The driver was unsuccessful in this regard. However, his actions caused the car to skid and all control was lost. The vehicle rolled over a number of times. Ms Maslen was seriously injured and was pronounced dead on arrival at the Goondiwindi Hospital a short time later.

These findings seek to explain how that happened and consider whether the officers acted in accordance with the QPS polices and procedures then in force. In a later bracket of evidence consideration shall be given to whether any changes to current policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because Ms Maslen died while attempting to avoid being detained by police, her death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2] However, as the driver of the vehicle was charged with dangerous driving causing death, the inquest could not commence until that charge had been dealt with.[3]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not seek to examine those authorities here with a view to settling that question. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [4]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[5] However, a coroner must not include in those findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[6]

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[1] See s10
[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. Section 27 requires an inquest be held in relation to all deaths in custody
[3] s29
[4] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[5] s46
[6] s45(5) and 46(3)

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[7]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[8] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[9]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[10]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[11] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I will now say something about the investigation of Samantha Maslen's death.

The Regional Crime Coordinator for the Southern District, Detective Inspector Noel Ragh was appointed to investigate the incident with assistance from Inspector Helen Payne of the Ethical Standards Command. Detective Sergeant Joseph Hildred, the officer in charge of the Goondiwindi Criminal Investigation Branch also assisted; indeed he was the first investigator to arrive at the scene.

He obtained a brief version from each of the officers involved in the pursuit. A roadside breath test was then conducted on each officer, both of which proved negative.

Sgt Hildred made arrangements for the attendance of a specialist accident investigator and then went to the Goondiwindi Hospital to obtain details of the

[7] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[8] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[9] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[10] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[11] (1990) 65 ALJR 167 at 168

other occupants of the vehicle. He formed the opinion that those people, Rohan Batchelor and Leonard Stanley should not be interviewed immediately on account of the injuries they had suffered in the car crash. However, a blood sample was obtained from Mr Stanley before both were flown to Toowoomba for further treatment.

Sergeant Darryl Morrison of the Accident Investigation Squad attended the scene and carried out a series of investigations with the assistance of Sergeant John Campbell of Goondiwindi police and Sgt Kearney. Sgt Morrison directed that photographs be taken of areas he viewed to be of interest and he prepared a scale plan of the scene.

Later on the day of the incident both of the officers involved in it were interviewed and one took part in a video recorded re-enactment.

On 7 June, Anastasios Georgas, a vehicle inspection officer for the QPS inspected the Ford Falcon Sedan Registered No. 073BVU at Goondiwindi Police Station. His findings are summarised later, suffice it to say he did not find anything that could explain the crash.

An autopsy was undertaken on Ms Maslen's body and the blood taken from Mr Stanley was analysed.

As can be readily appreciated whenever a death is connected with police action it is essential that the matter be thoroughly investigated to allay any suspicions that inappropriate action by the officers may have contributed to the death. It is also desirable that the general public be fully apprised of the circumstances of the death so that they can be assured that the actions of the officers has been appropriately scrutinised. The police officers involved also have a right to have an independent assessment made of their actions so that there can in future be no suggestion that there has been any "cover up."

I am satisfied that this matter has been thoroughly and professionally investigated and all sources of information have been accessed and analysed. I commend those involved in the investigation.

The inquest

A pre-hearing conference was held in Brisbane on 28 July 2008. Mr Harper was appointed Counsel Assisting. Leave to appear was granted to the Commissioner of the Police Service, the two officers involved in the pursuit and the pursuit controller and the compulsory third party insurer of the stolen vehicle. Ms Maslen's family was of course advised of the inquest and her mother at one stage indicated an intention to appear but this did not eventuate. A list of witnesses was settled and the issues to be examined during the inquest was agreed upon.

On 25 August a view of the scene was conducted. The inquest then proceeded on 26 and 27 August. Nine witnesses gave evidence and 44 exhibits were tendered.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Social history

Samantha Maslen was born in Newcastle on 24 October 1979. Her parents are Lorraine King and David Maslen

She spent her primary school years in Anna Bay and Raymond Terrace in NSW.

Her mother made it known to the court that when she was 5, Samantha was sexually abused by a friend of her fathers. The offender was convicted at a trial at which Samantha gave evidence when she was 9. Her mother believes this had a lasting effect on her.

In 1989 Samantha moved to Maryborough with her mother following her parents separation. She completed primary school at Maryborough Central School.

She then attended Maryborough High School. Ms King's best recollection is that Samantha only completed 2 years of High School before leaving.

At the age of 12 or 13 Samantha began to suffer increasingly severe depression which was a significant factor in her leaving school.

The following years saw her moving between her mother's residence in Maryborough and her father's residences in New South Wales. She was obviously unsettled and rarely worked.

Ms Maslen had three children, Jennifer, David and Lorraine who are now 9, 8 and 4 respectively.

In the years leading up to her death Ms Maslen was residing next door to her mother in Maryborough.

Samantha's depression became more severe and her behaviour more erratic in early 2005. Over the subsequent months, help was sought from mental health services in Maryborough. She had been prescribed and was taking Valium and anti-depressants. She also used marijuana over an extended period.

Approximately three weeks before her death, her children had been sent to reside with Samantha's father in Coonabarabran, NSW.

Several weeks before her death Samantha's family sought to have her made subject to an involuntary treatment order but this was declined. She was

annoyed with her family for doing this and her mother believes she sent the children away as a type of ‘punishment’ to the rest of the family.

It is Ms King’s understanding that on the day of her death Samantha was on the way to Coonabarabran to pick the children up and return them to Maryborough as a ‘surprise’. Ms King was not aware Samantha had made any plans to travel and was advised of this subsequent to Samantha’s death by a family friend Samantha had confided in just prior to the trip.

Ms King believes that Samantha’s friendship with Leonard Stanley and Rohan Batchelor was part of her increasingly odd behaviour. She states that Samantha had taken to attending the local court and befriending youths, apparently out of some calling or sense of duty that she was to take them in and look after them. Consistent with this, Mr Stanley described her as his guardian. The nature of her relationship with the 15 year old Rohan Bachelor is unclear. Ms King, who has a son who is a police officer, was aware of the criminal backgrounds of the youths and found it hard to understand why Samantha was friends with them.

Ms King wishes her family’s consistent attempts to seek help for Samantha to be acknowledged and for it to be recorded that she was much loved and is much missed. She was known by family and friends as a very caring person, albeit also, sadly, as something of a “lost soul.”

Background to the pursuit

Leonard Stanley was 17 and a half at the time of Ms Maslen’s death. He had known her for about six months having been introduced by Rohan Bachelor who was then 15.

In the months before the crash, Leonard had been staying at Samantha’s house as a condition of his bail. Rohan was also in trouble with the law and indeed was in a youth detention centre until a few days before the fatal crash.

His release coincided with Ms Maslen deciding to go to Coonabarabran where her children were staying with their grandfather. Exactly what was planned is unclear as there is conflicting evidence as to whether Ms Maslen intended to stay there for an extended period or only collect her children and return to Maryborough.

In any event, she suggested to the two boys that they accompany her and that they steal a car for the journey. They did not take much persuading in this regard.

It seems this plan was hatched and executed on 4 June 2005. Late at night, somewhere around midnight or perhaps a little earlier, the two youths walked a block or so from Ms Maslen’s house and found a red, unlocked, 1987, Ford Falcon sedan in the backyard of its owner. Their experience in such things enabled them to quickly start the car and drive it to where Ms Maslen was waiting with bags packed.

The trio then set off for Coonabarabran some 900 kms away. It seems they stopped a couple of times for petrol in Gympie and Toowoomba. They all took turns at driving even though neither of the males had licenses. However, Mr Stanley did most of the driving, a worrying aspect of the jaunt in that he had not slept since rising at about 8.00am on 4 June. Neither of the youths knew the way; Ms Maslen directed them.

The trip was uneventful until they reached Yelarbon, about 510 kms south west of Maryborough, at about 8.00am on Sunday 5 June.

Events at the Spinifex Café

The stolen car with its three occupants pulled up at the petrol bowsers outside the Spinifex Café at Yelarbon. Mr Stanley stayed in the car and one of the others put $20 worth of petrol into the car. This was probably done by Ms Maslen as the shopkeeper, Carol Cox, only saw the driver and her. Rohan Bachelor was probably asleep on the back seat.

Ms Cox says she saw the car near the petrol bowsers but did not take much notice, as she was busy making up an order.

When Ms Maslen went into the café, Ms Cox noticed she was agitated and that she paced around. Ms Maslen attempted to pay for the fuel using an EFTPOS card but the transaction was declined. Ms Maslen told Ms Cox that she was going to get another card from the car, which Ms Cox noticed had by then driven a short distance away from the petrol pumps. Ms Cox watched Ms Maslen go to the car, get in the front passenger seat and then reach over to the back seat. She then saw the car drive out of the car park and head in the direction of Goondiwindi. As it drove off she wrote down the registration number.

Ms Cox says that she thought there was only one other person in the vehicle but her view was from a distance and obscured, so she could not comment on the gender or age of the other person.

She then telephoned the Warwick Police Station to report the theft. She told the officer she spoke to, Constable Colquhoun, what had happened and gave a description of Ms Maslen. She told the officer that the woman who had come into the cafe appeared to be about 25 years old. She told him she did not see the other occupant sufficiently to give any description of that person.

They come to the attention of police

Constable Colquhoun was on duty in the Warwick District radio room when he received the call from Ms Cox. His first response was to call Goondiwindi police on the police radio or phone. He spoke with Senior Constable Sheraton and it was agreed that this officer should immediately commence to patrol towards Yelarbon with a view to intercepting the red Falcon.

Constable Colquhoun then checked QPS data bases for information about the motor vehicle described by Ms Cox. At 8.10, he found an entry indicating it had been stolen from Maryborough overnight. He relayed this information to Senior Constable Sheraton. This broadcast was also heard by the officer in charge of the Goondiwindi traffic branch, Sergeant Kearney, who was on his way to work. He arrived at the station a few minutes later and he and Senior Constable Sheraton discussed how they should deal with the emergent incident.

Senior Constable Sheraton said in evidence at the inquest that he considered it likely the car would not stop when directed to and that a pursuit would eventuate.

Senior Constable Sheraton indicates *"it was established that I would immediately head out along the Cunningham Highway and look for the vehicle. Sgt. Kearney informed me that he had a set of stingers in the back of his vehicle and he would go out onto the highway and find an appropriate position to deploy the stingers in the event that I became involved in a pursuit."* Sgt Kearney also instructed Senior Constable Sheraton to take a set of tyre deflation devices in his vehicle in case the car turned around.

Officer Sheraton was questioned about whether any plan was discussed as to how he would approach the situation. His answer was *"he did say to me that he would, I can't remember exactly what he said, but I was under the impression he would stay closer to town and I would go out onto the highway to try to find this vehicle."*

Sgt Kearney told the investigators that he got Senior Constable Sheraton to take the stingers out with him:-

"because it was always my intention that he would be going out in front of me to attempt to intercept them, and that if they failed to stop and if they tried to turn and go back the other way, then that would of course put Dean in front of them and I would have been at the back and I could have been the pursuing vehicle from the rear and he would be in a position then to be able to deploy the stingers."

Both officers say that they believed the occupants of the car were all adults. This was based on Constable Colquhoun telling them this was most likely to be the case because the single occupant who had been seen, Ms Maslen, was estimated by Ms Cox to be 25. He reasoned that any other occupants in the vehicle would also be adults. Senior Constable Sheraton made the next leap of logic to conclude that any other occupants would be licensed drivers. As we now know they were wrong on both counts. They had no basis on which to make these assumptions.

The pursuit commences

Senior Constable Sheraton proceeded out along the Cunningham Highway towards Yelarbon. In his record of interview he indicated that he drove along

the highway for about 12 to 15 kilometres out of town when he saw the Falcon coming towards him.

He said when interviewed and in evidence that he did not think that the vehicle was then travelling at more than 100 km/h.

Senior Constable Sheraton stopped his vehicle in the left hand lane observing the on coming red Falcon.

After it passed, he then performed a U-turn, immediately activated the lights and siren and attempted to intercept the stolen vehicle.

"I travelled behind the stolen vehicle for approximately 20 seconds with the lights and siren on. At this stage I was approximately 30 metres behind the stolen vehicle. I confirmed the stolen vehicle registration number to be 073-BVU. The stolen vehicle accelerated to 125 km/h and then further accelerated to 130km/h. I formed the opinion that the stolen vehicle was not going to stop and was accelerating in an attempt to avoid police. I also formed the opinion that I was involved in a pursuit. I called the entire pursuit on the police radio."

He said in evidence that after he had confirmed the registration number he dropped back until he was about 80 metres behind the stolen car and maintained this distance throughout the pursuit.

When he gave evidence, Senior Constable Sheraton said he did not observe the occupants of the vehicle when it was coming towards him because he was intent on checking the registration number of the car. That would not explain why he did not see the driver when the two cars passed driver's side to driver's side and is inconsistent with his evidence that when he turned to pursue the vehicle he came up close behind it to check the registration number. I don't believe him. I think it more likely he is concerned about being criticised for failing to have regard to the youthful appearance of the 17 year old driver.

The pursuit controller's role

Constable Colquhoun was as result of his position in the radio room, now the "pursuit controller." He described his discharge of the duties thus incumbent upon him in this way:

I then heard another radio transmission from Constable Sheraton who stated that he was now in pursuit of the red Falcon and he then confirmed the registration number. I then asked Constable Sheraton to keep me informed of the location, speed and behaviour of the pursued vehicle. Constable Sheraton then called a pursuit for a period of four minutes."

During that time, I also made certain decisions as the pursuit controller. I was made aware that the greatest speed achieved was 130 kph on a straight piece of National Highway. I was also made aware that the pursued vehicle

was being driven in a steady and reasonable manner. I was also told that the traffic at that time, on that highway was very light and there were no vehicles travelling in front of the pursued vehicle. In light of those things I decided that it was not suitable to terminate the pursuit due to the following considerations. If at any time the pursuit had become dangerous, I would have had no hesitation in terminating it.

He said the factors which militated against his discontinuing the pursuit when the car did not stop were:-

- *The vehicle had been confirmed as stolen.*
- *The occupants of the vehicle were not likely to be juveniles.*
- *The identity of the occupants was at that time unknown.*
- *The public, police and vehicle occupants were not at any significant risk as a result of the pursuit as it was being relayed to me.*

Constable Colquhoun was also obliged by police policies to give approval before a tyre deflation device could be deployed. He can be heard on the recording of the police radio transmissions to do this after a fashion. However, in reality the decision was made by the far more senior man on the ground; Sergeant Kearney.

Disengaging from the pursuit

Sergeant Kearney monitored the progress of the pursuit on the police radio from his position 5 kms north east of Goondiwindi. He heard Senior Constable Sheraton describe their movement towards his position and before he saw the cars, he heard the siren from Senior Constable Sheraton's police vehicle.

The pursuit continued until Senior Constable Sheraton saw Sergeant Kearney on the road. He can be heard to say on the recording of the police radio broadcast that he is "*approaching Rick now*". He goes on to advise that he is "*backing right off so I don't get hit with the stingers*." He estimated his distance from Sergeant Kearney to be about 500 metres. He says that he reduced his speed to about 80km/h and that the distance between the two cars increased to about 200 metres.

Senior Constable Sheraton's stated reason for discontinuing the pursuit changes when he is interviewed later in the day. He then says; *"I dropped back, I didn't want to feel like I was pushing the vehicle so I dropped back for Sgt Kearney's safety to give the driver of the vehicle every opportunity to stop at Sgt Kearney's direction".*

He further states that *"I just pulled back so I could give the vehicle every opportunity to stop for Sgt. Kearney's safety."*

When giving evidence at the inquest he explained that one of the reasons he did not take this action earlier than when he saw Sgt Kearney was because although he knew the tyre deflation device was to be deployed at Brigalow Creek, he did not know exactly where that was.

That was news to Sgt Kearney who said in evidence that he was confident that Senior Constable Sheraton knew this landmark as a result of working in Goondiwindi for some time. I share Sergeant Kearney's scepticism of Senior Constable Sheraton's claimed ignorance. In my view it is more likely that the officers did not believe there was a need to discontinue the pursuit sooner and indeed their counsel submitted to that effect.

The crash

As the chase was getting closer to him, Sergeant Kearney unpacked the tyre deflation device and unwound the cord that he would use to pull it into place. He laid it on the north west side of the highway. When he heard the siren approaching, he walked across to the southbound lane and put the cord down on the verge. The stinger remained compacted on the verge on the other side of the road. He then stepped onto the roadway. As the red Falcon approached, Sgt Kearney held up his hand indicating for the vehicle to stop.

When he realised that the vehicle was not going to stop, he reached down, grabbed the cord and quickly pulled the tyre deflation device across the road. Various estimates have been given as to how far the car was from the officer when he commenced doing this but in evidence at the inquest he said 50 metres or a bit more.

The speed of the vehicle obviously made it seem much less to the driver; Leonard Stanley says that he only saw the device when he was 10 to 15 metres from it. In any event, all witnesses agree that when he was almost on Sergeant Kearney and apparently saw the device snaking across the road, Mr Stanley caused the car to swerve suddenly and severely to the right.

That didn't prevent it running over the tyre spikes, although both Mr Stanley and Sergeant Kearney agree that was the intention that motivated the action. Sgt Kearney described what happens next:-

> *I saw the red Falcon hit the stingers extremely fast, he was still travelling, I would say, definitely at 130 kilometres per hour, it happened extremely fast and his actions, again I reiterate, I considered to be extremely dangerous. The stingers flew up into the air. The driver appears to overcorrect the vehicle bringing it back to facing south. As he did that he got into an acute broadside, sliding just about perpendicular to the direction of travel and off the edge of the road onto the northern side and towards a gradual sloping off of the road way, created a lot of dust and after it had travelled some 30-40 metres like that it left the ground surface and started to somersault through the air. The vehicle came to rest upside down on its roof.*

Senior Constable Sheraton gave a similar account. He said:

> *The stolen vehicle was driving in a straight line however as the stolen vehicle was almost level with Sgt Kearney it swerved dangerously to the right. From my observations there was no reason for the stolen*

vehicle to swerve as I could see nothing in the path of the vehicle. The stolen vehicle swerved hard right and went across the other lane of the highway and off that side of the road. The stolen vehicle has then lost control on the shoulder of the road and has flipped about 4 or 5 times before coming to rest upside down off to the northern side of the highway.

The calls made to the emergency services allow me to conclude that the crash occurred at about 8.24am.

The aftermath

The first to arrive at the scene after the vehicle had come to rest was Paul Dreier, a local security officer who had gone to the location at which Sergeant Kearney was setting up the tyre deflation device after hearing the plan being discussed over the police radio.

Mr Dreier approached the stolen vehicle and observed:

'*a dark haired youth on the east side of the car in the front passenger seat tangled up with a dark haired girl who was bleeding from the mouth. I didn't realise for quite a few seconds that there was a blond haired youth in the rear of the vehicle who was semi-conscious.'*

Sergeant Kearney then arrived at his side and the two of them removed the driver from the vehicle. Mr Drier thinks that the backseat passenger made his own way out of the vehicle.

He says of Ms Maslen:

'*The girl was not touched as our initial assessment of her was that she was deceased. This was determined after a pulse was felt for with no result. I also observed her face go a purple colour.'*

Mr Dreier says that a short time later an ambulance arrived followed by the fire brigade.

Sergeant Kearney and Senior Constable Sheraton provide accounts largely consistent with Mr Drier's observations as do Leonard Stanley and Rohan Bachelor.

Sgt Kearney says that after removing the tyre spikes from the road, he drove the short distance to where the car had come to rest. He grabbed his fire extinguisher and put some powder on the engine bay where he thought smoke or steam was emerging from the vehicle.

Sgt Kearney then observed the occupants:

'I could see a male person lying out through the passenger window a little bit. I could also, on that front passenger seat, on that side, I could see that there

was a female still suspended in her seat belt there, and I was aware that there was a third person in the back of the vehicle.'

Sgt Kearney removed the driver from the front of the vehicle to a safe area. He then tried to get a response from Ms Maslen without success. Sgt Kearney released the seatbelt holding Maslen and eased her onto the inside roof of the vehicle. He checked for any sign of life, however, could not detect any.

While awaiting emergency services the two officers conducted breath tests on each other in the presence of Mr Drier with negative results.

The two males who had been in the crashed car were not seriously hurt and as there were concerns that they might run away or interfere both were handcuffed.

Paramedic Rodney Burke arrived at the scene at about 8:30am. Another paramedic Brett Schultz travelled to the scene in a separate vehicle. Mr Burke conducted a quick primary survey of Mr Stanley and Mr Batchelor before being directed by Sgt Kearney to Ms Maslen. He established:

> *…that she was pulseless, non breathing and unconscious. At this stage officer Schultz arrived and I directed him to get his Heart Start 4000 (defribillator) which he did. I then connected this to the female patient where it displayed a sinus bradychardia rhythm. I then auscultated for heart sounds and heard heart sounds that matched those displayed on the cardiac monitor.*

Sgt Kearney assisted the ambulance officer in extracting Ms Maslen from the vehicle and moving her into the ambulance. Mr Burke then attempted to mechanically clear Ms Maslen's airways and unsuccessfully to insert a laryngeal mask airway. He began to ventilate the patient using a bag valve mask. It was apparent to Mr Burke that Ms Maslen had suffered a

> …*massive head trauma, with a significant soft spot to the base of skull region, a fractured lower jaw and significant upper airway trauma causing a significant haemorrhage to her upper airway.*

The paramedics agreed between themselves that they would 'transport code 1' to the Goondiwindi hospital. The QAS vehicle was driven by a QFRS officer so the paramedics could concentrate on caring for Ms Maslen.

The hospital was notified during this time of Ms Maslen's injuries and her impending arrival. Mr Burke handed the care of Ms Maslen over to Dr Bethany O'Neil on arrival at the hospital and assisted her until Ms Maslen was pronounced dead at 9.06am '*as her injuries were incompatible with basic life function'*

The investigation commences

Senior police were immediately advised of the death and the investigation referred to earlier in these findings then proceeded.

The crashed car was examined by Anastasios Georgas, a licensed and experienced motor vehicle examiner. He observed that the vehicle was in an unsatisfactory mechanical condition due to warn steering components, but he is of the opinion that this would not have contributed to the accident.

He found four tyre deflation device tubes embedded in the left front tyre; three in the right front tyre; one on the left rear tyre and none in the right rear tyre.

Sergeant Darryl Morrison is a member of the Accident Investigation Squad with the Queensland Police Service. He attended the scene of the accident on the day of the accident, and subsequently prepared the forensic map. His evidence is:

The tyre marks located at the scene indicate to me that the vehicle was in a yaw situation. A yaw situation usually occurs when the driver of a vehicle attempts to take a curve too fast.

The yaw situation also applies to a vehicle travelling on a straight section of road and the driver swerves, using an excessive steering manoeuvre for the speed at which the vehicle is travelling."

Sgt Morrison said that the evidence supports a finding that the primary cause of the accident was the driver's conduct in veering the car quickly to the left at high speed. He readily conceded however, that violently steering to the right could have had the same effect and in view of Mr Stanley's evidence that that is what he did, I find that to be the most likely explanation for the car's trajectory.

The evidence of accident investigation experts is that the tyre deflation device did not contribute to the driver losing control of the car.[12] They explained that the devices have been tested under similar circumstances and found not to affect the handling of the vehicle. In part, this is due to the spikes allowing slow and controlled egress of air, nothing like a blow out.

A sample of blood was taken from Mr Stanley at the Goondiwindi Hospital. Analysis of it showed metabolites of cannabis. This was consistent with his admission to police that he had smoked marihuana the day before the crash. The medical evidence was that the drug would not have affected his ability to drive because its intoxicating effects would have worn off after a couple of hours.

Fingerprints were taken from Ms Maslen's body and used to confirm her identity.

[12] Statement of Inspector Turner

The autopsy examination

On 7 June 2005, an autopsy examination was conducted on the body of Samantha Maslen by Dr Guy Lampe, an experienced forensic pathologist. His report provides:-

> *The autopsy examination showed evidence of a minor head injury with extensive bruising around the scalp, an undisplaced fracture at the back of the right side of the skull, and some minor bleeding over the surface of the base of the brain. The major injury was to the neck, where there was a fracture/dislocation of the upper neck, associated with a stretching injury to the spinal cord at this level.*
>
> *In my opinion this lady has died as a result of the neck injury. These sorts of injuries usually clinically result in quadriplegia at the least. After an injury to the neck at this level, the only muscle that may be able to provide any form of ventilatory function would be the diaphragm, with the spinal cord injury preventing the other muscles of respiration from working. Death usually results from respiratory failure, due to the lack of adequate ventilation/respiration. The head injury may have been a contributory factor to her death.*

An analysis of her blood found no alcohol or other drugs.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where she died, what caused the death and how she came by his death. I have already dealt with this last issue, the manner and circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased – The deceased person was Samantha Anne Maslen

Place of death – She died at Goondiwindi, in Queensland

Date of death – Ms Maslen died on 5 June 2005

Cause of death – She died from neck injuries sustained in a car crash following a police pursuit.

Concerns, comments and recommendations

Section 46, in so far as is it relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

As counsel assisting mentioned at the opening of this inquest, Ms Maslen's death is one of seven that followed a police pursuit in the period June 2005 to December 2006. Inquests will be held in relation to each of the other deaths in coming months. In relation to each, the conduct of the officers involved will be judged against the QPS policies in force at the relevant time. However, as those policies have changed significantly during that period, I shall refrain from making any recommendations for further change until the evidence from all seven inquests has been considered and the impact of the changes are evaluated.

In these findings I shall summarise the relevant policies in force at the time, and assess whether they were complied with and consider whether they contributed to the fatal outcome.

QPS pursuit policy

The policies in place in June 2005, have been developed over a number of years and appears quite sophisticated. It has two layers of controls. It requires the officers undertaking the pursuit to apply a set of risk assessment criteria to determine whether a pursuit should be commenced and continued, and their actions are to be over viewed by another officer who is kept informed of developments via the police radio system and who has authority to direct the pursuers to terminate the pursuit. I will deal with the two components separately.

The obligations of the pursuing officers

In the part headed "*Justification for initiating or continuing a pursuit*" the policy stipulates that *"(t)he risks involved must be balanced against the necessity for the pursuit. Pursuits may be conducted only when;*

(i) the known circumstances are sufficient to justify a pursuit;
(ii) identifying or apprehending the occupant(s) of the pursued vehicle at a later time is unlikely.

The policy goes on to direct that "*a risk assessment must be conducted in relation to every pursuit. The following factors must form part of the assessment*:

(i) the safety of all persons, i.e. police officers, members of the public and offenders is paramount;
(ii) the known circumstances that initiated the pursuit;
(iii) the possible consequences;
(iv) the type of police vehicle
(v) whether the pursuing vehicle is marked and has flashing lights and siren fitted;
(vi) the manner in which the pursued vehicle has been driven including the speed of both vehicles;
(vii) *whether the driver and occupants(s) of the pursued vehicle have been identified or are likely to be able to be identified;*
(viii) *the known or suspected age of the driver and occupants of the pursued vehicle;*

(ix) any other relevant circumstances such as road, weather, visibility and other traffic conditions.

The standard risk management approach is continued by the direction that *(t)he reasons for and risks involved must be assessed before initiating the pursuit and be continually reassessed during the pursuit. The mandatory operating principle is "the safety of police, the public and the offenders or suspects is paramount". The pursuit must be abandoned if the risk outweighs the necessity for and known circumstances of the pursuit. …*

The policy then further provides at section 14.23.7 that "*A pursuit must be abandoned immediately it creates an unacceptable risk to the safety of any person."*

As can be seen, the policies required the pursuing officers to balance the utility of a pursuit against the risks it generates. The utility is gauged by considering the consequences of failing to intercept the pursued. In this balancing exercise issues of safety are to be paramount.

Quite specific and useful examples are given of characteristics which will be relevant to assessing the risk of the pursuit resulting in injury or death. No guidance is given to assist officers to calculate the necessity of the pursuit with reference to the diminution of law enforcement.

The responsibility of the "pursuit controller"

The driver of the pursuit vehicle is not the only officer who had a responsibility to undertake the risk assessment and balancing of likely outcomes that I have described. In recognition that junior officers caught up in a chase can have difficulty making objectively reasonable assessments, the QPS has in its procedures added a second layer of control that gives the primary responsibility for continuing a pursuit to the duty officer at the closest police communications centre. That officer is nominated as the "pursuit controller." In regional and remote centres that responsibility lies with "the officer in charge or shift supervisor of the relevant communications centre or station from which the radio operator is transmitting"

The policy provides that immediately an officer initiates a pursuit, the accompanying officer is to advise the police communications centre of this and communicate over the police radio the circumstances of the chase as they unfold. The communications centre advises the duty officer who then monitors the chase as it is described by the officer in the pursuing vehicle. The officers in the pursuing vehicle are obliged to comply with any directions given by this senior officer. The pursuit controller is obliged to undertake the same risk assessment and balancing of risk and utility I have already described and terminate the pursuit if he/she considers it poses an unacceptable risk to the safety of anyone who might be affected.

Tyre deflation devices

The policies in relation to the deployment of tyre deflation devices inter-relate with the pursuit policy. This interaction is a somewhat uneasy one, making compliance difficult.

Section 14.23.12 outlines the policy. Similar to the pursuit policy, final authorisation for deployment of a TDD is the responsibility of the pursuit controller.

Relevant aspects of that policy are outlined below:-

> *Tyre deflation devices (TDDs) are designed to terminate pursuits with minimum injury to all participants and damage to surrounding property. TDD are deployed by being placed across the road in front of the vehicle being pursued."*
>
> *Where authority is given to deploy a TDD the deployment officer is to:-*
>
> *(i) Select a suitable site for the deployment of the TDD, having regard to the relevant circumstances of the pursuit and safety considerations concerning the potential location.*
> *(ii) Communicate the exact location of the deployment site to the radio operator or the reason why a suitable site could not be found;*
> *(iii) Monitor progress of the pursuit on the police radio network;*
> *(iv) Ensure no pedestrians are near the deployment site*
> *(v) Refrain from deploying the device if (a) personal or public safety is compromised; or (b) the authority to deploy the TDD is revoked by either the pursuit controller or the regional duty officer;*
> *(vi) Deploy the TDD in accordance with the instructions and tactics provided in the Good Practice Guide"*
>
> *Where authority has been given to deploy the TDD, the primary unit is to:-*
>
> *(i) maintain radio contact to ensure that authorisation to deploy a TDD has been given by the pursuit controller and that the exact location of the employment site is identified;*
> *(ii) reduce speed when approaching the deployment site and remain a minimum of five seconds behind the pursued vehicle to prevent the police vehicle engaging the TDD. Distance between the pursued vehicle and the pursuit vehicle may need to be increased due to other circumstances including speed, road and weather conditions;*
> *(iii) where practicable, intercept the pursued vehicle after engagement with the TDD.*
>
> *"Where authority has been given to deploy a TDD, the regional duty officer is to:*
> *(iv) monitor the pursuit and if of the opinion that it is in the greater interest and safety of the public, terminate the pursuit pursuant to s.*

14.23.7 "Abandoning a pursuit" of this chapter, and/ or rescind authorisation for the TDD deployment."

The wording of the TDD policy as it stood at the relevant time seemed to be premised on the basis that a pursuit is already on foot, and that the decision in relation to deploying the TDD was necessary to end that pursuit**.**

Compliance with the pursuit and TDD policies in this case

The officers involved in this pursuit had the opportunity to consider their options and assess likely risks. When they were first notified of the incident, the car was some 50 kms away. They were not confronted with some extreme emergency that required an instant response. It is true that decisions needed to be made quickly, but when the policy (and commonsense) required a risk assessment to be done before conducting the pursuit there is no justification for it not being done.

Mr Braithwaite, on behalf of the officers, submits that the risk assessment could be conducted perhaps "in their own minds" or during the conversation captured on the radio when the pursuit was underway.

In my view the police did not perform a risk assessment, at least not in the terms the policy required. They had regard to factors which they rightly considered reduced the risk: matters such as the light traffic flow, the good road conditions, the appropriateness of the pursuing vehicle and the stable driving of the pursued vehicle.

However, they ignored others such as the likelihood that the pursued driver might take dangerous evasive action if the tyre deflation devise was pulled in front of him suddenly when he was travelling at high speed. This was induced perhaps by their falsely assuming that the driver was an adult, licensed, competent driver when they knew nothing about him. Risk assessment does not involve making the best case supposition when nothing is known about the risk factor under consideration.

In addition to underestimating the risks, the officers, in my view, over estimated the necessity for the pursuit and seem to have had no regard to other means of apprehending the offenders at another time.

It is difficult to conclude that safety was the paramount consideration in assessing options. I accept that the officers did not act recklessly or carelessly. However they gave scant regard to determining where the balance lay between the necessity to pursue and the risk associated with it. They were determined to pursue and use the stingers, albeit in a situation they considered relatively safe. They took this approach because they seem to have elevated the need for immediate apprehension. While not down-playing the problem of vehicle theft, these offenders had stolen an old car of limited value and some petrol. There was no evidence of any other offending behaviour. They did not represent a danger to the public at large. There was no need to intercept them immediately. The offences which they had

committed could have been investigated and pursued through normal policing methods when they were inevitably apprehended at some point in their road trip or abandoned the car when it ran out of petrol.

Counsel for the Commissioner submitted that they were entitled to consider the possibility that the trio might have crashed into other motorists further down the highway. With all due respect, not only is this line of "reasoning" inconsistent with the policy which requires officers to only have regard to the "*known circumstances that initiated the pursuit*" when deciding to continue, it is contrary to the evidence of what had in fact occurred: they had driven 500kms without incident and they were driving at or below the speed limit in a stable manner when the pursuit commenced.

I also question whether the officers complied with the terms of the TDD policy. For example, it requires the exact location of the deployment to be known by all involved. As mentioned Senior Constable Sheraton claimed not to know this and cited it as a reason he continued to pursue until the location was in sight. Further, the policy provides the distance between the pursued vehicle and the pursuing vehicle may need to be increased due to circumstances such as speed. In this case the pursued vehicle was closely followed to close proximity of the stinger deployment sight while travelling at 130 kms/hr. The overriding and "paramount" concern for safety of all of those involved received too little weight in assessing the options in this case.

Sergeant Kearney formed the view that the site which he had identified was a safe one and complied with good practice guidelines. The safety issues arising in the event that the driver were to attempt to evade the TDD at high speed do not appear to have been given sufficient weight.

It is clear that the combination of speed and the sharp steering motion created a situation dangerous to the occupants and to Sergeant Kearney. It was undertaken in response to the sudden deployment of the stingers when the driver had little opportunity to react.

This was done because apprehending the offenders was given greater emphasis than safety. Sgt Kearney chose not to lay out the tyre spikes sooner because that increased the likelihood of the stolen car driving safely around them and carrying on its way.

It is of concern that the terms of tyre deflation device policy seem to authorise the strategy adopted.

The clear implication from Sergeant Morrison's evidence is that as soon as Mr Stanley decided to try and go around the stinger by swerving the situation became exceedingly dangerous. The vehicle could just as easily have veered violently to the left, perhaps colliding with Sergeant Kearney in the process.

Conclusions

The officers involved in the pursuit believed they were acting appropriately and attempted to adhere to the relevant policies. However, the matter should have been handled differently which may have led to a better outcome.

Chasing a car being driven at 130 km/hr by a driver of unknown age and experience, with a view to pulling tyre spikes across his path at the last possible moment, involved a level of risk not justified by the purposes for which it was done. When the driver turned out to be an unlicensed, fatigued and panicked 17 year old, it is not surprising disaster followed.

The situation arose because the officers involved did not have sufficient regard to all the known safety risks and inflated the significance of the law enforcement objectives of the pursuit. The policies then in place gave them insufficient guidance as to how they should attempt to balance these competing objectives.

Policy issues for future consideration

At the completion of the further six inquests connected to police pursuits I will address some of the policy issues.

Arising from the evidence at this inquest, the issue of training of pursuit controllers has been raised, and warrants further evidence and consideration.

Similarly the policies surrounding the use of TDDs give rise, at least on first consideration, to some concerns, particularly in relation to the safety of officers deploying them, and potentially other members of the public. I acknowledge that this observation is based upon the limited information arising in this inquest, and I express no opinion other than that it warrants further consideration.

This inquest is closed.

Michael Barnes
State Coroner
Goondiwindi
28 August 2008