OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Barry William Cavanagh**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/3707
DELIVERED ON:	01 November 2012
DELIVERED AT:	Atherton
HEARING DATE(s):	13 September 2012, 31 October – 1 November 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Police pursuit.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Mr & Mrs Cavanagh:	Mr Josh Trevino (instructed by Legal Aid Queensland)
JoAnne Cavanagh:	Mr Wayne Pennell (instructed by Rapid Legal Solutions)…..
William Shaw and Sergeant Michael Musumeci:	Mr Steve Zillman (instructed by Gilshenan & Luton Legal Group)
QPS Commissioner:	Mr Wayne Kelly

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The *Coroners Act 2003* (the Act) provides in s. 47 that when an inquest is held into a death that happened in the course of or as a result of police operations, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system including the Attorney-General and the Minister for Police, Corrective Services and Emergency Services. These are my findings in relation to the death of Barry William Cavanagh. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

On the evening of 29 October 2010, Barry Cavanagh stopped at the Club Hotel in Ravenshoe where he had eight glasses of beer. Shortly after leaving he was pulled over by two police officers for disobeying a stop sign and was found to have a high blood alcohol level. He was charged and released at about 1.30am. Although banned from driving for 24 hours Mr Cavanagh returned to his vehicle and drove south on the Kennedy Highway, towards his parents house.

At about 2.00am, the same police officers who had intercepted Mr Cavanagh earlier were patrolling the Kennedy Highway between Ravenshoe and Innot Hot Springs heading north. They were passed by a car travelling at high speed in the opposite direction. They set off after it but soon lost contact. Arriving in the town of Innot Hot Springs they saw debris and then the badly damaged vehicle of Mr Cavanagh upside down in a ditch by the side of the road. On gaining access to the vehicle the officers found Mr Cavanagh suspended upside down and believed he had broken his neck. They could not detect a pulse and waited for an ambulance to arrive. A post-mortem examination later revealed no fractures but showed Mr Cavanagh had been asphyxiated due to the inhalation of blood.

These findings:-

- establish the circumstances in which the fatal injuries were sustained;
- confirm the identity of the deceased person, the time, place and medical cause of his death;
- consider whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force; and
- consider whether the officers involved should have extracted Mr Cavanagh from the car or otherwise provided to him first aid.

The investigation

The coronial investigation was conducted by the QPS Ethical Standards Command (ESC) and a detailed report was prepared by Senior Sergeant David Cousins. The other ESC officer involved in the investigation was Inspector Roger Lowe. He gave oral evidence at the inquest.

The initial management of the scene was conducted by the acting district officer, Inspector Kroon, in consultation with the ESC officers. An officer from the Cairns forensic crash unit, independent of the Mareeba District in which the crash occurred, was sent to conduct the collision analysis. A scenes of crime officer attended and took a number of photographs which were tendered at the inquest. The officers involved in the incident were breath tested within an hour and this was witnessed by the Queensland Ambulance Service (QAS) paramedic at the scene. The officers were required to provide a urine sample later that day.

Officers from Mareeba CIB spoke to local residents and took initial versions of what they had seen and heard at the relevant time. Those who had witnessed the crash or its aftermath were later interviewed by the ESC investigators. Two attended the inquest to provide oral evidence.

The ESC investigators arrived in Cairns on the afternoon of 30 October 2010 and spent the evening conducting interviews with various police officers involved. They attended the scene the following day and conducted a videotaped re-enactment of events with the driver of the police vehicle.

A post mortem examination took place on 2 November 2010 and the findings of the pathologist made it clear the actions of the police immediately post-crash could be of significance. Another interview was conducted with each of the police involved in order to obtain further detail of their assessment of Mr Cavanagh and the basis of their decision not to extract him from the vehicle.

The vehicle driven by Mr Cavanagh was inspected by a QPS mechanic. Investigators seized communication tapes of police radio transmissions as well as job log records and notebook entries from the officers involved. They obtained call charge records for all telephones involved including the public telephone near the scene of the crash.

I am satisfied that all relevant sources of information have been accessed and the results effectively collated. I thank Inspector Lowe and Senior Sergeant Cousins for their efforts, but express my disappointment that the report was not received until 21 months after the incident.

The inquest

A pre-inquest conference was held in Brisbane on 13 September 2012. Mr Johns was appointed counsel assisting and leave to appear was granted to the parents and partner of the deceased, the Commissioner of the QPS, and the officers involved in the incident. The inquest was held in Atherton on 31 October and 1 November 2012. A view was conducted of the incident site.

One hundred and three exhibits were tendered and eight witnesses gave evidence.

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 and background

Barry William Cavanagh was born on 30 March 1980 meaning he was 30 years of age when he died. At this time he was residing at a hotel in Townsville having separated from his wife Jo-Anne in 2009. Although he had previously worked in the mining industry, his marriage breakdown, mental health problems and associated heavy drinking had contributed, in part, to his being unemployed. In addition to his parents and wife, Mr Cavanagh is survived by his then four year old son, Ethan. It is clear his sudden death has had a devastating effect on his immediate family and I offer them my sincere condolences.

In the days prior to his death, Mr Cavanagh had purchased a 1998 silver Holden Calais sedan from a private seller in Townsville. A roadworthy inspection at the time of sale revealed a number of faults that were rectified prior to completion of the sale.

At around 6:30pm on 29 October 2010 Mr Cavanagh left Townsville having arranged to visit his parents. They lived on a property on the Kennedy Highway, near the Wild River, several kilometres to the north of the small town of Innot Hot Springs. This was to have been Mr Cavanagh's first visit to that property.

It is evident from eye-witness accounts and CCTV footage that at 10:15pm Mr Cavanagh entered the Club Hotel in Ravenshoe, a town to the north of Innot Hot Springs and his parents residence. Over the following 2 hours 15 minutes he drank eight glasses of beer although it is not clear what size they were or what alcohol content they contained. At 12:30am on 30 October 2010 Mr Cavanagh left the hotel, got into his car and drove away on the wrong side of the road.

Intercept in Ravenshoe

Sergeant Michael Musumeci and Constable William Shaw were stationed at Ravenshoe police station and had commenced their eight hour shift at 8.00pm on the evening of 29 October 2010.

They were patrolling through the town in a marked Toyota Prado police vehicle when, at 12:37am and only a short distance from the Club Hotel, they observed Mr Cavanagh's vehicle proceed through a stop sign without coming to a halt. Mr Cavanagh obeyed their direction to pull over. He immediately admitted having failed to stop, telling police he had thought the sign in

question was a ‘give way’ sign. As is standard in such situations he was breath tested and returned a reading of 0.89%.

After safely parking the silver Calais, the police officers transported Mr Cavanagh to Ravenshoe police station where he was breath tested again and on this occasion recorded a blood alcohol content of 0.79%. As a result he was served with a notice to appear in court and a notice of suspension of his driver’s licence. This was operable for 24 hours commencing 12:56am on 30 October 2010.

Sergeant Musumeci told the inquest that while he was arranging this paperwork Mr Cavanagh was appropriately conversant and polite. It was apparent that Mr Cavanagh was having difficulty obtaining reception with his mobile telephone and Sergeant Musumeci offered use of the police station land-line to make a call. Mr Cavanagh had already told the officers he was intending to visit his parents at their residence near the Wild River. He told Sergeant Musumeci his parents’ telephone number.

After calling this number Sergeant Musumeci says he heard a ring tone but there was no answer. He also says that a short time later Mr Cavanagh was issued with a fine for his failure to obey a stop sign and, for the first time, became annoyed and then increasingly antagonistic. Sergeant Musumeci told the inquest that after failing to make contact with his parents Mr Cavanagh told him that he would ‘sort himself out’ with regards to accommodation and his subsequent movements. It was acknowledged at the inquest that there were limited if any options for accommodation in Ravenshoe at this hour of the morning. Sergeant Musumeci took the view that, by the latter part of their dealings, it was best to finalise matters as soon as possible due to Mr Cavanagh’s increasing annoyance. Mr Shaw (he has since left the QPS) told the inquest that Sergeant Musumeci had intended to drive Mr Cavanagh to his parents’ house but changed his mind when the other man became rude.

As he was seeing Mr Cavanagh out of the police station, Sergeant Musumeci said he warned him not to drive during the 24 hour suspension. He said Mr Cavanagh acknowledged this warning. Records indicate he left the station at about 1.30am.

The officers had a cigarette and planned what they would then do for the next part of their shift. They then resumed patrol, travelling south on the Kennedy Highway. On their way they drove past the silver Calais of Mr Cavanagh and, using their spotlight, satisfied themselves no one was inside.

The attempted intercept

The officers performed two random breath tests over the following half hour. A short time after the second of these, at around 2.00am, Sergeant Musumeci was driving the police Prado north along the highway towards Ravenshoe. He and Constable Shaw observed the lights of a vehicle travelling in the opposite direction as they negotiated a rise just to the north of the Wild River camping ground. It was immediately clear to them that the vehicle was travelling at excessive speed. Their mobile radar failed to take a reading of the oncoming

vehicle but both officers said it was travelling at about 140km/h as it passed their 4WD. Neither could see the number plate and Sergeant Musumeci believed the vehicle to have been a blue roof-less sports car.

Sergeant Musumeci slowed his vehicle, did a three point turn, activated the red and blue rotating lights on the roof of the police vehicle and set off south after the speeding car.

He told the inquest he intended to try to obtain a follow speed on the vehicle and then attempt to intercept it. After accelerating up to, perhaps, 120km/h and travelling several hundred metres the officers negotiated a downhill bend giving them a clear view of the road ahead for a considerable distance. When interviewed, Sergeant Musumeci said that when he reached this point he was surprised to see no vehicle lights ahead. At the inquest he said that he saw brake lights in the distance for a brief moment before they were obscured. If that was so it was the last time he saw the vehicle ahead moving. Mr Shaw said when interviewed and at the inquest that they did not sight the speeding vehicle at any time after it went past them.

Over the following 4 -5 kilometres the officers checked side roads for any sign that the vehicle they were attempting to intercept had travelled off the highway. Sergeant Musumeci said in his evidence that this was an occurrence he had experienced previously with drink drivers. This meant that his speed varied as he slowed near intersections and then resumed at full speed. On the basis of his statements to investigators and at the inquest, and the circumstances he was in, I expect that full speed was likely towards the high end of Sergeant Musumeci's estimated range of 100-120km/h.

After 4-5 kilometres Sergeant Musumeci switched off the rotating coloured lights and, a short time later at 2:03am, contacted Mareeba Communications by radio. A recording of that transmission was heard at the inquest. In it Sergeant Musumeci says a vehicle had "*driven past at 140 plus at least"*. The communications operator is heard to seek and obtain confirmation that there is no pursuit on foot. Sergeant Musumeci told the operator that he had *"nah, we have definitely lost vehicle*" and described it as a *"small sports car*". He requested the Mount Garnett police crew which had finished their shift at 2.00am be contacted to assist. This was refused by the communications operator on the basis that the vehicle would be "*long gone*" before that could be arranged.

Sergeant Musumeci was not inclined to accept that refusal and asked Constable Shaw to contact those officers directly by mobile telephone. This was unsuccessful. When asked why such efforts would be made for what, at that stage, was merely a speeding offence, Sergeant Musumeci told the inquest that the extreme speed of the vehicle led him to believe that a more serious offence may have been committed. He agreed though, that there was no basis on which suspicion of a separate offence could have been used to have justified any aspect of the attempted intercept and said that this was based solely on the observed speed.

The crash

It is almost certain the speeding vehicle observed by officers Musumeci and Shaw was in fact the silver Calais driven by Mr Cavanagh, which means he drove right by his parent's property without stopping. The reason why he did this will likely never be known but it is clear it happened because several minutes after he had passed the police Prado he lost control of his Calais on a sharp right hand, downhill bend on the edge of the township of Innot Hot Springs. The loss of control resulted in the Calais over-steering and travelling off the right hand side of the sealed bitumen. As it struck the uneven terrain it rolled and came to rest on its roof with Mr Cavanagh still restrained by his seatbelt and suspended upside down.

The inquest heard from two witnesses who were awake at the time of this crash. Susan Stacpoole was in a house across the road and less than 50 metres from where the Calais came to rest. She described hearing a noise which sounded like wheelie bins being struck and knocked over. The noise caused her husband to wake and she then ran to the front of her house to see what had happened.

Michael Grkovic was several hundred metres from the scene of the crash and out of the line of sight. He recalls hearing the revving of an engine which was slightly louder than he would have expected for that stretch of road. He then heard the scraping sound of tyres sliding on gravel before louder noises that clearly signalled to him, and apparently some others in the house, that a vehicle had crashed. After 30 seconds or so he and others from the house set off on foot towards the highway to see what had happened.

A resident at a third location, Brian Newton, was woken by "*four loud bangs*". The resident of the house closest to the scene of the crash was spoken to by police but was not woken by the crash.

Aftermath

Sergeant Musumeci continued driving along the Kennedy Highway until he reached Innot Hot Spring. As they took the right hand corner into town he and Constable Shaw saw debris across the road and then saw a badly damaged vehicle upside down in the drainage ditch to their right. Sergeant Musumeci drove past, performed a U-turn and then parked next to the wrecked car using the left hand side light to illuminate the scene. He also illuminated the rotating roof lights.

Mrs Stacpoole could see nothing of significance when she first lookout out of a front window in her house. After moving to a window on the other side, she lookout out to see a police vehicle with its emergency lights flashing and in the process of performing a U-turn. She saw the police vehicle drive a short distance before coming to a stop. She has clearly given significant thought to the timing of her movements and I believe that her estimate of 1 to 1 ½ minutes being the interval between first hearing the crash and seeing the police car is reliable.

Mr Grkovic has consistently estimated in his account to police and again at the inquest that it was around three minutes between when he heard the crash and when he first saw the police car. At this time the police car was stationary and had its emergency lights activated. Consistent with the accounts of both officers in the police vehicle, there is no evidence that the siren on the police vehicle was ever activated.

On arrival Constable Shaw contacted Mareeba Communications by radio to tell them:

> *We've got a motor vehicle accident we've come across….need an ambulance here ASAP, just checking now if we can locate anybody. It's a bad one, it's a rollover.*

That radio communication occurred at 2:08am and although heard by the Mareeba communication centre, their reply was not heard by the officers who concluded they were in a radio "black spot". He then joined Sergeant Musumeci who, after stopping, had immediately approached the upside down vehicle and made attempts to gain access via the badly damaged doors. He and Constable Shaw had great difficulty with this task, with Sergeant Musumeci even attempting to prise open the crushed metal with his torch.

At an early stage after their arrival Constable Shaw saw the "*Calais*" insignia on the vehicle and it became apparent to him that the vehicle was that of Mr Cavanagh. He told this to an at first unbelieving and then distressed Sergeant Musumeci. Sergeant Musumeci's initial impression of his observations of the driver from outside the vehicle was that, the person he now knew to be Mr Cavanagh, had been decapitated. One of the officers was heard saying words to the effect of "*Can you hear me Barry?*". This was heard by Mrs Stacpoole who was continuing to watch events from the front of her house.

Still unsuccessful at gaining entry Sergeant Musumeci left this task to Constable Shaw while he ran to the other side of the road where he had spotted a public telephone box. There, at 2:12am, he made the first of two "000" calls to Mareeba communications. It seems to have been unclear to him whether any request for help had been made and he told the inquest he wanted to ensure the request got through in an area with poor mobile telephone and radio coverage.

It transpires the QAS had already been contacted within seconds of the radio call from Constable Shaw at 2:08am. It must have been clear to Sergeant Musumeci by the time of this first "000" call that the driver was in fact Mr Cavanagh because he told the communications officer that the driver of the crashed vehicle was the "*drink driver we caught*". He also said of the driver in this call: "*Mate he's gone, he's, he's deceased*". Sergeant Musumeci asked for help to be sent urgently.

While Sergeant Musumeci was in the telephone box Constable Shaw managed to gain access to the vehicle. Constable Shaw told investigators that prior to joining the QPS he had spent two years at nursing school and then

maintained his first aid qualifications over the ensuing 20 years. This included battle medic training during a stint in the military. Once he could access Mr Cavanagh, Constable Shaw says he checked for a pulse and checked for signs of breathing. Both were absent. He observed Mr Cavanagh's lips to be blue and felt his hand was abnormally cold. Most strikingly he saw that Mr Cavanagh's head was bent on what he considered an unnatural angle to the side. Constable Shaw formed the view that Mr Cavanagh had likely broken his neck and was dead.

Constable Shaw told Sergeant Musumeci on his return from the phone box that Mr Cavanagh was "*gone*". Sergeant Musumeci then entered the vehicle to check himself. His initial impression from his angle of approach was that Mr Cavanagh had been decapitated. On closer inspection it was clear that this was not the case but he also formed the view that Mr Cavanagh's neck was broken. He also felt for a pulse without finding one.

At the inquest both officers stated they had serious concerns about their safety due to the strong smell of petrol and some smoke coming from the front of the vehicle. Sergeant Musumeci says he believed the vehicle might explode. He said he considered whether they should cut the seatbelt and attempt to release Mr Cavanagh but was concerned that they would not be able to stop the large man falling placing greater force on his injured neck. Mr Shaw said this was not considered by him as he believed the driver was dead and he wanted to get away from the car as quickly as possible.

The officers moved away from the vehicle. At 2:21am Sergeant Musumeci again called "000" from the public phone box. This was primarily and properly to highlight the need for involvement of specialist police and the ESC given the circumstances of the death.

In that call Sergeant Musumeci told the communications officer that the "*ambos have arrived*" although the QAS records show an "arrival at patient" time of 2:25am. The QAS paramedic sent to the scene was Mount Garnet based officer, David Lee. He received a message in transit advising him that the driver of the crashed vehicle was believed to be deceased. He spoke briefly to the police officers when he arrived who confirmed this view. Mr Lee says he was not given any warning about the possibility of the vehicle exploding. Sergeant Musumeci told the inquest that by this time the smoke had abated and he no longer held fears in relation to the stability of the vehicle.

On approaching the Calais Mr Lee could clearly smell fuel. He conducted some initial observations of Mr Cavanagh before returning to his vehicle to obtain a stethoscope. He says that in such a situation he would normally attach a defibrillator to obtain an electronic assessment of the patient's vital signs. He explained that he was trained not to use such electronic equipment in circumstances where there was spilt fuel and so he did not do so here. After making his assessment Mr Lee issued a formal declaration that Mr Cavanagh was deceased at 2:28am. He made the following note in the QAS records:

> *On assessment I found no palpable pulse – carotid or radial, no respirations, no breath sounds, no response/unconscious, fixed and dilated pupils. Head and neck of pt angulated/deformed at unusual angle (high speed RTA – rollover).*

When he was interviewed by ESC officers on 31 October 2010 (importantly, prior to the post mortem examination) he told them:

> *…and, the way his head positioned I, I had no doubt that he's broken his neck.*

Although it seems that the two officers involved had a brief opportunity to speak to each other about the events leading to Mr Cavanagh's death they were separated at an appropriately early time. They were clearly both very upset at what had occurred and there is no suggestion of collusion.

The autopsy

A post-mortem examination was conducted on the body of Mr Cavanagh at the Cairns Base Hospital mortuary on the evening of 2 November 2010 by an experienced forensic pathologist, Professor David Williams.

Professor Williams found no bone fractures. He told the inquest that extensive bruising and external injuries to the head would likely have resulted in significant blood flow in and around the mouth. In his detailed autopsy report which was tendered at the inquest, Professor Williams stated the following with respect to Mr Cavanagh's respiratory system:

> *The strap muscles of the neck are free of bruising. The laryngeal skeleton is intact. The larynx, trachea and bronchi contain frothy material and the lungs are bilaterally heavy, dense and purple in colour. Each weighs 750gm and each lung has dilated lymphatics visible on the visceral pleura, especially to the left lung. These petechial haemorrhages are similar to those seen over the skin externally. The left lung also has an area where there is frank haemorrhage into the lung and both lungs appear severely congested and there is an impression that there has been, at some stage, aspiration of blood.*

At the time of writing his report Professor Williams was unaware of the positioning of Mr Cavanagh's neck during the period following the crash. He agreed with counsel assisting that it was possible for the neck to be positioned so as to restrict the airway without there necessarily being pathological evidence of this at autopsy. He agreed that an abnormal or unnatural positioning of the neck during the initial minutes after the crash could have contributed to the asphyxia in addition to the aspiration of blood.

He told the inquest that it was possible for Mr Cavanagh to have survived for up to eight minutes after sustaining the injuries observed at autopsy. He acknowledged that other experts consider the maximum time period to be closer to 4 or 5 minutes. When asked later for the likely range of possible survival time for Mr Cavanagh he stated "…*three to eight minutes*". He also

noted, however, that by even an early stage Mr Cavanagh is likely to have inhaled blood. The extent to which that could be rectified or overcome is more properly a question for an expert in emergency medicine such as Dr Stephen Rashford who also gave evidence at the inquest. That issue is addressed later in these findings.

Blood and urine samples taken at autopsy were subject to toxicological screening. This revealed the presence of alcohol at a level of 51mg/100mL in the blood and 97mg/100mL in the urine. Therapeutic levels of prescribed drugs were also present.

Professor Williams, having considered the facts as set out by police on the Form 1 issued an autopsy certificate listing the direct and antecedent cause of death as:

(a) Postural asphyxia and inhalation of blood; *due to or as a consequence of*
(b) Motor vehicle accident (driver).

The investigation findings

A forensic crash investigation conducted by Sergeant John Fisher of the Cairns Forensic Crash Unit concluded that Mr Cavanagh lost control of his vehicle while approaching the right hand turn on the Kennedy Highway just north of Innot Hot Springs. Tyre marks on the roadway were attributed to the Calais and lead off the highway and into the grass and dirt on the right hand side (as per Mr Cavanagh's direction of travel). At a point 49 metres after the commencement of the tyre marks it is evident that the vehicle has 'tripped' and commenced to roll ultimately coming to rest upside down a further 48 metres away. Sergeant Fisher calculated that the vehicle was travelling at a minimum speed of between 96 and 109km/h at the point Mr Cavanagh lost control.

The breath and urine samples taken from the two police officers involved showed that they had no alcohol or drugs in their systems.

Measurements taken in the days following the crash established that the distance between the point where Mr Cavanagh passed the officers while travelling in excess of 140km/h and the position where his car came to rest was 14.1km. It is not possible to compare this to any independently recorded time.

Dr Stephen Rashford is the medical director of the QAS and an eminent expert in emergency and pre-hospital medicine. He was asked by counsel assisting to consider aspects of the events leading to Mr Cavanagh's death. In particular he was asked to assess the information contained in the autopsy report and the accounts of Mr Cavanagh's presentation in the minutes after the crash. He pointed out that as Mr Cavanagh had been suspended upside down it is unlikely any significant quantity of blood would occlude or pool in his upper airway such as to result in aspiration.

Findings required by s45

I am required to find, as far as is possible, who the deceased person was, how he died, when and where he died and what caused the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, the material parts of which I have summarised above, I am able to make the following findings.

Identity of the deceased - The deceased person was Barry William Cavanagh.

How he died - He died as a result of injuries sustained when he lost control of his vehicle resulting in it leaving the roadway, rolling and leaving him suspended upside down.

Place of death - He died at Innot Hot Springs in Queensland.

Date of death - He died on 30 October 2010.

Cause of death - He died as a result of positional asphyxia.

Concerns, comments and recommendations

Section 46, in so far as it is 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.

There are matters arising from the facts of this inquest which require consideration from this perspective as follows:

- whether the officers who charged Mr Cavanagh acted appropriately when they released him;
- whether those officers engaged in a pursuit of Mr Cavanagh contrary to the relevant QPS policies; and, if not, the appropriateness or otherwise, of their driving; and
- the adequacy of the officers' response to Mr Cavanagh's situation after he crashed.

Assistance at the station

Mr Cavanagh's family wish the officers had driven Mr Cavanagh to his parents' home after he was charged with drink driving, rather than allowing him to go off with the car keys in his possession. I expect the officers also wish that had occurred. It is easy to have sympathy with that view but it is a different matter to criticise the officers for not ensuring it happened.

It was put to Sergeant Musumeci that a section of the QPS Operational Procedures Manual (OPM) titled "*Rendering assistance to stranded motorists*

and passengers" was applicable to this situation. Sergeant Musumeci told the inquest that he considered the policy only to applied to situations where passengers of a vehicle were left stranded due to the driver being detained. He and Constable Shaw both told the inquest they had often applied the policy to such situations.

However, the policy is arguably drafted in a way that could mean it is applicable to the circumstances of this case. It requires that where enforcement action has resulted in a person being left without transport officers are to offer assistance to ensure the person is transported to his/her destination *"or a place of safety"*.

Obviously the characteristics of a person will be relevant to determining what is required to discharge this requirement. For example, in my view it would be unsafe to leave a 9 year old girl from Brisbane on the streets of Ravenshoe at 1.30am in the morning, whereas to do the same thing to a 30 year old male local resident would probably be quite acceptable.

In this case it was suggested that when deciding what assistance to offer, the officers ought to have been more cognisant of Mr Cavanagh's mental health history which he had disclosed. However, they were also aware he had travelled by himself from Townsville, was able to communicate effectively and was clearly a functioning member of the community. There is no suggestion he was floridly psychotic or morbidly depressed. It was suggested by Constable Shaw that Mr Cavanagh's belligerence appeared to result in Sergeant Musumeci taking a less charitable approach to assisting him. However, I accept the submission that Sergeant Musumeci used the station phone to attempt to contact Mr Cavanagh's parents after Mr Cavanagh's demeanour had become hostile.

It seems to me Mr Cavanagh become increasingly annoyed at his predicament and chose to go off by himself, albeit, there was no offer to transport him anywhere. However, in the circumstances, I am of the view there was no obligation on the officers to do more than they had already done.

There was some interchange near the conclusion of the proceedings about the wisdom of drink drivers being given their car keys after they have been charged and released. I accept that legislation would need to authorise any other course and I have insufficient evidence before me on which to base any recommendation about the issue.

Attempted intercept of Mr Cavanagh

The direct and proximate cause of the death of Barry Cavanagh was his losing control of his vehicle as he approached the town of Innot Hot Springs. It is likely that this was precipitated by the speed of his vehicle and the effect of the alcohol in his system. However, in view of the proximity of police officers to those events, it is appropriate to consider whether the actions of the officers in attempting to intercept Mr Cavanagh were lawful and reasonable. The best way to do that in my view is to assess whether the officers complied with the relevant QPS policies.

QPS pursuit policy

On 1 January 2008, after an extensive trial period, the QPS implemented a new pursuit policy state wide. The policy has subsequently been refined and is again undergoing an extensive review to consider recommendations made in previous inquests. I acknowledge that the reforms to date and the current process of review evidence an ongoing commitment by the QPS to grapple with the very complex challenges thrown up by this aspect of policing.

I shall now summarise those parts of the policy that were in force in December 2009 and that are relevant to this case.

When can a pursuit be commenced and continued?

The principles underpinning the policy are outlined in the OPM. Those of particular relevance to this case are:

(i) *Pursuit driving is inherently dangerous. In most cases the risk of the pursuit will outweigh the benefits.*

(ii) *Pursuits should only be commenced or continued where the benefit to the community of apprehending the offender outweighs the risks.*

(iii) *If in doubt about commencing or continuing a pursuit, don't.*

The policy assures officers that suspects who fail to stop when directed will still be the subject of law enforcement action, but less dangerous means than high speed pursuits will be utilised. It says:

> *The revised pursuit policy seeks to shift the manner of apprehension of people who fail to be intercepted from pursuits into other strategies. The Service will continue to apprehend offenders who fail to be intercepted but pursuits will not be the principal means of effecting apprehension.*

The policy requires 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 – the seriousness of the offences the person fleeing may have committed and the strength of the evidence indicating they have committed those offences. In this balancing exercise, issues of safety are to weigh more heavily than has been the case under earlier policies.

According to the policy, “pursuit” means the continued attempt to intercept a vehicle that has failed to comply with a direction to stop where it is believed on reasonable grounds the driver of the other vehicle is attempting to evade police.

“Intercept” means the period from deciding to direct the driver of a vehicle to stop until either the driver stops or fails to stop. It includes the period when the

police vehicle closes on the subject vehicle in order to give the driver a direction to stop.

The urgent duty driving policy applies to the period in which the intercept is being attempted. That permits, within reasonable limits, a police officer to, for instance, exceed the speed limit.

The policy specifically excludes some matters from being sufficient on their own to justify the commencement of a pursuit. These are termed "*non-pursuit matters*" and they include license and vehicle checks, random breath tests and traffic offences.

When an intercept becomes a pursuit

When an officer is attempting to intercept a vehicle, if the vehicle fails to stop as soon as reasonably practicable, and the officer reasonably believes the driver of the vehicle is attempting to evade police, a pursuit is said to commence if the officer continues to attempt the intercept.

The reference to "reasonably believes" means the question is not determined by the subjective views of the pursuing officer, rather, as with most aspects of law enforcement, officers must align their conduct with what a reasonable officer would do or believe in the circumstances.

If a pursuit is not justified, an attempted intercept must be abandoned. Similarly, if a pursuit that had initially been justified becomes one where either the officer, the occupants of the pursued vehicle or members of the public are exposed to unjustifiable risk, then it must be abandoned. In such cases the officer must turn off the flashing lights and siren, pull over and stop the police vehicle at the first available safe position.

Was there a pursuit in this case?

It is uncontroversial that in this case there was no basis under the policy on which a pursuit could have been justified – speeding is a non pursuit offence.

A direction to stop was given and an intercept was attempted when Sergeant Musumeci activated the rotating coloured lights when he turned to follow Mr Cavanagh's car. It would only become a pursuit if a reasonable officer would in the circumstances conclude the other car had become aware of the intercept and was attempting to evade police.

Sergeant Musumeci said he did not believe this was the case. I do not consider his view in this regard was unreasonable. If Mr Cavanagh's car was doing 140km/hr and it is assumed it would take the police car 30 seconds to slow, execute a three point turn and set off after it, the first car would already be 1200 metres in front. The road at the point in question was undulating and winding. It is quite feasible Mr Cavanagh did not become aware the officers had given him a direction to stop, even if he suspected they may try to if he recognised their car as he sped by.

If follows that there was no pursuit in this case. The speed of what is now known to be Mr Cavanagh's vehicle entitled Sergeant Musumeci to attempt an intercept. The urgent duty driving policy permitted him to exceed the speed limit to a reasonable degree to do so. I am satisfied his subsequent driving was appropriate in the circumstances.

Response at the scene

Mr Cavanagh was first assessed by Constable Shaw who had gained access to the vehicle while Sergeant Musumeci was at the public telephone calling Mareeba communications. Sergeant Musumeci had formed an initial impression that the driver in the vehicle had been decapitated. He says he later made his own assessment inside the vehicle but it is evident he relied heavily on the opinion of Constable Shaw who told him shortly after he had entered the car that Mr Cavanagh was 'gone'.

I accept that soon after they arrived on scene both officers genuinely believed that Mr Cavanagh was dead. It is necessary to consider whether that belief was reasonable and, in the circumstances, whether Mr Cavanagh could have been saved if more had been done.

Dr Stephen Rashford was asked by counsel assisting to consider these questions in the context of the events leading to Mr Cavanagh's death. Dr Rashford makes the following important observations in his report:

> *It appears that Mr Cavanagh has rapidly suffered cardio respiratory arrest prior to the arrival of the attending police officers. If there was any chance of survival Mr Cavanagh needed his airway re-established almost immediately. Given the clinical scenario it is unlikely that Mr Cavanagh would have spontaneously started to breathe, even by just re-establishing his airway……Unless Mr Cavanagh could have been removed from the vehicle this (sic) would have been impossible to provide such support in the car without repositioning of the entire body.*
>
> *…I would be of the opinion that no peripheral pulse was palpable at the time of arrival of the police officers but it would be impossible to say with 100% certainty that no central pulse was detectable. At best Mr Cavanagh was in an extremely low cardiac output state or peri-arrest situation upon the arrival of the first police unit. It is unlikely that either officer would have been able to palpate a central pulse in those circumstances.*

Dr Rashford and Professor Williams both stated at the inquest that blue lips would likely be evident on a patient within a short period after cardio or respiratory arrest. Dr Rashford stated blueness to the lips would be visible as soon as four minutes after the arrest. He similarly stated that a patient's hands would start feeling cold to the touch within a short time. This provides compelling corroboration for Constable Shaw's evidence that he had made such observations shortly after gaining access to the vehicle. The observation from the report of Dr Rashford re-produced above confirms the likelihood that even a well-trained person would have had trouble detecting a pulse at the

relevant time. Finally, Dr Rashford stated that in his opinion the conclusion drawn by the police officers that Mr Cavanagh had broken his neck was reasonable in the circumstances. It would be difficult for me to find otherwise when the paramedic Mr Lee told investigators the day after the crash that he was "*sure*" Mr Cavanagh's neck was broken.

I accept that his observations of blue lips, cold hands, an apparently broken neck and absence of a pulse allowed Constable Shaw to reasonably conclude Mr Cavanagh was dead. Sergeant Musumeci was similarly entitled to draw this conclusion based on his own observations and the assuredness of his colleague.

It became evident in submissions on behalf of Mr Cavanagh's family that they remain confused and upset as to why Mr Cavanagh was left in the vehicle when the police were concerned it may explode or catch fire. As upsetting as it might be for the family I have no hesitation in concluding that the police officers in this case were entitled to take that decision where they had reasonably concluded Mr Cavanagh was already deceased. I also accept that when such an assessment has been made it is in most cases proper, even in the absence of any danger, to leave a body *in situ* for forensic purposes.

At the inquest Dr Rashford re-iterated his written opinion that when the police officers first assessed Mr Cavanagh he was already in cardio-respiratory arrest. When asked to consider the likelihood that Mr Cavanagh could have been saved Dr Rashford drew an analogy with the outcomes for hanging victims who are in cardiac arrest at the time they are treated by QAS paramedics. In such cases QAS statistics show that only around 10% of patients survive. Even then, survival prospects are of course dictated by the speed at which resuscitation attempts commence. Dr Rashford told the inquest that he did not believe Mr Cavanagh could have been successfully resuscitated without his removal from the vehicle. He also said in his experience such removal would take at least 1 ½ to 2 minutes. Mr Lee had expressed doubt as to whether it could be safely done at all without more personnel.

I accept that the officers made reasonable attempts to gain access to the mangled Calais shortly after their arrival. I also accept the evidence of Constable Shaw that he gained access to the vehicle via the front passenger door when Sergeant Musumeci was at the public phone box. The recorded times of that call and the radio message made by Constable Shaw on arrival at the scene allows me to draw the conclusion that it took around 4-5 minutes to gain access to the vehicle. This is consistent with Constable Shaw's own assessment when he was first interviewed that it took him '*several* minutes'.

This, combined with the 1 to 1 ½ minutes it likely took the officers to arrive on the scene after the crash, and the 1 ½ to 2 minutes Dr Rashford says would be needed to extract Mr Cavanagh, means that effective resuscitation attempts would not have been possible until around 7 or 8 minutes after the crash even in the best case scenario. I am led to the conclusion that there was no reasonable opportunity for Mr Cavanagh to have been saved.

I close the inquest.

Michael Barnes
State Coroner
Atherton
1 November 2012