CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Ethan Stephenson**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO:	2014/1984
DELIVERED ON:	26 July 2017
DELIVERED AT:	Brisbane
HEARING DATES:	5 October 2016, 6 - 7 December 2016
FINDINGS OF:	Mr John Hutton, Coroner
CATCHWORDS:	Coroners: inquest: Russel Island; drink driving; speeding; mechanical defects; skateboarding on public roads; pedestrian safety; footpaths; street lighting; Council resourcing; police resourcing, speed enforcement, alcohol testing; and drug testing

REPRESENTATION:

Counsel Assisting:	Mr Peter De Waard (Coroners Court of Queensland)
Ms Lisa Berry (Ethan's sister):	Ms Lisa Willson (instructed by Mr Peter Traganza of Queensland Law Group)
Redland City Council:	Mr John Bremhorst (instructed by Mr Cameron Dean of McCullough Robertson)
Queensland Police Service:	Mr Michael Nicholson (instructed by Ms Melanie Johnston of Queensland Police Legal Services)
Sergeant Graham Staib:	Mr Troy Schmidt

INTRODUCTION

1. On Saturday 7 June 2014, a four-wheel drive vehicle struck a 14-year-old boy, Ethan Stephenson, as he was either walking or skateboarding along the edge of Centre Road on Russell Island. Ethan died at the scene from head injuries.

2. I conducted a site visit at Russell Island on 8 November 2016. An inquest was held from 5 – 6 December 2016. A comprehensive brief of evidence was compiled and distributed to the parties. I heard oral evidence from the following witnesses:

   a. Mr George Holford (the driver of the vehicle which collided with Ethan);

   b. Ms Jennifer McIlroy (the driver's former spouse);

   c. Sergeant Graham Staib (Officer In Charge of the Russell Island Police Station at the time of the incident);

   d. Mr Murray Erbs (Group Manager City Infrastructure, Redland City Council); and

   e. Associate Professor Adam Pekol (Civil Engineer, Pekol Traffic and Transport).

3. These submissions address the following issues, which were identified at a Pre-Inquest Conference on 5 October 2016:

   a. The identity of the deceased, when, where and how he died and what caused his death;

   b. The adequacy of the procedures applied by the Russell Island police in relation to drug and alcohol testing of the driver;

   c. The adequacy of the action taken by Redland City Council to improve pedestrian safety on Russell Island; and

   d. Whether any recommendations can be made to reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

FINDINGS REQUIRED BY S. 45

4. Pursuant to s. 45(2) of the *Coroners Act 2003* (Qld), I find:

   a. *Identity of the deceased* – The deceased person is Ethan Stephenson.

   a. *How he died* – At about 5:15pm on 7 June 2014, Ethan Stephenson was either

skateboarding or walking on the edge of Centre Road on Russell Island, travelling south in the same direction as traffic behind him, when a four-wheel drive vehicle struck him. The primary causes of the collision were that the driver, Mr George Holford, was driving in excess of the speed limit of 60km/h; whilst intoxicated; in a vehicle with numerous serious mechanical defects, including a non-operational passenger side headlight and a loose steering pitman arm joint.

b.	*Place of death* –	Ethan died at 205 Centre Road, Russell Island, in the state of Queensland.
c.	*Date of death* –	Ethan died on 7 June 2014.
d.	*Cause of death* –	The medical cause of Ethan's death was head injuries, which resulted from a vehicle collision.

FINDINGS ON THE ISSUES

The adequacy of the procedures applied by the Russell Island police in relation to drug and alcohol testing of the driver

5. I find that the procedures applied by the Russell Island police in relation to drug and alcohol testing of the driver was adequate, given resourcing and legislative constraints.

The adequacy of the action taken by Redland City Council to improve pedestrian safety at Russell Island

6. I find that the action taken by the Redland City Council since Ethan's death to improve pedestrian safety at Russell Island was adequate.

RECOMMENDATIONS

7. Section 46 of the *Coroners Act 2003* (Qld) 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.

8. I recommend that:

   a. **The Redland City Council:**

      i. Request the Redland City Speed Management Committee to conduct a speed review of all roads on Russell Island. Consideration should be given to reducing the speed limit to 50km/h (with the exception of the ferry terminal area which should be 40km/h due to pedestrian activity, the school zone, which should remain at 40km/h during school hours and dirt roads, which should be 40km/h due to dust suppression and visibility issues); and

      ii. Continue to consult with Russell Island residents to determine whether priority should be given to increased street lighting on the Island and extending the shared pathway system to Sandy Beach, and if so, the way in which these projects should be funded.

   b. **The Queensland Police Service:**

      i. Increase permanent police numbers on Russell Island to keep up with demand. (The former OIC of the Russell Island Police Station's suggestion of one Sergeant and three Constables is recommended);

      ii. Increase speed enforcement activities generally on Russell Island to support any reduction in speed limits on the Island implemented by the Redland City Speed Management Committee;

      iii. Allocate a vehicle mounted radar to the Russell Island Police station, and training, to facilitate more effective speed enforcement on the Island;

      iv. Amend the Queensland Police Service Traffic Manual to include a time limit for a second alcohol breath test;

      v. Allocate a saliva drug swab testing device to the Russell Island Police station, and training, to enable police officers the ability to conduct initial drug tests on drivers, to determine whether it is necessary to escort drivers to the mainland for a blood test;

vi. Implement a policy that all drivers on Russell Island involved in a serious motor vehicle accident be subjected to an initial road side breath test and saliva drug test; and

vii. Nominate a Police Liaison Officer to attend each Redland Transport Advisory Group meeting and to liaise with the Russell Island police regarding traffic safety matters.

c. **The Department of Transport and Main Roads:**

i. Introduce a public bus service on Russell Island, utilising the Translink Go-Card system; and

ii. Take the lead in a safety campaign on Russell Island (in consultation with the Redland City Council and the Russell Island Primary School) to promote safe road usage by children (including the importance of using footpaths, not riding skateboards and other wheeled devices on the roads, and wearing helmets).

d. **The Queensland government:**

i. Amend regulation 240 of the *Transport Operations (Road Use Management – Road Rules) Regulations 2009* (Qld) *(TORUM Road Rules)* to prohibit skateboards, scooters, and similar wheeled recreational devices from all public roads; or

a. At the very least, amend regulation 256 of the *TORUM Road Rules* to mandate helmets, and the use of reflective clothing / illumination devices at night time, for all riders of skateboards, scooters, and similar wheeled recreational devices on roads;

ii. Amend section 80 of the *Transport Operations (Road Use Management) Act 1995 (Qld) (TORA)* to mandate an initial drug saliva swab test or blood test on all drivers involved in motor vehicle accidents that have resulted, or are likely to result in a fatality;

iii. Amend section 80 of the *TORA*, to only require police officers to take one saliva swab for initial drug testing (rather than two). (As was done previously to comparable provisions in relation to alcohol breath testing); and

iv. Review whether it is feasible to amend section 80 of the *TORA*, so that Queensland Ambulance officers can be authorised to take blood tests from drivers involved in serious motor vehicle accidents for drugs. This provision could be limited to remote communities, such as Russell Island, where there are no after hours doctors, nurses or qualified assistants to take blood tests.

EVIDENCE, DISCUSSION AND GENERAL CIRCUMSTANCES OF DEATH

The collision

9. On Saturday 7 June 2014 at around 5:15pm, a 14-year-old boy, Ethan Stephenson was either walking or riding his skateboard along the edge of Centre Road on Russell Island when a four-wheel drive vehicle struck him. The incident occurred about 100m from Ethan's home. Ethan died at the scene from head injuries.

10. Ms Courtney Skinner provided a witness statement dated 19 June 2014, in which she stated that she saw Ethan skateboarding on the right hand side of Centre Road as she drove to the IGA about five minutes prior to the collision.

11. Mr Paul Moran was driving his car on Centre Road on 7 June 2014 travelling in the opposite direction to Ethan. Mr Moran's evidence was relied on in the criminal prosecution of the driver. Mr Moran's contemporaneous account of Ethan's location captured on Sergeant Graham Staib's digital recorder immediately after the collision was: "*We saw him skateboarding along the side of the road here, along the road, and … we were driving along and … we just heard a hell of a bang*…" Mr Moran also provided a statement to police dated 11 June 2014. He stated:

    a. "*I saw a kid on the opposite side of the road skateboarding on the edge of the road…*;

    b. *"He was riding the skateboard with a lot of skill to be able to keep it on the edge of the road as he was"…*; and

    c. *"The next thing about 5 seconds later I heard a hell of a bang".*

12. The eyewitness evidence is that prior to the collision, Ethan was riding his skateboard along the edge of Centre Road in a southerly direction travelling in the same direction as traffic behind him. I note that Ethan's skateboard was a 'longboard', which was designed for road use at speed. However, no evidence was available as to Ethan's location or actions at or immediately prior to the collision.

13. The 1984 Toyota Landcruiser was driven by Mr George Holford. He was travelling south along Centre Road, in the same direction as Ethan. The passenger side of his vehicle struck Ethan from behind.

Road conditions

14. Centre Road is a sealed bitumen road that connects the north and south sides of Russell Island.

15. At the time of the incident, the road was dry, the speed limit was 60km/h, and the road was straight and predominately level with only minor undulations along its length. The road was in good condition.

16. The road is around 6.85m wide, which is wide enough for two vehicles to pass in opposite directions. There were no dividing line markings on the road.

Pedestrian facilities

17. At the time of the incident, there were no footpaths on either side of the road. There was loose gravel on the shoulders of the road but this presented difficulty for pedestrians.

18. Since Ethan's death, the Redland City Council installed a footpath along Centre Road. It is unknown whether Ethan would have used the footpath to walk or skateboard on, had the footpath existed prior to the collision. In my view, the existence, and use, of the footpath may well have prevented Ethan's death.

Speed of the vehicle

19. During the inquest, Mr Holford initially stated that he did not believe that he was speeding. He stated that he imagined he would have been travelling at the speed limit of 60km/h, especially because it was coming on dusk.

20. Mr Holford was reminded that he had in fact admitted to speeding for the purposes of sentencing at his criminal trial. He then reluctantly conceded that it was possible he was speeding. He went on to state that if he were driving 65 or 70km/h, he would have slowed down for an approaching vehicle, which he states was coming his way just prior to the collision.

21. Some witnesses estimated that Mr Holford was travelling 100km/h or more at the time of the incident. Mr Holford's former spouse, Ms Jennifer McIlroy, stated that in the 20 years she had known him, he would rarely drive at a speed of less than 80km/h.

22. It is clear, based on Mr Holford's own admission during his criminal trial that he was driving above the speed limit of 60km/h at the time of the incident. However, it cannot be determined, with any level of certainty, how fast he was driving. This is because the witnesses did not have any relevant expertise in determining speed, Mr Holford's former spouse's evidence was tainted due to their acrimonious relationship, and she was not with him at the time of the incident.

23. Mr Holford's reluctance to admit at the inquest that he was speeding, despite his earlier admission in his criminal trial, is indicative, in my view, that he was not a particularly honest witness. His evidence should therefore be treated with caution.

Attendance by police

24. The Officer in Charge of the Russell Island Police station, Sergeant Graham Staib, was the first police officer on the scene at about 5:30pm. He managed and secured the scene to preserve order and safety and to

preserve evidence in a forensic crash investigation. I am of the view that Sergeant Staib acted professionally, appropriately and reasonably in the circumstances.

Alcohol consumption of the driver prior to the collision

25. Mr Holford did not participate in a formal police recorded interview, nor did he provide a statement prior to the inquest. He advised police at the scene that he had consumed four full strength beers between around 3:15pm and 5:10pm that day and that he had not taken any drugs.

26. At the inquest, Mr Holford stated that he might have consumed up to five VB cans within a two to three hour period. He stated that he took a six-pack of VB cans to an unplanned gathering at a house on Canaipa Road with a couple of friends to discuss the sale of his outboard engine. He then dropped into the Russell Island Motel to pick up his tools for work the next day and headed home along Centre Road. He thinks he still had a couple of VB cans left in his car.

27. A closer examination of the police report and the photographs taken of the inside the Mr Holford's vehicle at the scene reveal that an esky cooler designed to hold a six-pack of beer cans was located on the passenger side of his vehicle. There is no information as to whether beers were found by police within the esky. I make no criticism of Sergeant Staib for not looking inside the esky cooler, given the other responsibilities he was carrying, in terms of managing the scene of a fatal crash. I also note that by the time the vehicle had been impounded and conveyed to the police station, it was the responsibility of the forensic crash investigators to examine the vehicle, and not Sergeant Staib.

28. Whether there were beers inside the esky or not is irrelevant in terms of assessing Mr Holford's level of intoxication at the time of the crash. I had the benefit of the breath certificate and the expert evidence of the Forensic Medical Officer, as well as Sergeant Staib's evidence as to intoxication.

Testing of the driver for alcohol after the collision

29. Sergeant Staib observed that Mr Holford smelled of alcohol, had slurred speech, and bloodshot eyes. He therefore initiated a roadside breath test, which returned a reading of between 0.08% and 0.09%. Sergeant Staib stated that in his experience, initial roadside breath tests are usually consistent with the subsequent breath certificate (presumably in cases where the certificate is able to be obtained within a short time afterwards).

30. Mr Holford was subsequently detained in the rear of a police vehicle, pending a subsequent test at the police station. The second breath test was taken at 7:20pm (about two hours after the incident) at the Russell Island Police Station. This testing utilises a more accurate apparatus for evidentiary purposes. Mr Holford returned a blood alcohol concentration in the second breath test reading of 0.056%.

31. Given the time that had lapsed between the incident and the second breath test, a count back report was obtained from a Forensic Medical

Officer. It was estimated that Mr Holford's blood alcohol concentration would have been in the range of 0.76 to 0.118% at the time of the incident.

32. The Forensic Medical Officer stated that all drivers show at least some impairment in the ability to drive at a blood alcohol concentration of 0.08% and higher. The risk of being involved in a motor vehicle crash increases rapidly at blood alcohol concentration levels above 0.08%.

33. Mr Holford stated at the inquest that he had always felt confident that he was at least, if not right on the limit, just under. He claims that he had consumed a similar number of beers over a similar period of time in the past and blown 0.05% or under.

34. As I indicated earlier, Mr Holford did not present as a particularly honest witness. He therefore cannot be relied upon to give an accurate account of his alcohol consumption for the purposes of a more accurate count back. In my view, Mr Holford's blood alcohol concentration is likely to have been around 0.08% or higher at the time of the collision and he is likely to have been impaired by alcohol.

Visibility

35. At the scene, Mr Holford initially denied to the police at the scene that he had hit Ethan until the damage to his vehicle was pointed out to him.

36. At the inquest, Mr Holford stated that he did not see Ethan at any stage. This is supported by the fact that at the scene there was no evidence of braking.

37. Mr Holford stated at the inquest that he heard a noise and that as a result of that noise; he drove 50 to 100m before turning around. He thought the noise had been caused by someone throwing something at his car or that something had been flicked up by his tyres. He stated that this was the reason he turned his vehicle around.

38. Mr Holford could not recall whether he had his headlights on prior to the collision. He initially stated that he would usually drive along Centre Road at night time with his low beam lights on. After prompting by me during the inquest, Mr Holford stated that he would in fact drive with his high beam lights on and then flick them onto low beam when there was another car approaching, unless it was an overcast night and it was a little bit darker than normal.

39. Mr Holford stated that at the time of the incident it was getting darker. It seemed like it was night time to him but he thought that this could have been because it was overcast.

40. The Bureau of Meteorology data indicates that the weather at the time of the incident was fine and clear. This is supported by the observations of witnesses on the same road at the same time. The incident occurred at about 5:15pm, which was 17 minutes after the official sunset time. This was during a period known as 'civil dusk', which went until 5:22pm on the

day. During civil dusk, it is said that there is still enough light to see objects without complete dependence on artificial light (ie. headlights).

41. At the inquest, Mr Holford stated that he thinks that just prior to the collision with Ethan there was an oncoming vehicle with its high beam lights on. He implied that the lights had blinded him and that this, as well as Ethan's dark clothing, had resulted in his failure to see Ethan.

42. I note that it would have been difficult to see Ethan due to his dark clothing and the time of the day. However, it is unlikely in my view, that Mr Holford or an oncoming vehicle would have had their high beam lights on at that time. It was only civil dusk and the weather was fine and clear.

Defective front passenger side low beam light

43. A police vehicle inspection identified a number of defects with Mr Holford's vehicle. Of particular relevance was the discovery that the passenger side low beam headlight was non-operational prior to the incident. The non-operational headlight was on the same side of the road as the impact with Ethan.

44. Mr Holford stated at the inquest that he would usually service his own vehicle and he was not aware that his headlight was non-operational. Also, after prompting from me during the inquest, he stated that he saw no noticeable difference or diminution in the amount of light cast on the left hand side of the road at the time of the incident.

45. In terms of street lighting, Centre road has a system of street lighting, approximately 250m apart. However, in this case, there happened to be a street light at an intersection around 25m from the impact site, which would have also provided some illumination.

46. Visibility would have been poor at the time of the incident due to a combination of Ethan's dark clothing, civil dusk, and Mr Holford's defective passenger side low beam headlight. There was no evidence of braking at the scene, which tends to support Mr Holford's evidence that he did not see Ethan.

47. However, due to Mr Holford's general dishonesty at the inquest, it cannot be determined whether he was aware of the defective headlight prior to the incident. Had he have had an operational passenger side low beam headlight; he may well have seen Ethan on time to avoid the collision.

Loose steering pitman arm joint

48. Witnesses reported seeing Mr Holford's vehicle swerve off the road a couple of times prior to the impact. One witness reported that Mr Holford's vehicle almost wiped their vehicle out at an intersection along Centre Road.

49. During the inquest, Mr Holford stated that he did not think that happened. He stated that at the time he heard the noise (ie. the time of impact), he

didn't believe his tyres were off the road. He stated that if he had been swerving, it would have been to pull over to the left of the road a little extra to give way to an oncoming vehicle.

50. Mr Holford conceded that his vehicle's steering needed adjusting and that the steering would take some extra force to turn because the steering pitman arm joint was loose. He stated that he was aware that the steering would sometimes overcorrect but that he had control of his vehicle at all times.

51. Under cross examination, Mr Holford conceded that if a vehicle was approaching his vehicle from the opposite direction and he was veering off to the left of the road to make room, he could have oversteered and travelled very close to other vehicles prior to the collision with Ethan.

52. Mr Holford stated that prior to the collision, he had already made a booking for his vehicle to be serviced at the local service station. This was to occur within a couple of days after the incident but this has not been verified. Mr Holford initially stated that the reason for the booking was that he had requested them to go over everything because he was mainly worried about his handbrake. However, he later stated that he remembered being pulled over by the police, possibly within the few days prior to the incident, and possibly for the tread on his tyres, and that is why he had booked his vehicle in for a service. Mr Holford stated that he had the extra tyres at home with rims on them ready to go.

53. Sergeant Staib could not recall pulling Mr Holford over a few days prior to the incident. He explained that if he did, he would not have kept a record of it. This was because it was his practice to do cursory inspections of superficial issues like tyres and lights. He would generally deal with any deficiencies informally by instructing people to fix them up by the time he saw them next. He was not a vehicle inspector or mechanic capable of identifying issues such as loose steering pitman arm joints. He had only issued two to three infringement notices in his five years on the Island. (Incidentally, it was his practice to do a roadside breath test for alcohol on all drivers he pulled over, so if he did pull Mr Holford over a few days before the incident, Mr Holford must not have been intoxicated at that time).

54. Mr Holford stated that he knew how to do a roadworthy check on his vehicle and he would do it ritually. He admitted to knowing, prior to the incident, all about the deficiencies identified in the police vehicle inspection report, except for the non-operational passenger side headlight.

55. In my view, it is likely that the loose steering pitman arm joint on Mr Holford's vehicle contributed to the collision because this would have caused him to oversteer his vehicle to the left when making room for an oncoming vehicle. Mr Holford was well aware of this defect and with his mechanical knowledge, he would also have been aware of the dangers. He should therefore have taken earlier action to remedy this.

56. I am unable, based on the limited evidence before me, to determine whether a police officer pulling Mr Holford over prior to the incident should have known that his vehicle was unroadworthy, even at a cursory glance.

Autopsy results

57. A forensic pathologist conducted an external and full internal examination on 10 June 2014. Femoral venous blood, urine and vitreous humour were taken for toxicology analysis. The toxicology certificate was completed on 4 July 2014 and the autopsy report was completed on 11 August 2014.

58. The forensic pathologist noted subcutaneous and intra-muscular bruises to Ethan's right thigh, the back of his right knee, and the back of his left knee, which indicated that these were the sites of impact by Mr Holford's vehicle.

59. The forensic pathologist noted that Ethan's death was due to head injuries. The head injuries resulted from extensive skull fractures and multiple small contusions to Ethan's brain, in patterns consistent with traumatic diffuse axonal injury.

60. The forensic pathologist was of the opinion that Ethan's head injuries would have been sustained after the initial impact with the vehicle (ie. by further impact with the vehicle, by the impact from Ethan falling onto the ground, or both).

61. No drugs or alcohol were detected in Ethan's system.

62. The forensic pathologist concluded that the medical cause of Ethan's death was:

    1(a). Head injuries, due to or as a consequence of

    1(b). Motor vehicle collision (pedestrian).

63. I accept the forensic pathologist's opinion regarding the medical cause of Ethan's death.

Safety concerns raised by past and present Russell Island residents

64. As a result of Ethan's death, I received an unprecedented number of letters from concerned residents and past residents of Russell Island about safety on the Island. These letters were forwarded to me by a community group member, Ms Melissa Warne. I thank Ms Warne for bringing these concerns to my attention and I acknowledge the Russell Island community contribution to this inquest.

65. I received letters from the following people:

    a. Mrs Deirdre and Mr Robert Underwood, dated 11 July 2014;

    b. Ms Andrea Wright and Ms Regina Lang (the President and Secretary

of the Russell Island State School P&C Association), dated 27 June 2014;

c. Ms Charmayne Parkes, dated 11 July 2014;

d. Ms Jo-Anna Katts, dated 9 July 2014;

e. Ms Ingrid Seiler, dated 17 July 2014;

f. Mrs Jan and Mr Vic Schut, dated 16 July 2014;

g. Ms Tracy Taberer, dated 12 June 2014;

h. Ms Jessica Thompson, dated 15 July 2014;

i. Mr Chris Connor, dated 16 July 2014;

j. Ms Amanda Jones, dated 16 July 2014;

k. 'Lynn' (Cleveland Visitor Villas Motel & Shailer Park Garden Villas), dated 19 July 2014;

l. Mr Jack Graham, dated 17 July 2014;

m. Mr Ian Larkman, dated 11 June 2014; and

n. Ms Melissa Warne, dated 7 July 2014.

66. I directed the police to obtain formal statements for the purposes of the inquest, however, not all community members were able to provide statements. I have summarised each of the police statements received below.

Statement from Deirdre Underwood signed 12 November 2016

67. Mrs Underwood stated that:

a. She did not know Ethan;

b. She was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death;

c. She notified the Coroner's office that there was a Facebook page called 'Change, Unity, Prevail' that has a record of the building of the pathway;

d. The only other death on Russell Island she was aware of arose out of a failure to wear a helmet and the death was not related to lighting or footpaths; and

e. She believed the footpath should be finished.

Statement of Andrea Jane Wright signed 12 November 2016

68. Mrs Wright stated that:

    a. At the time of Ethan's death, she was the President of the Russell Island Parents and Citizens Association (PCA);

    b. Issues were raised in PCA meetings in relation to safety on Russell Island, but she was unable to recall specifics or whether the concerns were passed on to the Council;

    c. The only death on Russell Island she was aware of, which occurred prior to Ethan's death, happened on Canaipa Road and she could not say whether this death was due to lack of lighting, footpaths or line markings;

    d. For the PCA, the main concern was the danger for kids from the southern end of Russell Island riding back to the school without a footpath; and

    e. It was good now that the footbath had been introduced. She was satisfied with the action taken by the Council in relation to pedestrian safety.

Statement of Charmayne June Parkes signed 11 November 2016

69. Mrs Parkes stated:

    a. She did not know Ethan;

    b. She was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death in relation to lighting, footpaths or pedestrian infrastructure on Russell Island;

    c. The only death on Russell Island that she was aware of, which occurred prior to Ethan's death, was a vehicle accident that occurred because the driver failed to take a corner; and

    d. She would like to see a pedestrian crossing near the Russell Island IGA, and an upgrade of street lighting, as well as a pedestrian crossing where the footpath crosses over Centre Road near Waratah Street.

Statement of Jo-Anna Rosemary Katts signed 11 November 2016

70. Ms Katts stated:

    a. She did not know Ethan;

    b. She was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death in relation to lighting, footpaths or pedestrian infrastructure on Russell Island;

c. The only pedestrian death on Russell Island she was aware of related to the death of a child on Canaipa Road, which she was told occurred on dusk and that insufficient lighting was to blame;

d. She was satisfied with the action taken by Council in relation to pedestrian safety on Russell Island and had written to Councilor Mark Edwards thanking him for the footpath and bitumen roads; and

e. The Council should finish the footpath along Minjerriba Road.

Statement of Ingrid Karen Seiler signed 11 November 2016

71. Ms Seiler stated:

a. She is the grandmother of an eight year old child who died as a result of a traffic incident on Canaipa Drive, Russell Island;

b. She did not know Ethan;

c. She was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death;

d. Her grandson's death was different to Ethan's and for her, the two incidents could not be compared;

e. She did not believe that her grandson's death was the result of a lack of lighting, footpath or markings on the road and the Coroner's report into his death indicated that the reason for his death was that he wasn't wearing a bicycle helmet and his bicycle brakes did not work;

f. Kids on Russell Island do tend to skateboard in the middle of the roads; and

g. She was now satisfied with the Council's actions, but there should be more streetlights.

Statement of Janice Schut signed 11 November 2016

72. Mrs Schut stated:

a. She did not know Ethan;

b. She was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death in relation to lighting, footpaths or pedestrian infrastructure on Russell Island;

c. She was not aware of any deaths, serious injuries or near misses for pedestrians on Russell Island prior to Ethan's death; and

d. The number of streetlights needed to increase and the footpath should be completed.

Statement of Tracey Leigh Taberer signed 11 November 2016

73. Mrs Taberer stated:

    a. She did not know Ethan;

    b. She was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death in relation to lighting, footpaths or pedestrian infrastructure on Russell Island;

    c. She was aware of the death an eight year old child on Canaipa Road, Russell Island, and thought his death was because of the footpath, but she was not there;

    d. The Council went ahead with the footpath to Stradbroke Road, Russell Island, but still needed to finish the footpath; and

    e. She believed that the Council used some funds for culverts but thought that the footpath was to go all the way to Sandy Beach and that the Council needed to put in more street lighting.

Statement of Christopher Mark Connor signed 11 November 2016

74. Mr Connor stated:

    a. He did not know Ethan;

    b. He was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death, relating to lighting, footpaths or pedestrian infrastructure on Russell Island;

    c. He had made various comments on social media in relation to the footpaths and lighting prior to Ethan's death but had not made any comments directly to the Council;

    d. He was not aware of any pedestrian deaths, serious injuries or near misses on Russell Island prior to Ethan's death; and

    e. The Council could have done some of the jobs quicker.

Statement of Amanda Louise Jones signed 11 November 2016

75. Mrs Jones stated:

    a. She was not aware of any previous representations, complaints or requests made to the Council prior to Ethan's death in relation to lighting, footpaths or pedestrian infrastructure on Russell Island;

    b. She was aware of two pedestrian incidents having occurred on Russell Island, being the death of an eight year old child killed on

Canaipa Drive and an accident involving a young boy who came off his skateboard late one night. She believed that the young boy's accident occurred on High Street near the primary school but she was only aware of those details through what she had been told by other kids. Mrs Jones was not aware whether the police or the Council were called about the young boy's accident; and

c. The Council should complete the footpath along Minjerriba Road to connect with Centre Road, Russell Island.

Statement of Jack Nelson Clarke Graham signed 4 November 2016

76. Mr Graham stated:

a. He was involved in a traffic incident on 31 January 2010 when he was making his way home from a friend's house and was hit and run over by a vehicle. The traffic accident occurred on the corner of Barcelona Terrace and Centre Road, Russell Island;

b. There had been more incidents, including Ethan's death, which happened not far from his accident in 2010;

c. He believed that these incidents could have been avoided if footpaths could prevent people, pedestrians, bike riders and skate boarders from riding on the road;

d. He recalled a traffic accident occurring on 7 June 2014 but did not witness the accident where Ethan was killed. He knew Ethan from when he lived on Russell Island, having moved there at the age of six years old and starting school in year 2. When he moved to Russell Island, "everyone knew everyone" and you did not have to worry about road safety; and

e. The community had now grown and he believed the roads had become unsafe.

The historical context regarding the Redland City Council's budget and priorities

77. On 12 May 1973, the Queensland Government assigned administrative control of Russell Island (along with the other Southern Moreton Bay Islands) to the Redlands City Council. The consequence was that the funding burden of constructing infrastructure on the Islands fell to Council ratepayers.

78. At the time the Queensland Government handed over Russell Island, there was no roadway infrastructure, only dirt roads. There was no sewerage system. There were no more residential lots available for subdivision, and a number of lots that were subject to flooding had already been approved and sold by the Queensland Government.

79. The consequence has been that over many years the Redlands City Council has had to buy back flood susceptible lots as they became available, using funds collected from general rates. The Council now owns much of the land at the southern end of Russell Island, which have been designated as conservation areas.

80. There is no effective mechanism for the Council to get developers to fund infrastructure development on the Island in the usual way, due to a lack of development.

81. Residents migrate to Russell Island in part due to the low cost of land, housing and rent. There has been a historical recognition by the community that mainland style infrastructure is not an inherent characteristic on Russell Island.

82. In 2011, the Redlands City Council conducted extensive consultation with the Southern Moreton Bay Island community to develop its '2030 Plan'. The 2030 Plan is a roadmap to future planning for the Islands from December 2011 and beyond.

83. In 2011, the community expressed to the Council that its priorities for expenditure were:

    a. Reduced ferry fares between the mainland and South Moreton Bay Islands (SMBI) via access to the State Translink Go-Card system;

    b. Free inter-island ferry transport;

    c. The provision of additional car parking infrastructure at ferry terminals; and

    d. The sealing of roadway surfaces on the SMBI.

84. Since 2011, the main issues of concern on the SMBIs identified to Council by the community have been:

    a. Dust suppression on roads (which is being remedied by sealing them);

    b. Car parking requirements at both ends of journeys to and from the SMBI; and

    c. Port facilities.

85. Expenditure on the above community-prioritised infrastructure has therefore taken precedence. For example, there are still around 20 – 25km of unsealed roads on Russell Island. At the current rate of completion and on the current budget, this will be completed within the next four to five years.

The lack of footpath infrastructure along Centre Road at the time of Ethan's death was adequate

86. Leading up to the inquest, the Redland City Council commissioned Associate Professor Pekol to provide an expert opinion as to whether Centre Road (and the non-existence of a footpath along Centre Road) was adequate from a technical engineering perspective at the time of the incident.

87. Associate Professor Pekol noted that Centre Road now has features, which are indicative of a ‘collector road’ under the Redland Planning Scheme. As a collector road, new developers would have to provide a footpath if the road were to be built today. However, Associate Professor Pekol concluded that despite this, the absence of a footpath on Centre Road on 7 June 2014 was consistent with the relevant design guidelines in use at the time.

88. Associate Professor Pekol conducted a video survey of Centre Road over two 12-hour periods on a Friday and a Saturday (18 – 19 November 2016). He also visited the Island to observe local conditions. The two-way traffic volume of Centre Road (just north of Kurrajong Street) was calculated as being around 1,300 vehicles per day. On the Friday, 21 pedestrians, 5 cyclists and 3 mobility scooters were recorded travelling alongside Centre Road. On the Saturday, there were 10 pedestrians and 5 cyclists. There were no skateboarders recorded on either day.

89. The cyclists and mobility scooters were observed using the new pathway provided. 90% of pedestrians used the new pathway and 10% of pedestrians used the verge. In my view, this proves the utility of the new pathway because the majority of people appear to have been using it.

90. Associate Professor Pekol also obtained Department of Transport and Main Roads data, which established that between 2004 and 2013, there were five pedestrian crashes on Russell Island. On a per capita basis, this was about twice the amount as the rest of the Redland City Council area. However, Associate Professor Pekol advised that this proportionality comparison couldn’t be relied upon with any certainty due to the small sample size relating to Russell Island.

91. Associate Professor Pekol concluded in his report that there were no technical means by which Ethan’s death could have been avoided. He also argued that there was no guarantee that Ethan would have used the footpath if one had been provided. He drew a distinction based on the particular type of skateboard involved in this incident as being designed more to be used on roads than footpaths.

92. I accept Associate Professor Pekol’s opinion that at the time of the collision, Centre Road on Russell Island complied with the relevant design criteria in the local planning scheme and the absence of a concrete footpath was consistent with the relevant design guidelines in use at the time.

The current footpath infrastructure along Centre Road is adequate

93. After Ethan's death, the Redland City Council added to the existing 5km of pathways and constructed around 3km of shared pathways (at a cost of around $1 million). The section of footpath constructed along Centre Road was the maximum footpath length possible for the available funds allocated. This resulted in the need to cross the road in some sections, and left 2 – 300m of missing links. The missing links included a swamp crossing and a culvert extension.

94. During my view on Russell Island, the footpath and two missing link sections were inspected. Each missing link was estimated to cost $250,000 and was completed on 3 March 2017, prior to completion of this inquest.

95. Now that the missing links complete, aside from the need to cross roads, there is a continuous footpath from the jetty on Russell Island through to the southern end of Centre Road.

The Council should review community needs for further footpath infrastructure on the Island

96. One resident has suggested to me that the footpath should be extended further to Sandy Beach, but a request has not been made directly to the Council. The Council has advised that the cost of constructing such a footpath extension would be in the order of $1 million.

97. I note that the Southern end of Russell Island (where Sandy Beach is located) is sparsely populated as a result of significant expenditure by the Council to purchase back flood susceptible lots. This buy-back program is still ongoing, such that the number of potential users of a footpath to Sandy Beach may actually decrease over time.

98. Nonetheless, it is important in my view, that the Council consult further with residents about this suggestion to determine whether other residents see this as a priority, and if so, the way in which such a project would be funded. The best opportunity to conduct this formal community consultation would appear to be now, given that the Council is already underway with consultation regarding the outcome of the SMBI Integrated Local Transport Plan.

The street lighting along Centre Road at the time of Ethan's death was adequate

99. The Redland City Council did have a record about a complaint made about lighting on Centre Rd in 2007. But that complaint was adequately dealt with and was not relevant to this case.

100. Enquiries with both Energex and the Redland City Council have revealed that Energex currently hold a monopoly on the provision of street lighting on public roads. The Council determines where they go, but Ergon sets the prices for lighting infrastructure, maintenance and operation.

101. Street lighting within Redland must conform with:

a. The relevant Australian Standard, AS1158 – Lighting for public roads and spaces;

b. The Austroads Guides; and

c. Ergon Policies and Standards.

102. The policy purpose of street lighting is to allow drivers to see the road alignment and to highlight infrastructure or obstacles (such as traffic islands, pedestrian crossings, road calming infrastructure and intersections). Street lighting is not directly aimed at assisting pedestrians and other road users such as skateboarders and cyclists (but they would obviously benefit from better illumination for motorists).

103. Vehicles using roads at night are required to have their own headlights for illumination, including high beam lights where there is no street lighting.

104. Streetlights are installed by exception rather than as a matter of course. This is due to the high capital cost when additional poles are required (up to $30,000 per pole) and the high operating cost (about $300 per light per annum).

105. The Redland City Council installs street lights according to the following priorities:

a. In zones of high pedestrian density (eg. around shops and transport locations); and

b. In zones of high traffic density (eg. around car parks to assist drivers to see their surrounds).

106. The design logic applied for the delivery of a lighting program is to start from more densely populated areas and work out from there. In the case of light system provision at Russell Island, the lights are most dense at the ferry terminal, shops and school zones. The lights radiate out up Canaipa Road, decreasing in intensity. The lights radiate down High Street, Minjerriba Road and Centre Road gradually reducing in intensity.

107. The intersections down Centre Road have had 'flag' lighting installed at intersections with side roads. The purpose of flag lighting is to alert drivers travelling on Centre Road to the existence of intersections and the possibility of incoming traffic.

108. When determining the allocation of lighting, the Australian Standard AS 1158 is the applicable guideline. I note that the Australian Standard AS 1158 recommends spacing for streetlights to be *every 100 – 120m*. However, it is only a guideline, and a guideline for new construction. It is not retrospective. There is therefore no technical requirement to retrofit streetlights to meet the 100 – 200m spacing guideline. I also note that the Council maintains its own policy '2350' regarding lighting requirements.

The Council should review community needs for further street lighting on the Island

109. The Group Manager of City Infrastructure at the Redland City Council, Mr Murray Erbs, advised that to implement street lights every 100 to 120m along Centre Road, it will cost many millions of dollars due to the number of poles that will need to be retrofitted.

110. This is, in my view, a discussion that the Council now needs to have with residents, in terms of their overall priorities on the Island and their willingness to pay. The best time for this consultation to occur would appear to be now, given that the Council has begun consultation as part of their review of the outcomes of the SMBI Integrated Local Transport Plan.

The Redland City Speed Management Committee should reduce speed limits on the Island

111. Although the roads on Russell Island are under the Redland City Council's control, they do not have the authority unilaterally to change the speed limits. The Redland City Speed Management Committee determines speeds for Council roads. This is a formal inter-governmental process.

112. The determination of current speed limits on Russell Island came out of a speed review conducted in 1999. The review was conducted as part of a project that included South East Queensland Local Government Authorities to introduce the general 50km/h speed limit on urban roads and to ensure that similar road and street types across South East Queensland had similar speed limits.

113. The current speed limit on Centre Road is 60km/h from the corner of the Minjerriba Road intersection with Centre Road, heading south. However, there is no record as to why 60km/h was chosen as the speed limit.

114. Part 4 of the Manual of Uniform Traffic Control Devices (MUTD) deals specifically with the setting of speed limits. The principles and general requirements used when determining speed limits for all roads throughout Queensland include:

    a. Speed limits should not be so low that a significant number of road users ignore them;

    b. Speed limits should not be applied specifically for the purpose of compensating for isolated geometric deficiencies;

    c. Speed limits should be capable of being practically and equitably enforced by the use of speed zones of adequate length, by limiting speed limit changes, and by clarity and frequency of signposting; and

    d. Speed limits should be set to maintain a balance between a road user's reasonable perception of the speed environment and an acceptable level of safety and environmental amenity for all road users and abutting land users.

115. The Redland City Council is of the opinion that if there was to be an adjustment of the speed limit on Centre Road, given that it is in an environment where a 60km/h limit has been historically applied and found to be appropriate, there is a likelihood that behaviours of motorists will not change in the absence of the ability to properly enforce this speed. Even if there is enforcement of lower speed limits, this may simply become an exercise where imposing a lower speed limit will have the effect of increasing the number of fines imposed rather than changing motorist behaviour. Speed enforcement measures are of course a matter for the Queensland Police Service.

116. Associate Professor Pekol has reviewed several research papers about the relationship between pedestrian fatality risk and the impact speed of vehicles. Not surprisingly, the results indicate that the likelihood of a pedestrian fatality increases as impact speed increases. However, the relationship between these variables is not linear.

117. The probability of a fatality is low at *impact* speeds of up to 35 – 50km/h (depending on the source data). By comparison, the probability of a fatality is quite high (eg more than 90%) at impact speeds greater than 50 – 100km/h (depending on the source data). At mid-range speeds, the probability of a pedestrian fatality increases more sharply as speed increases (which for one research paper is defined as 35 – 50km/h and another paper is defined as 50-100km/h).

118. Part 4 of the MUTD includes a typical distribution of vehicle speeds for a 60km/h road under free-flow conditions. It indicates that about 55-60% of vehicles usually travel at or below the speed limit. 15% travel more than 7 – 8km/h faster than the speed limit and 1-2% travel more than 20km/h above the speed limit. This is why the 85th percentile speed and not the maximum speed are adopted as the design speed for most aspects of road design.

119. Associate Professor Pekol was of the opinion that a 60km/h speed limit on Centre Road was technically appropriate. However, both he and the Redland City Council agreed at the inquest that Ethan's death was a trigger for a speed review on Russell Island and that it is worthwhile having one. I support their recommendation for a speed review and suggest that:

    a. Consideration be given to reducing the speed limit on the Island to 50km/h with the exception of:

        i. The ferry terminal area which should be 40km/h due to pedestrian activity;

        ii. The school zone, which should remain at 40km/h during school hours; and

        iii. Dirt roads, which should be 40km/h due to visibility and dust suppression issues.

The delay in police testing of the driver for alcohol after the incident was reasonable

120. Concerns were raised with me by some Russell Island residents in relation to the time that it took police to test Mr Holford for alcohol.

121. The first alcohol breath test was conducted soon after the incident. However, after a positive result, the second breath test was not conducted until 7:20pm (a period of around 2 hours after the incident).

122. Sergeant Staib stated that the delay was caused by the necessity to source another police crew from Redland Bay and to have them travel to Russell Island.

123. I note that Sergeant Staib was the only police officer on duty to attend to the incident. He had to manage and secure the scene in order to preserve order and safety, as well as preserve evidence for the forensic crash investigation.

124. Sergeant Staib has advised that the relevant Queensland Police Service policy is contained in section 7 of the Traffic Manual, which states in part:

 "*Officers who intend to conduct breath tests are to make the requirement of the subject person as soon as practicable and within three hours after the occurrence of the event to which the test relates".*

125. This time period relates only to the initial test or roadside breath test. Once the person returns a positive result in the first test, there is no time limit as to when police must conduct the second test or breath analysis.

126. In my view, the delay in relation to the second test of Mr Holford was not unreasonable in the circumstances. However, the Queensland Police Service Traffic Manual should set a time limit for second breath tests.

The decision of police not to test the driver for drugs after the incident was reasonable

127. A concern was raised with me by a Russell Island community member that Mr Holford was not tested for drugs, in circumstances where the police were alleged to have been aware that he was a known drug user.

128. Mr Holford's former spouse provided evidence at the inquest about alleged past drug use by Mr Holford. However, this evidence was of limited assistance because it was based at best on historic observations during the course of their relationship. Mr Holford admitted at the inquest to having taken 'pot' in the past but stated that he didn't remember taking it on the day of Ethan's death. He denied having ever taken 'ice' or 'speed', as alleged by his former spouse.

129. Police records were searched, as part of the coronial investigation, and there was no record of any complaint or concern having ever been made about Mr Holford's alleged drug usage prior to the incident. Further,

Sergeant Staib stated that he had no police intelligence at the time to indicate Mr Holford may have been a drug user.

130. Sergeant Staib was experienced in observing people under the influence of marijuana and speed. He did not note any indicia indicating that Mr Holford was under the influence of such drugs. He noted that Mr Holford had blood shot eyes and that he had gone to a water tap at a nearby residence to wash his mouth out. He considered this to be consistent with alcohol consumption and that is why he did not arrange a drug test.

131. Mr Holford's former spouse stated that on either the day after Ethan's death or the next day, when she found out about the incident, she phoned the Russell Island Police Station and spoke with Sergeant Staib. She asked whether Mr Holford had been drug tested and was advised that he had not. She asked why, and Sergeant Staib responded that the police didn't have the ability to test for drugs on the Island and would have had to take him to the mainland. She replied that that was a pity because Mr Holford was on 'Pot' or 'Ice'.

132. Sergeant Staib recalled receiving the phone call but thought that it could have been two days after the incident. He explained that he was unsure of what the 'window of opportunity' was for drug testing but he wouldn't have tested after someone had left his custody because there was nothing to say that they hadn't taken something in between the incident and the testing. He noted the acrimonious relationship between Mr Holford and his former spouse, that she had moved interstate two months earlier, and he placed more credence on the indicia displayed by Mr Holford at the time of the incident.

133. I note that in the police photos taken at the scene of the inside of Mr Holford's vehicle there was what appeared to be a loosely rolled cigarette. It is possible that this was a 'joint' containing marijuana but it is also possible that it was tobacco. The presence of such an object would not necessarily have been remarkable at the time of the police investigation and I am not critical of the police for not examining it.

134. In my view, the decision by Sergeant Staib not to test Mr Holford for drugs after the incident was reasonable in the circumstances. However, police policy and the relevant legislation should be amended so that drug testing is mandatory in the event that a motor vehicle accident causes, or is likely to cause a fatality.

Police numbers on the Island should be increased

135. By way of background, Russell Island commenced as a single officer police beat in February 2008. Continued demand required an increase in resources and it was increased to its current strength as a two-officer division in late 2011.

136. There is currently a Sergeant 'Officer in Charge' and Senior Constable residing on the island in police service provided housing. In accordance with the award provisions for two officer police establishments, they are

required to be available 24 hours, 7 days per week, to provide ready accessibility to policing services for the community. Outside their rostered duty hours, one officer remains on call to ensure capacity to provide first response. Surrounding stations provide additional first response capacity.

137. Bayside road policing officers usually undertake patrols on Russell Island once a month. This is for a short period of time because their arrival is communicated amongst the community and policing is hampered through this obstruction.

138. The Assistant District Officer of the South Brisbane District, Acting Superintendent Huxley, advised that since 2014, the Bayside road police have made 10 arrests for drug driving and 31 arrests for drink driving. Sergeant Staib stated that he had arrested just under 100 drink drivers in the five-year period he had been stationed on the Island. However, no statistics were provided in relation to the success of speed enforcement activities on Russell Island.

139. Acting Superintendent Craig Huxley stated that although Macleay and Russell Islands are two officer establishments, significant resources support policing operations in the bay islands. These include additional police from Redland Bay, Redland Bay Water Police, Capalaba Road Policing unit and Bayside Tactical Crime Squad. Additional resources are brought in from other stations on a short-term basis, as required.

140. There was some discussion about why other Islands such as North Stradbroke Island had around four times more police staff than Russell Island, despite comparable population sizes. Acting Superintendent Huxley stated that the allocation of policing resources is not based on a police to population ratio. Calls for service, demographics, availability of other resources and the population numbers are all considerations in allocation of resources.

141. The comparison with the policing resources on North Stradbroke Island (Dunwich Police Division) is not 'like for like' because Dunwich Police has a significant holiday and transient base, together with a large employer and culturally significant challenges. It has higher calls for service and higher overall crime and offending levels. Administratively, Dunwich Police manages absences internally and do no obtain officer relief from mainland sections unless there are special circumstances.

142. Acting Superintendent Huxley acknowledged that the most significant issue for policing on Russell Island was fatigue management due to call out of the officers (approximately 100 instances per annum). He acknowledged that the rostering ability of the two-officer location does not match demand.

143. Sergeant Staib explained during the inquest that his attendance to calls for service diminished his ability to conduct enforcement activities on the Island. Sergeant Staib recommended that there should be four permanent police officers (one Sergeant and three Constables) stationed at Russell Island.

144. I note that a review is currently being conducted to determine future policing needs on all of the bay islands and how to overcome present issues in attracting and retaining staff into these stations. The Commissioner of Police has submitted that a specific recommendation in relation to staff numbers on Russell Island is not required and that I should simply support their review process. He has submitted that future police staffing on the Island will be dependent on a number of factors, that I have insufficient information, and that I may not appreciate the full implications or possible unintended consequences of such broad scale recommendations.

145. However, my view remains that the current police numbers on Russell Island are inadequate to keep up with demand. Police numbers should be increased to assist with enforcement activities involving speeding, and drink and drug driving. Sergeant Staib's recommendation of four permanent police officers is a reasonable one.

It is important that mainland police enforcement activities continue on the Island

146. It is noted that the Russell Island police are also residents of the Island and have to live closely with those that they police. Ethan's sister has submitted that some inferences may be made that this may be why informal warnings were being issued for vehicle roadworthy matters, in place of vehicle safety notices. I make no criticism of Sergeant Staib or other police officers on Russell Island in relation to this. However, it does in my view, highlight the importance of continuing to have police officers from the mainland visit regularly for the purposes of these types of enforcement activities, to supplement the activities by local police; and continued oversight by the mainland police.

A vehicle-mounted radar should be allocated to the Island and police trained in its use

147. Sergeant Staib explained that he did not have a vehicle-mounted mobile radar, which made speed enforcement difficult. Without it, he could only detect drivers who were speeding by following them. He was once able to "beg, borrow and steal" a vehicle mounted mobile radar for a two month period but had not been able to get it back to Russell Island since.

148. The Commissioner of Police has advised that he does not wish to allocate a vehicle-mounted radar to the Russell Island police at this stage. The police officers currently stationed there have not been qualified to operate a vehicle-mounted radar. He proposes that a hand held device be allocated to them for a six-month trial. The Russell Island police would be trained to operate the hand held radar during this period. An evaluation would then be undertaken to determine whether the hand held radar has been successful and whether there is a need to allocate extra resources and progress to a vehicle-mounted radar.

149. However, my view remains that a vehicle-mounted radar would be more beneficial. I have not been advised how much this would cost but it would be money well spent. I place great weight on the recommendation of Sergeant Staib, who has been the OIC on the Island for around five years. From a safety perspective, I see no point in delaying this initiative.

A drug saliva-testing device should be allocated to the Island and police trained in its use

150. In terms of drug testing drivers, Sergeant Staib explained that they were completely reliant on identifying indicia and then having to escort people over to the mainland for a blood test.

151. They did not have the ability to take saliva swabs on the roadside because only selected Bayside road police had the necessary training.

152. I note that the saliva swabs only detect the existence of a relevant drug, not the concentration of the drug in the bloodstream, so if there is a positive result, further blood testing is still required.

153. The Commander of Engagement and Road Policing Command, Superintendent Dale Pointon, has advised that since 2013, drug testing conducted by police officers has moved from a Brisbane based model to a state based model. As such, training of officers is a resource issue. To date, the Queensland Police Service has 503 officers trained in drug testing. Of that number, 372 officers are within the Road Policing Command. The remaining 131 officers are from an identified specialist area.

154. Superintendent Pointon has also advised that the cost of drug testing is more expensive and time consuming than the RBT process. The Queensland Police Service currently only has 64 drug testing devices in Queensland. The cost of the device ranges in price from $6,000 to $8,000. The device is currently allocated in Queensland with a range of one device between 9,000/63,0000 licensed drivers.

155. Superintendent Pointon stated that historical records of drug testing on Russell Island from the Road Policing Command indicate that the Island has no greater drug problem than other regions. Superintendent Pointon is of the view that a device allocation to Russell Island would therefore be impractical. However, I wonder whether the statistics would change on the Island if there was more testing, due to better resources?

156. I understand that there is a cost involved with the allocation of a saliva drug testing device and the training of police officers on Russell Island. However, I am still of the view that because Russell Island is a distinct Island community, with an increasing population, and no availability of health practitioners to conduct blood testing after hours, a saliva drug testing device should be allocated. This is likely to increase community faith in police drug testing procedures and act as a deterrent for drug drivers. Safety should be the priority on the Island.

157. From a financial perspective, a saliva drug testing device on the Island may well save money in the future because it will free up resources by circumventing the need to loose police officers for hours to escort drivers to the mainland for blood testing in the event there is an initial negative saliva test result.

Initial saliva drug testing procedure should be simplified

158. Sergeant Staib explained that the legislative regime for saliva drug tests was a constraint because there was a requirement for two separate swabs to be taken by two separate police officers - one on the roadside and one back at a police station.

159. In my view, consideration should be given to removing the legislative constraint to conduct two saliva swabs. It is only an initial test to determine whether a further blood test should be conducted, so why have two initial tests? My understanding is that a similar review was conducted in relation to RBTs years ago and the requirements were decreased.

Initial drug and alcohol testing should be mandatory

160. Ethan’s sister has submitted that drug testing of drivers should be mandatory for all motor vehicle accidents, which result in a fatality. I agree. In my view, all drivers should be subjected to an initial alcohol and drug test where they have been involved in a motor vehicle accident that has, or is likely to, result in a fatality. This will require legislative change.

161. In the meantime, I am of the view that the police should implement such a policy on Russell Island and I note that Superintendent Pointon has suggested this as an option.

Consideration should be given to whether Queensland Ambulance Service officers could take blood samples for drug testing of drivers

162. Under the current legislative regime, blood tests for drugs have to be conducted by a doctor, nurse or qualified assistant.

163. Although there are two doctors who work at a Clinic on Russell Island during the day, they do not reside on the Island and there is no after hours service. There are also no nurses or qualified assistants residing on the Island. Therefore, if a Russell Island Police Officer observes indicia of drugs after hours, they have to arrest the person and escort them to the mainland. This takes considerable time and it is not practical if the police officer is the only officer on duty.

164. I am of the view that the Queensland government should consider whether it is feasible for Queensland Ambulance officers to be given the legislative authority and training to conduct such testing in more remote communities such as Russell Island.

Police participation at Redland Transport Advisory Group Meetings should be improved

165. The Redland City Council has advised that the incident, which resulted in Ethan's death, was discussed at a Redland Transport Advisory Group (RTAG) meeting. These meetings are generally held twice a month and are attended by representatives from the Queensland Police Service (usually the Officer in Charge of the Capalaba Road Policing Unit), the Council, and the Department of Transport and Main Roads.

166. The Council has advised that if police identify deficiencies as part of their reports, the Council will always assess this and take action where warranted.

167. Noting the importance of the RTAG meetings, it was disappointing that Sergeant Staib was not even aware that there was such a meeting. He stated that he did not feed information relating to traffic incidents on Russell Island to his chain of command, except for fatal incidents.

168. In my view, if the RTAG meetings are to be representative of the traffic issues in the Redland City Council community, it is important that the Officer in Charge of the Capalaba Road Policing Unit communicates with all Officers in Charge of each police station within the region about traffic safety matters, prior to attendance. I also recommend that a Police Liaison Officer attend each RTAG meeting.

Public transport on the Island should be increased

169. There is currently no public bus service on Russell Island. A bus service was trialled on Macleay Island in around 2008, but this ceased due to the lack of utilisation and cost.

170. The Redland City Council has advised that they have continually lobbied the Queensland Government (Department of Transport and Main Roads, as well as TransLink) for a bus service under the Go-Card system, but no services have been agreed to be provided to date.

171. In my view, the Department of Transport and Main Roads should re-consider a public bus service on Russell Island from a safety perspective. A public bus service would provide clear safety benefits to the growing community by keep vulnerable residents (such as children and elderly people) off roads that are not serviced by footpaths. It would also discourage drink and drug driving and would fill the gap, where residents are not drinking at a commercial venue.

Skateboards and similar wheeled recreational devices should be prohibited from public roads

172. In Queensland, providing that the speed limit on the road is 50km/h or lower, and there is no dividing line or medium strip, it is legally permissible to ride a skateboard on a road during the daytime. There is no requirement to wear a helmet when doing so.

173. Mr Erbs advised that South Australia requires skateboarders to wear helmets on roads. Victoria and New South Wales are currently reviewing this issue.

174. In my view, it is unsafe to allow skateboards and the like on public roads. I agree with the concerns raised by the Redland City Council that they are an unregulated form of transport. They do not need to meet safety standards that other regulated forms of transport must. For example, bicycle riders are required to wear helmets but skateboard riders are not. Skateboards do not have brakes, so their braking ability is limited. Also, reflective clothing or illumination devices are not legislated for skateboard riders who may use a road at night.

175. Skateboard riders on a road are mixing in an environment where they rely on the terrain as to what side of the road they travel on. They will naturally gravitate to smoother parts of the road. Skateboards generally have small diameter wheels that are better suited to concrete or asphalt. If a skateboard is ridden into a pothole or onto loose gravel, the rider may be susceptible to unanticipated dismounting.

176. As it turns out, Ethan was not legally permitted to ride his skateboard on Centre Road because the speed limit was 60km/h at the time of the incident. Ironically though, if the speed limit on Centre Road were reduced to 50km/h, as per my suggestion, skateboarders would then be legally permitted on that road. This is an unsatisfactory outcome.

177. In my view, the TORUM should be amended so that skateboards and other similar wheeled recreational devices are prohibited from all public roads in Queensland. At the very least, the TORUM should be amended to mandate helmet usage (and reflective clothing / illumination devices at night time).

178. I offer my condolences to Ethan’s family and friends and to the Russell Island community.

179. I close the inquest.

John Hutton
Coroner
Brisbane

26 July 2017