QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of George Robert LOWE**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2009/2264
DELIVERED ON:	2 November 2012
DELIVERED AT:	Cairns
HEARING DATE(s):	9 September 2011 and 2 November 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Police pursuit.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Sergeant Anthony Lesic and and SPLO Robert Paul	Mr Craig Pratt (Gilshenan & Luton Lawyers)
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 organizations 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 George Robert Lowe. 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 morning of 25 September 2009, 80 year old George Lowe set off from his house in Malanda and drove towards Cairns. His manner of driving alarmed another driver sufficiently for the driver to immediately report it to police. A crew from Kuranda police station was notified of the complaint and went on patrol to see if they could intercept Mr Lowe as he drove along the Kennedy Highway.

They soon spotted Mr Lowe's vehicle on the western side of the Kuranda Range travelling towards Cairns. They also observed his vehicle to be driven erratically and issued a direction to stop by use of their siren and emergency lights. Twice Mr Lowe's vehicle veered to the left, apparently to pull over, only to return to the eastbound lane and continue at moderate speed. The driver of the police vehicle decided to abandon the attempt to intercept Mr Lowe contemporaneous with an order to do so from the Cairns based pursuit controller. Minutes later police received notification that Mr Lowe's vehicle had been involved in a collision while descending the eastern side of the range. His vehicle had veered into the opposite lane striking a prime mover and killing him instantly.

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; and
- consider whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force.

The investigation

The coronial investigation was conducted by the QPS Ethical Standards Command (ESC) and a detailed report was prepared by Senior Sergeant Richard Symes. He gave oral evidence at the inquest.

The initial management of the scene was necessarily conducted by the officer driving the vehicle that had initially attempted to intercept Mr Lowe. He was

driving the nearest police vehicle to the scene of the accident when police were notified and it was appropriate that he responded to provide emergency assistance or first aid. Thereafter officers from Cairns police took over management of the scene. ESC officers were notified given the earlier involvement of police and travelled from Brisbane that afternoon to begin their investigations.

Senior Constable Andrew Ezard from the Cairns Forensic Crash Unit attended the scene and made observations that later allowed him to construct a forensic map of the scene and to provide an explanation of the likely cause of the collision. He arranged for a series of photographs of the scene to be taken.

Senior Sergeant Symes and a colleague conducted interviews with the two officers involved directly in the incident and the Mareeba communications officer who had taken the role of pursuit controller. They arranged for the driver of the police vehicle to provide a urine sample on the afternoon of 25 September 2009 and this was sent for toxicological analysis. Later a videotaped re-enactment was conducted with this officer.

The prime mover and Mr Lowe's vehicle, both involved in the collision, were inspected by QPS mechanics.

The ESC officers arranged for statements to be taken from civilian eye witnesses to the collision and to the manner of Mr Lowe's driving in the lead up to the incident. A statement was also taken from Mr Lowe's son.

I am satisfied all relevant sources of information have been accessed and the results effectively collated. I thank those involved for their efforts, although I express my concern that the investigation report was not provided to my office until twenty-two months after the death.

The inquest

A pre-inquest conference was held in Brisbane on 9 September 2011. Mr Johns was appointed counsel assisting and leave to appear was granted to the Commissioner of the Queensland Police Service and the officers involved in the incident. The inquest was held in Cairns on 2 November 2012 at which the investigating officer and the two officers who had attempted to intercept Mr Lowe gave evidence. In drawing my conclusions for these findings I also considered information contained in the 65 exhibits tendered.

The evidence

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

Social history

George Robert Lowe was born on 18 December 1928. He had worked as a fitter and turner for many years but was long retired at the time of his death. He was residing alone in Malanda although is son Darren lived nearby. It appears that in the weeks leading to his death, Mr Lowe was suffering from some health problems. He had suffered a fall which his son says was playing on his mind. He had also complained of suffering some 'bad nights' in the week prior to his death. This was not discussed in any further detail and there is no indication of any other particular change in mood or demeanour.

Although his destination on 25 September 2009 is not known, he had been to Cairns for medical treatment in the days following his fall. Darren Lowe told investigators he thought his father must have been having a 'bad day' on the day of his death as his clothes were left on the floor near his shower. This was most unusual, he said, as his father was usually very neat. Darren Lowe also told investigators that his father was a safe driver, his only complaint being that his father would occasionally cut corners too much for his liking. He had no criminal history and no dealings with police that might have caused him to fear or dislike them. His apparent failure to stop when directed by police remains baffling to his family.

Mr Lowe was a member of the Atherton Bowls Club and, in keeping with his trade, enjoyed working with his hands in various forms. He is sadly missed by his family and friends.

Background

John Epson was travelling from Ravenshoe to Mareeba on the Kennedy Highway on the morning of 25 September 2009. He recalls an oversize escort vehicle travelling in the opposite direction and could see the prime mover and oversize load coming towards him. Looking in his rear view mirror Mr Epson saw what he described as a sandstone coloured Nissan pull out violently from behind a Toyota utility travelling directly behind his vehicle. He stated the Nissan accelerated at great speed, up to 160km/h on his assessment, and overtook the Toyota. This brought the Nissan directly in the path of the prime mover and Mr Epson was convinced there was going to be a collision. At the last second the Nissan pulled back into the correct lane behind Mr Epson, missing the prime mover by inches. As the Nissan was still travelling at high speed Mr Epson feared it was going to run into the rear of his vehicle and he yelled a warning to his passenger. In his rear view mirror he saw the Nissan break heavily before speeding up again to pass Mr Epson's vehicle. As it did Mr Epson saw the driver was an elderly man.

Once it had passed him the Nissan continued to drive erratically, breaking so hard at one point that blue smoke emanated from the tyres. Mr Epson was so concerned by the manner of driving, convinced as he was that the driver was trying intentionally to kill himself or someone else that he pulled into Mareeba police station and advised an officer of what had occurred. He told police the other vehicle was driving towards Cairns and provided a registration number of 250JJZ.

That report resulted in a radio communication from Mareeba to Kuranda station advising of the complaint they had received from Mr Epson. The information conveyed was that the vehicle in question was driving erratically and had just overtaken some vehicles as it came into Mareeba.

Initial police contact and attempted intercept

This message was heard by Sergeant Anthony Lesic and Senior Police Liaison Officer (PLO) Robert Paul at Kuranda Station. Sergeant Lesic told the inquest that this message was followed by a telephone call from the female officer at Mareeba who had spoken to Mr Epson. He says it was made clear in this call to him that the complaint received was an apparently serious one and left him with the understanding that the allegation was one of dangerous driving.

As a result, he and PLO Paul left the station in their marked police vehicle and headed south-west from Kuranda towards Mareeba in order to attempt to locate the vehicle. Several kilometres from Kuranda, just after 11.00am, the officers saw the Mazda 626 sedan with licence plate 250GGZ; this was the vehicle being driven by Mr Lowe. It had a sufficiently similar number plate to that given (250JJZ) and was sufficiently similar in description for the officers to surmise, correctly, that it was the vehicle subject of the complaint at Mareeba.

Sergeant Lesic and PLO Paul both told the inquest that when they first saw this vehicle it was travelling very close to the vehicle in front and was to the far left of the lane in which it was travelling.

Sergeant Lesic performed a U-turn and set off after the Mazda. As he was travelling above the speed limit in order to do this he turned on his emergency lights. Around three kilometres further on, the police officers sighted the Mazda which had slowed behind a line of traffic near the intersection of the highway with Rob Veivers Drive. As there were traffic lights at this intersection and Sergeant Lesic realised he may have to traverse it through a red light he turned on his siren as a precaution. It was around this time he saw the Mazda begin to drive erratically. Specifically, it was veering sharply right as far as the centre line and then left until it was over the fog line. Sergeant Lesic thought it highly likely the driver was affected by alcohol.

A short time after the police vehicle travelled through the traffic lights the Mazda pulled more significantly to the left of the road. PLO Paul recalls it slowing to a near stop although Sergeant Lesic thought it only slowed marginally. In any event both thought the driver was obeying the direction to stop. This was short-lived as it quickly veered back into the centre of the lane and resumed its speed. The officers say the speed of the Mazda did not exceed the speed limit of 80km/h during the period in which they were following.

Just before the Barron River Bridge, Mr Lowe's vehicle again pulled to the left of the road so that it's left wheels were well over the fog line. Again it veered to the right and back into a normal line of travel, this time only just missing the

guard rail on the bridge. A few hundred metres past the bridge a third such incident occurred although this time at a point on the road where there was no obvious place to pull over. This resulted in the Mazda striking a series of guide posts.

At this time the vehicle in front of the Mazda pulled over and Mr Lowe then veered sharply to the right and overtook that vehicle. Sergeant Lesic also overtook the other vehicle and continued after the Mazda.

Shortly after they had sighted the Mazda Sergeant Lesic advised Mareeba Communications. They appropriately maintained contact with the communications supervisor at Mareeba, Sergeant Brian Smith. Under QPS policy he soon became the 'pursuit controller'. At around the time Mr Lowe was pulling over to the left for a third time (though before he had passed the car in front) the following communication took place:

LESIC:	*293 Mareeba*
OPERATOR (Smith):	*Go ahead*
LESIC:	*Yeah 293 Mareeba can you just show us attempting to intercept vehicle 250GGZ, ah I believe it's a Mazda of sorts, he's all over the road and a danger to other drivers at this stage.*

Termination of the attempt

After Mr Lowe and Sergeant Lesic had both passed the other vehicle they entered a straight section of highway that leads to a sharp right hand turn. This signals the commencement of a sharply winding section of road ascending the western side of the range. It is during this section of road, around 300m after Mr Lowe had struck the guide posts that Sergeant Lesic decided it was too dangerous to continue. He considered by this stage he was in a pursuit but says he was mindful of the nature of the road ahead and combined with the erratic driving from the Mazda believed the pursuit needed to be terminated because the risks it posed outweighed the potential benefit of intercepting Mr Lowe.

Almost simultaneously, although Sergeant Lesic is sure it was moments after he had made his own decision to terminate, the following conversation took place:

SMITH:	*If that vehicle's failing to stop and you've commenced a pursuit have you got a pursuit category that you're following the vehicle for?*
LESIC:	*Yeah. Vehicle has um UI twenty kilometres an hour just refusing to stop at this stage. Um he was UI in relation to a suspect driver*

	ah on the road UI the info on him, he's still refusing to stop.
SMITH:	*Mate it doesn't come under any, under any of those pursuit categories so um just terminate the pursuit now please UI failing to stop.*
LESIC:	*Yeah. UI he's a danger on the road at this stage, he's already run off the road UI. He's not continued, we've terminated, I'll give you odometer when you're ready.*

The last sentence is a reference to QPS procedure on termination of a pursuit. In accordance with that policy Sergeant Lesic pulled to the side of the road, provided his odometer reading to the pursuit controller and conducted an inspection of his vehicle. A short time later he noticed an off duty officer known to him travelling west. He flagged his colleague down and asked that officer if he had noticed Mr Lowe's vehicle but that officer had not.

As he was walking back to his car he received a radio broadcast advising of a traffic crash at the bottom of the range.

The collision

On being advised of the crash Sgt Lesic and PLO Paul went to the site. They were the first emergency service officers on scene.

The crash occurred on a section of road, approximately 2.5km east of the Rex Lookout. It has a speed limit of 60km/h. A 45km/h recommended speed sign applied to the corner on which the collision occurred. Eye witnesses indicate that Mr Lowe was travelling over the speed limit at the time his vehicle veered onto the wrong side of the road into the path of a prime mover and trailer travelling in the opposite direction. The collision caused the truck to jack-knife. The driver of the prime mover and several other people assisted in moving parts of the wrecked Mazda to gain access to Mr Lowe. The positioning of his body in the wreckage meant he was unable to be immediately extricated. Those present attempted to provide first aid although early assessments were that he had no pulse and, despite the arrival of Sergeant Lesic and, shortly after, a Queensland Ambulance Service paramedic, nothing could be done to save Mr Lowe. He was pronounced deceased at the scene.

The autopsy

A post-mortem examination was conducted on the body of Mr Lowe at the Cairns Base Hospital mortuary on 29 September 2009 by an experienced forensic pathologist, Dr Paull Botterill.

Toxicological testing on blood samples taken at autopsy was negative for the presence of alcohol or other drugs.

In his report Dr Botterill stated:

> *The relatively short time between the loss of control of the vehicle and death means….the possibility of an underlying irregularity of heart rhythm or very recent stroke cannot be completely excluded.*

He noted the significant injuries suffered by Mr Lowe in the collision and determined the cause of death to be:

> (a) Multiple injuries; *due to or as a consequence of*
> (b) Motor vehicle collision (driver).

The investigation findings

The urine sample taken from Sergeant Lesic on 25 September 2009 proved negative for alcohol or drugs.

Mechanical inspections of the prime mover and the Mr Lowe's vehicle showed both were in satisfactory condition, certainly to the extent that no mechanical fault was a contributory factor in the collision.

The forensic analysis conducted by Senior Constable Ezard showed evidence of sharp braking by the prime mover involved in the collision. Applying recognised mathematical formulae to the observations made at the scene he was able to determine the prime mover was travelling at between 48 and 51km/h at the time it commenced braking.

On his examination of the scene Senior Constable Ezard was unable to find any friction marks associated with the vehicle of Mr Lowe. He concluded this meant either Mr Lowe had not braked or had not applied the brakes with sufficient force to generate the heat necessary to leave any such mark. Senior Constable Ezard attributed the collision to Mr Lowe's vehicle having travelled into the westbound lane while descending in an eastbound direction. This left the driver of the prime mover insufficient time to take effective evasive action.

Inquiries revealed Mr Lowe to be a law abiding and responsible citizen. His behaviour on the day of his death was completely out of character. Although I can not prove it, I strongly suspect Mr Lowe suffered a sudden and undiagnosed health related event that degraded his judgment and his ability to properly control his car. I do not consider it likely his actions were intentional.

Findings required by s. 45

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 his 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 George Robert Lowe.

How he died -	He died as a result of injuries sustained when the vehicle he was driving veered into oncoming traffic and collided with a prime mover while he was descending the Kuranda Range towards Cairns. A short time before this he had failed to stop his vehicle when directed to do so by police.
Place of death -	He died on the Kuranda Range near Cairns in Queensland.
Date of death -	Mr Lowe died on 25 September 2009.
Cause of death -	Mr Lowe died as a result of multiple injuries suffered in a motor vehicle collision.

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.

The direct and proximate cause of the death of George Lowe was the manner of his driving which saw him travel onto the wrong side of the road as he descended a steep and winding section of the Kuranda Range on the Kennedy Highway. This brought him into the path of a slowly ascending prime mover leaving the driver of that vehicle with no opportunity to take evasive measures. Notwithstanding he was principally the architect of his own demise, in view of the proximity of the death to the police pursuit it is appropriate to consider whether the officers involved complied with the relevant QPS policies.

QPS pursuit policy

On 1 January 2008, after an extensive trial, 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 relevant to this case.

When can a pursuit be commenced and continued?

The principles underpinning the policy are outlined in the Operational Procedures Manual (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 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.

If the circumstances do justify a pursuit, the policy sets out to aid the process of risk analysis by dividing these situations into three categories:

- Pursuit category 1 –There are reasonable grounds to believe the driver or occupant of the vehicle will create an imminent threat to life; he/she has or may commit a homicide or attempt to murder or has issued threats to kill any person.

- Pursuit category 2 – It is known the driver or occupant has committed an indictable offence, a summary offence involving the unlawful use of the vehicle or dangerous driving prior to the attempted interception.

- Pursuit category 3 – There is a reasonable suspicion the driver or occupant of the vehicle has committed an indictable offence or a summary offence involving the unlawful use of the vehicle.

The category of the pursuit becomes relevant to the process of risk analysis because the policy makes it clear to officers that, the less serious the category, the less tolerance there is for risk and, therefore, the more likely it will be that the risks of a pursuit will outweigh any potential benefits. The policy also sets out several factors that must form part of the ongoing process of risk assessment to be considered by an officer.

The policy makes it clear that if the pursuing officers are relying on the indictable offence of *dangerous operation of a motor vehicle* to justify the pursuit, then the driving constituting that offence needs to have occurred prior to the initial attempt to intercept.

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?

All parties agreed at the inquest that there had been a pursuit in this case. Sergeant Lesic considered it commenced when Mr Lowe pulled over to the left of the road for a third time after the police had activated their siren but then, again, failed to stop. I am of the view the pursuit commenced shortly after the first occasion Mr Lowe pulled over to the left, but then resumed on a normal course. At this time it ought to have been clear he had disobeyed a direction to stop and, by continuing to drive even at a moderate speed, was attempting to evade the police vehicle.

Was the pursuit in accordance with QPS policy?

Sergeant Lesic had a reasonable basis to suspect Mr Lowe had committed the offence of dangerous operation of a motor vehicle based on the information he received from Mareeba. It follows that he was entitled to pursue Mr Lowe when he failed to stop, subject to the application of continued assessment of risk. This was a category three pursuit which meant the risks of continuing would quickly outweigh any likely benefit. There was a requirement to terminate earlier on a scale of risk than one would in a category 1 or 2 pursuit.

I accept the evidence of Sergeant Lesic that he terminated the pursuit of his own volition prior to reaching the first of a series of sharp turns leading up the Kuranda Range. This means the pursuit lasted for around 1.5km at speeds which did not exceed the sign posted limit. It is clear from his contemporaneous explanation to PLO Paul and in his interview later that day that Sergeant Lesic was mindful of QPS policy and of the need to undertake a continual process of risk assessment.

That risk assessment was appropriately undertaken by both Sergeant Lesic and Sergeant Smith, the pursuit controller. While there had been justification to pursue Mr Lowe, despite his erratic driving, on the relatively straight section of road either side of the Barron River, the risks would have increased significantly if the pursuit had continued down the winding section of highway descending the range.

The approach taken by both officers demonstrated the way in which I expect the authors of the policy would have hoped it would be applied. This close adherence to policy continued when Sergeant Lesic pulled the police vehicle to the side of the road, turned off the engine and conducted an inspection. This served the purpose for which it is designed – to break the nexus between the police vehicle and the vehicle subject of the pursuit.

I conclude the actions of the police officer who attempted to intercept Mr Lowe in no way contributed to his death and was in accordance with all relevant QPS policies.

I close the inquest.

Michael Barnes
State Coroner
Cairns
2 November 2012