OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Chloe Louise Shelley**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Gladstone
FILE NO:	COR 1462/07 (5)
DELIVERED ON:	Ex tempore decision delivered on 17 July 2008 and written decision on 22 July 2008
DELIVERED AT:	Gladstone
HEARING DATE(s):	3 March 2008, 17 July 2008
FINDINGS OF:	Mr John Lock, Brisbane Coroner
CATCHWORDS:	CORONERS: Inquest – Motor vehicle crash, Speeding, condition of road

REPRESENTATION:

Senior Sergeant Mark Gorton – appearing to assist the Coroner

Mr Barry Ross lawyer of VAJ Byrne Lawyers– representing Ms Angela Elizabeth Connor

CORONERS FINDINGS AND DECISION

1. These are my written findings in relation to the death of Chloe Louise Shelley who died at the Royal Brisbane Hospital on 5 April 2007 from head injuries sustained in a motor vehicle crash which occurred at Gladstone on 9 February 2007. I gave ex tempore findings on 17 July 2008, on the basis that these written findings would be delivered shortly after. These findings seek to explain how the death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act 2003*[1] provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

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

    a) whether a death in fact happened;
    b) the identity of the deceased;
    c) when, where and how the death occurred; and
    d) what caused the person to die.

3. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

4. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."* [2]

5. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3] However, a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[4]

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[1] *Coroners Act* 2003, s45
[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[3] s46
[4] s45(5) and 46(3)

The Admissibility of Evidence and the Standard of Proof

6. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate."*[5] That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

7. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt. As already stated, it is an inquiry rather than a trial. If a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person, the coroner may require the witness to give evidence that would tend to incriminate the witness if satisfied it is in the public interest to do so. The evidence, when given, and any derivative evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.[6]

8. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

9. It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

10. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed a criminal offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence, and to the chief executive of the department which administers legislation creating an offence which is not indictable.[11]

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[5] s35
[6] s39
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168
[11] S 48(2)

The Evidence

11. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence.

12. Chloe Louise Shelley died from injuries sustained in a car crash on 05 April 2007. She was born on 04 January 1987 and was 20 years old at the time of her death. She is the daughter of Ms Dellma Johnston. She was the mother of a young child.

13. On 09 February 2007, at approximately 2205 hours, Chloe was a passenger in a Ford Falcon sedan bearing Queensland registration number 719 JHV. The vehicle was driven and owned by Angela Elizabeth Connor. Ms Connor and Ms Shelley were friends.

14. Sergeant Andrew Caris was the investigator in charge and he has provided a comprehensive report to the Coroner. He also gave evidence at the inquest. The substance of the investigation material is uncontroversial and is not in dispute.

15. Ms Connor provided a version of the crash to Constable Carmichael at the Gladstone Base Hospital at 0100hrs on 10 February 200. This conversation was recorded by Constable Carmichael.[12] She said that on the night of the accident, Ms Connor had been at the Chloe's home when Ms Connor had indicated to Chloe that she wished to go home. Ms Connor estimated that this would have been at about 9.30pm. Ms Connor suggested that before going home, the two of them should go for a drive into town to see if there was anyone that they knew in town.

16. Their travels saw them take the back road towards the Marina. The investigation would support that the vehicle was travelling south along Bryan Jordan Drive from the intersection with Alf O'Rourke Drive before colliding with a concrete pole.

17. Ms Connor indicated to Constable Carmichael that they got to a roundabout (intersection of Alf O'Rourke Drive and Bryan Jordan Drive) and she reports that Chloe indicated that there was a bump in the road up ahead that can give the effect of "butterflies" when travelled over in a car. Ms Connor turned south onto Bryan Jordan Drive where ultimately the vehicle she was driving travelled over the undulations in the road and then she must have lost control of the vehicle because it impacted with a concrete power pole, which was 1.3 metres from the side of the road and on the opposite side of the road on which she was travelling. The pole was severed at its base by the impact.

18. Ms Connor said to Police the following;

> *Yeah, once we got to the roundabout I knew I had to turn right and I knew I had to go a little faster that what was normal. I knew to get butterflies in your belly you had to go a bit faster but I don't remember*

[12] The tape was played in court and is exhibit E@

anything from then on. I don't know whether I did push the accelerator, I don't remember anything. I had my seat belt on….
Q. Angela, how fast were you going when you hit the bump in the road?
a. Honestly I don't know. I know when we approached the roundabout, there was another car there. I know I slowed down a bit to let the other car around. I think it was going to where the big boats are……..
Q. Do you think you were going over the speed limit?
A. Honestly, I don't know, it was all a blur, I don't know.
Q. Angela, do you remember losing control of the vehicle?
A. I remember going over.. I don't know. I remember seeing the bump in the road and how the car… I don't know….
Q. What do you think caused the crash?
A. Probably my stupidity, I don't know.

19. Sergeant Caris formed the opinion that the vehicle had left the bitumen at some point prior to impact and travelled on the dirt shoulder that abutted to the left of the vehicle on Bryan Jordan Drive. He said the roadway is the major thoroughfare through the Gladstone marina precinct. The speed limit is a combination of 60kmh and 40kmh but was 60kmh at the crash site. The crash site was 384.4 metres from the intersection with Alf O'Rourke Drive. There are several undulations and ridges in the roadway the most prominent being located 93.75 metres north of the crash location. He did not observe any skid marks on the roadway. There were markings consistent with a vehicle having driven on dirt leading from the roadway centre line to the point of impact.

20. A vehicle inspection report revealed it was in a satisfactory mechanical condition and no defects were found which could have contributed to the cause of the accident. The vehicle was extensively damaged but its use as forensic evidence was affected by the fact that the vehicle had to be broken apart by rescue workers. The first priority of course must be to road victims in such cases. The lack of yawls marks, skid marks also meant that accurate calculations of speed could not be given. The lack of tyre skid marks could be explained by the virtues of ABS breaking systems. He stated that there had not been any other serious accidents in the area although it was a known "hoon driver hotspot". He said that a 6 cylinder vehicle such as the one driven by Ms Connor would not have to be driven hard or at high revs to get it to 100 km/h, for instance in the distance between the roundabout and the undulations.

21. There were no direct witnesses to the crash. David John Ross provided a statement to the lawyers for Ms Connor. He had provided that statement within a week of the accident and before the death of Chloe. He also gave telephone evidence. He was at the time on the back deck of his motor vessel which was dry docked at the slipway of the marina adjacent to Bryan Jordan Drive. He says he was having a few beers but was not intoxicated. This is supported by police witnesses who thought they could smell alcohol but he was not drunk and it could not be said his evidence was otherwise unreliable on that basis. He says there are 2 big humps in the road which seem to have formed over time and were not designed to be there. He describes the road

and the humps as a bit of a hoon spot. He saw a late model sedan travelling along the road that night. He said the speed may have been 50, 60 or 65 km/h but it was not of such a speed that he noticed the speed as anything extra-ordinary. The vehicle was only noticeable because it was the only vehicle on the Bryan Jordan Drive in that vicinity at that time. The lighting was good and he took no particular notice of it. He would have noticed if it had any significant speed. He heard what sounded like 2 wheels hit the dirt on the left hand side of the road. He heard 2 wheels skid. He had an impression the vehicle was braking. He heard 4 wheels screech. He heard a slide and then a crash. He heard an explosion which he thinks was the pole disintegrating and a flash from the electrical wires. He ran towards the crash site and rang 000. He assisted the driver and did what he could for Ms Shelley who had obviously suffered severe injuries. The main impact to the vehicle was on the passenger side.

22. I formed the view that Mr Ross was giving an honest account of his recollection. He has had some experience in the tow truck industry and has been to such traumatic events before. He accepted that the scene of the crash and the damage found made it look like speed was a factor but was very firmly of the view that from his observations speed was not the issue. It would seem he was some 120 metres away when the vehicle passed. Sgt Caris said, and I accept, that a vehicle such as this would not need to be driven hard (thereby emitting loud revving sounds) to reach a speed at say 100 km/h. What I think I can take from his honestly held evidence is that the vehicle was not travelling at a demonstrably fast speed, nor was it revving as such, but I do not accept that from his position he could be able to categorically fix the speed at between 50 to 65kmh. I do accept that based on his evidence it is unlikely the vehicle was travelling at a speed demonstrably excessive, but a vehicle travelling at something like 80kmh would not be something he could categorically differentiate upon.

23. Whilst Ms Connor provided a version to police on the night of the incident, upon legal advice, she had refused to participate in a formal electronic record of interview. No one has been charged with any criminal offence arising out of the incident. She did give evidence to the court and did not claim that her evidence may tend to incriminate her.

24. Her evidence does not tell us anything more than what she essentially has said to the police although she now claims she does not recall talking to police at the hospital. Notable she said this when being questioned in court about her comment during the interview that she would need to go a bit faster than normal to get the butterfly affect. Her description of events; the route taken; and the events leading immediately up to the crash and as described by her in her evidence are consistent with the version she gave to police shortly after the crash, so to that extent there would be no reason to suggest that what she told police after the accident as compared to now, were somehow affected by the trauma of the events that occurred the day before. I could have readily accepted that she was traumatised and what she may have said was unreliable. I can take judicial notice of the fact that it is not uncommon for witnesses to traumatic events to have difficulty in recollecting the events. I could tell in the interview that she was understandably upset and

crying at one point, as she did in court. But it is notable that the one issue that prompts her to suggest that she cannot remember talking to police about is the one issue that provides some substance to a suggestion she was travelling greater than the speed limit. Why should I simply now accept that she could tell police accurate details about everything else but on that one part of her statement she now draws issue with as being something she cannot remember because of the trauma. In that respect I was not that impressed with her as a witness.

25. She compounded my impressions when she made the gratuitous bland assertion that she "does not drive fast in cars or do silly things." Yet here we have a person who is driving her relatively new large 6 cylinder vehicle at almost certainly faster than normal speed with the intent to get a butterfly effect over a bump in the road. That seems to me pretty silly for a start. I also do not accept, from viewing the photographs that simply going over the undulations in the road at 60 km/h is going to have any significant sensation. That was confirmed by Sergeant Caris when he said that when he has travelled over it he felt quite comfortable at 60 km/h and in an urgent situation would be comfortable in doing 100 km/h.

26. In cross examination she was also forced to admit that the bland assertion that she does not speed was incorrect, with an admission that she had been convicted of speeding in the past on three occasions. That issue would be totally unremarkable except for the fact that she somehow thinks she has to try to colour her record and put it in a rosy picture. She somewhat also unrealistically tried to suggest that she knows little about motor vehicles and whether this was a 6 cylinder vehicle or whatever when she has worked for the car dealership for some time; knew the vehicle as a demonstration model; and bought it for herself to compensate for some of the horrible things that happened to her in the past. I am afraid she just did not convince me.

27. I do not suggest she is deliberately lying. I suspect she internally does not want to face the real events that occurred. That is not unusual nor evidence of deliberate withholding of information. It is clear in my view based on all of the evidence that she was travelling faster than the speed limit and that she has then lost control of her motor vehicle. As to the extent of the speed and the factor it played in her losing control of the vehicle, I cannot make any specific findings.

28. At the same time I fully accept that she did not intentionally bring about these horrible circumstances and that she is obviously and in my view genuinely remorseful. I understand Chloe's family may not agree with this finding.

29. Ms Connor was also taken to Gladstone Hospital. She was treated in the Emergency Department. She was seen by Doctor John-Paul Cotter who has provided a statement and gave telephone evidence. He has no recollection of treating Ms Connor but as his is his procedure he took notes which are recorded in the Hospital file. His notes include the following note of what typically he would assume was information provided by the patient but he is unable to confirm as being from a conversation with Ms Connor:

Post MVA. ~80kph, as driver in car, came around roundabout, unsure of events after that.

30. Dr Cotter gave evidence which does not differ from his statement. In my view this evidence on its own does not conclusively prove anything but can be added to other evidence for consideration.

The Autopsy and Medical Treatment

31. Chloe was taken to the Gladstone Base Hospital and was later transferred to the Royal Brisbane Hospital on 08 March 2007. She later died there on 5 April 2007. The autopsy report indicates that she died from head injuries due to or as a consequence of a motor vehicle accident.

32. Dr Beng Ong performed an external autopsy examination, took toxicology samples and reviewed the Royal Brisbane Hospital medical file on 8 April 2007. Her injuries revealed from the Hospital file and as described by Dr Ong included the following:

- Subarachnoid haemorrhage to the brain with severe hypoxic brain damage
- Fracture of the right zygomatic arch(facial bone)
- Fracture of the transverse process of T12 vertebra
- Fracture of the left sacral alar
- Fracture of the left inferior and superior pubic bone
- Fracture of the left proximal femur (thigh bone)
- Fractures of the right tibia and fibula (legs)
- Fractures of the left radius and ulnar (forearm bones)

33. She developed aspiration pneumonia and had problems with ventilation. Her lower limb fractures were externally fixed initially and then removed. She showed some improvement initially but developed an infection which required her transfer to Royal Brisbane Hospital. She was given antibiotics, nutritional support and therapies including Physiotherapy and speech therapy. However her neurological damage was such that she showed no improvement. In what must have been a painful and harrowing decision on 15 March 2007 her family understandably and properly withdrew active treatment and she was given comfort care. She passed away on 5 April 2007.

Findings required by s45

34. The facts establish that at about 10pm on 9 February 2007 a single vehicle crash occurred. Ms Connor was the owner driver of a Ford falcon Sedan registration number 719 JHV. It was being driven in a southerly direction along Bryan Jordan Drive. Ms Shelley was in the passenger seat. The vehicle travelled over an undulation in the roadway and left the roadway and collided with a concrete power pole with such force that it snapped at the base. The passenger side of the vehicle sustained the most severe damage. There is really no doubt that Ms Connor lost control of the vehicle she was driving. There is no way of suggesting otherwise. It has travelled to the left hand side of the road and then travelled back across the roadway,

onto the incorrect side and hit the pole on the passenger hand side. The vehicle was extensively damaged. The pole was snapped in two at its base. That is clear. Scientifically this physical evidence was not in a state to be able to accurately state at what speed the vehicle was travelling when it hit the undulation. Sgt Caris submits that a likely scenario is that the vehicle was travelling sufficiently fast enough to momentarily lose front wheel contact and the steering wheel turned sufficiently to put the vehicle out of control. It hit the dirt to its left momentarily and then over corrected into the wrong lane. That does seem a possible scenario based on the evidence at the scene.

35. To the extent that a finding of a specific speed can be made or the extent to which the speed played a factor in the vehicle losing control I am not able to say. What I can say is that this vehicle was not travelling at 60 km/h. Ms Connor's statement to police that she was intending to go over the humps in the road to get a butterfly effect and that to do so she had to go a bit faster than what was normal paints a truer picture. It is supported by the evidence of Dr Cotter who records a speed of 80 km/h in his notes. This might contradict the evidence of Mr Ross who saw a vehicle travelling at a normal speed but his evidence would have to be balanced with the fact that he was not paying a lot of attention and the difference between a vehicle travelling at 60 km/h or at say 80 km/h from where he was sitting would not be that noticeable. However taking into account the lack of scientific accuracy and his evidence, overall it does not support a finding of speed higher than that. That may very well have been the case but the evidence is not such that on the balance of probabilities I could go make a finding to that extent.

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

    (a) The identity of the deceased was Chloe Louise Shelley

    (b) The place of death was Royal Brisbane Hospital, Brisbane, Queensland.

    (c) The date of death was 5 April 2007.

    (d) The formal cause of death was:
    1(a) Head Injuries, due to, or as a consequence of
    1(b) Motor Vehicle accident (driver).

Concerns, Comments and Recommendations

37. Section 46 of the Act 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. It is apparent that this stretch of road

is used by so called “hoon drivers”. I do not think that the undulation in the road inherently is dangerous or necessarily contributory other than that there is some evidence the undulations are used by drivers to drive in a manner which uses the undulations, perhaps with excessive speed, and thus makes the driving potentially dangerous. I intend to write to the Gladstone Shire Council pointing out the circumstances of this case and aspects of the evidence and suggesting they consider remove the undulations if this is practical. A warning sign is not appropriate and may only encourage or advertise its existence.

To the family of Chloe Shelley, I again offer my condolences.

I close this inquest.

John Lock
Brisbane Coroner
22 July 2008