QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquests into the deaths of Kenneth Roland OWENS & Daniel Arthur STILLER**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/1631 & COR 2010/4091
DELIVERED ON:	15 March 2013
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HEARING DATE(s):	16 August 2012; 16-19 October 2012 & 26 October 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Wide loads management, investigations of police related fatalities

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns

<u>Owens Inquest</u>

Senior Constable Mark Doust:	Mr Glen Cranny (Gilshenan & Luton Legal Practice)

Commissioner of Queensland Police Service:	Mr Wayne Kelly (QPS Solicitors Office)

Stiller Inquest

Wife of Deceased:	Mr Andrew McGinness (McGinness & Associates)
Mr John Dodd:	Mr Richard King (instructed by Potts & Co Solicitors)
Officers Mearns, Norrish, Stocker, Lindsay & Sparkes:	Mr Glen Cranny (Gilshenan & Luton Legal Practice)

Both Inquests

Department of Transport & Main Roads:	Ms Susan Martin

Table of Contents

The *Coroners Act 2003* provides in s. 45 that a copy of inquest findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the subject matter of any recommendations. These are my findings in relation to the deaths of Kenneth Roland Owens and Daniel Arthur Stiller. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Preface

Kenneth Owens and Daniel Stiller died within six months of each other as a result of separate traffic crashes on the Bruce Highway. In each case the collision was associated with the escort of wide loads from southern to central Queensland. Their deaths, and other similar deaths in Queensland, established the basis for a detailed examination of the regulations and practices associated with the escort of wide loads in this state. This is especially so given the increasing incidence of such escorts which are commonly associated with mine and gas extraction development in central and southern Queensland.

The overlap of issues and witnesses relevant to the safety questions raised by these cases made it appropriate to conduct the inquests into the deaths of Mr Owens and Sergeant Stiller concurrently. I will make findings as to the circumstances of each death and then consider possible risk reduction reforms arising from the evidence heard in both cases.

Part 1: Death of Kenneth Roland Owens

Introduction

Kenneth Owens, accompanied by his wife and two friends, was travelling south on the Bruce Highway just before sunrise on 17 May 2011. Several hours earlier a prime mover transporting a miner's hut had set off from the Gold Coast under police escort intending to travel north to Moranbah. The two vehicles crossed paths just south of Maryborough on a two lane stretch of the highway. The width of the miner's hut caused it to protrude into the southbound lane. Mr Owens failed to avoid the miner's hut, striking its front right corner. His three passengers survived the collision, however, Mr Owens was killed instantly.

The investigation

An investigation into the circumstances of the death was conducted by Senior Constable Glenn Rusten of the Wide Bay Forensic Crash Unit.

Senior Constable Rusten travelled to the scene of the collision with his supervising officer within 1½ hours of it occurring. He told the inquest that on arrival he could not locate any defects on the road surface that in his opinion would have contributed to the crash. Senior Constable Rusten took a series of photographs and later engaged a scenes of crime officer to take a more detailed set of photographs. He inspected each of the vehicles involved in the collision and those in the convoy associated with the oversize load. He inspected the QPS permit, work diaries and other documentation associated with the drivers involved in the escort of the oversized load.

Senior Constable Rusten collected relevant pieces of debris and made markings which later allowed him to utilise a LIDAR measuring device to map the scene and create a scale plan. He obtained traffic histories of the drivers and arranged for mechanical inspections of the prime mover, silver Commodore and the police vehicle driven by Senior Constable Doust. Breath testing of the driver of the prime mover and Senior Constable Doust had occurred prior to his arrival. Statements were taken from the three surviving occupants of the silver Commodore, from all members of the oversize load convoy and from a number of other civilian eye witnesses.

The involvement of Senior Constable Doust in the escort of the vehicle meant that the QPS Ethical Standards Command was notified. Officers from that unit attended and conducted the interview with Senior Constable Doust and later reviewed the report of Senior Constable Rusten.

I am satisfied the investigation was thoroughly and professionally conducted and all relevant material was accessed. I am grateful to Senior Constable Rusten for his efforts.

The Inquest

A pre-inquest conference took place on 16 August 2012. Mr Johns was appointed as counsel assisting and leave to appear was granted to representatives for the QPS Commissioner and the Department of Transport and Main Roads.

I viewed the scene of the collision with representatives of the parties on 15 October 2012. The inquest commenced in Maryborough on 16 October 2012 and leave to appear was granted on behalf of Senior Constable Doust. Further evidence common to the issues for consideration in this inquest and the Stiller inquest was heard in Brisbane on 19 October 2012.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The evidence

Movements of Mr Owens prior to the collision

At the time of his death Kenneth Owens, known as ‘Taffy’ to his family and friends, was 84 years of age and living at Hervey Bay with his wife, Norma. He and Norma had been together for 65 years and over the preceding 22 years had been friends with Keith King and his wife, Myrna. Myrna King had arranged for Mr Owens to drive her to Brisbane Airport on the morning of 17 May 2011 where she was due to catch an international flight later in the day.

Mr Owens and his wife arrived at the King residence at approximately 4:30am. Mr Owens was driving a 1994 silver Commodore which he had on loan while his own car was being serviced. They set off in the dark towards Brisbane with Mr Owens driving, Mrs Owens in the front passenger seat, Mr

King in the rear passenger seat and Mrs King seated behind the driver. They had plenty of time to travel to Brisbane. Mrs King told the inquest that in her experience Mr Owens was a good driver and this was reflected in the way he drove that morning. He drove at around 90km/h on those stretches of road with a speed limit of 100km/h and at no time was she concerned with his manner of driving.

This observation of Mr Owens' driving was corroborated by another witness who appeared at the inquest, Warren Larkin. At about 5:20am he was driving south on the Bruce Highway from Maryborough to Tiaro. In the area to the north of the intersection with Old Gympie Road (just south of Maryborough) he was travelling 200 to 300 metres behind the silver Commodore he now knows was being driven by Mr Owens. He says the Commodore was travelling at about 90 to 95km/h and there was nothing out of the ordinary in the manner in which it was being driven. At this time, moments before the collision, the weather was fine and clear, the sun was yet to rise and a full moon lit the area from the west.

The wide load

Queensland Police Central Permit Office (CPO) issued a single trip permit (No. 879/11 SER) to Beattie Transport Pty Ltd on 16 May 2011. The permit enabled an excess dimension indivisible load to be moved from Ormeau to Moranbah. The load was to be a miner's hut with a width not exceeding 5.49 metres. The permit allowed travel between the hours of 00:01am and sunset on Tuesday, 17 May and between the hours of sunrise and sunset on Wednesday, 18 May 2011. It required (for the relevant section of road) an escort of one police vehicle and two civilian pilot vehicles.

As with all permits issued by the CPO it required the operator to comply with the Form 4 guidelines on the escort of such loads issued by the Department of Transport. I will examine the contents of that guideline later in these findings. At the moment it is sufficient to note that the guidelines address the type and positioning of warning lights attached to the load and escorting vehicles; the signage to be carried by vehicles in the convoy; and the spacing of those vehicles while in transit depending on the type and location of road traversed.

Escort prior to the collision

The police officer assigned to escort duty for the load was Senior Constable Mark Doust. He told the inquest that prior to becoming a police officer he was employed as a heavy vehicle inspector with the Department of Transport. He had also escorted many other oversize loads since becoming a police officer.

He arrived at the staging area in Ormeau shortly before midnight on 16 May 2011. Senior Constable Doust inspected the prime mover, trailer and oversize load. On measuring the load he noted it to be approximately 5.4 metres wide and confirmed it also otherwise fitted within the dimensions listed on the permit. He then inspected the lighting and signage on the prime mover and pilot vehicles.

The prime mover was fitted with a yellow and black ‘oversize’ sign and a single rotating orange light. Another two rotating orange lights were attached to the rear of the trailer. Red and yellow warning flags were situated at the four extremities of the load. Orange and red marker lights had been positioned at two metre intervals along both sides of the load. Another large ‘oversize’ sign was attached to the rear of the trailer body.

In addition to these measures which were all required by the Form 4 guideline, the driver of the prime mover had attached large fluorescent markers on each of the forward, lower extremities of the load. The driver, Robert Burton, told the inquest he did this to enhance the visibility of the load.

This was only the second time Mr Burton had driven an oversize load at night. On the first occasion he was disconcerted by the number of ‘near misses’ he had experienced from oncoming traffic. In the course of that first night-time escort another vehicle had collided with the rear of his trailer.

Each of the pilot vehicles was fitted with two rotating amber lights and an ‘oversize load ahead’ sign.

The inquest was told that, because the width of the load was less than 6.1 metres, the Form 4 guideline (in place at the time of the collision) did not require lighting to be attached to the forward extremity of the load.

The load was positioned on the trailer so that it overhung the driver’s side more than the passenger side. Mr Burton told the inquest this was done in order to assist with the balance of the vehicle which was affected by the predominantly right to left downward camber on most sections of road.

Senior Constable Doust inspected the work diary of Mr Burton and the drivers of the pilot vehicles. Once satisfied that the load and each of the vehicles to be used in the escort complied with the permit and the requirements of the Form 4 guideline, he allowed the convoy to set off. This occurred shortly after 12:30am on 17 May 2011.

The load travelled north along the Bruce Highway limited by the maximum statutory speed of 80km/h. After negotiating the dual carriageway section of the Bruce Highway, the convoy travelled north on the two lane section of highway north of Cooroy to an area just to the south of Maryborough.

At this time the lead pilot vehicle was travelling approximately 900 metres in front of the wide load with the high visibility red QPS highway patrol vehicle of Senior Constable Doust 500 metres behind it and 400 metres in front of the wide load. The blue and red emergency lights were activated on the highway patrol vehicle.

Mr Burton told the inquest he was driving so that the passenger side of the load was as close as he could safely position it to the guideposts on the left hand side of the road. He agreed with the assessment of Senior Constable

Rusten that the effect of this was that the load protruded between 1.2 to 1.5 metres into the opposite lane on this stretch of road.

At 5:20am the convoy rounded a gentle left hand bend and entered a straight stretch of road several hundred metres south of the intersection with Old Gympie Road.

The collision

As the silver Commodore driven by Mr Owens passed the intersection with Old Gympie Road Myrna King was discussing with Mrs Owens arrangements to be picked up at Brisbane airport on her return to Australia. She had not noticed the pilot or police vehicle pass them and says there had been no discussion in the car about those vehicles or the oversize load. Mr King was asleep and Mrs Owens now has no memory of events leading to the collision. Mrs King says she saw Mrs Owens reaching into her handbag to remove some contact details when she heard a loud crunching noise.

Neither the driver of the lead pilot vehicle, nor Senior Constable Doust noticed anything remarkable about the Commodore as it passed each of them. The driver of the prime mover, Mr Burton, was likewise unconcerned about the passage of the Commodore until he felt the jolt of a collision.

Mr Lakin, in the car following Mr Owens, remembers the Commodore travelling close to the left fog line in the lead up to the point of collision. He had passed many wide loads during his daily trips on this stretch of road. He clearly recalls seeing the lead pilot vehicle and a police escort vehicle. He knew from experience that the presence of the police vehicle meant the upcoming load would likely interfere with his lane and that he would need to move to the left side of the road. He says he was able to see the wide load clearly from approximately 800 metres away and well before the silver Commodore 200 to 300 metres in front of him had reached it.

The crunching noise heard by Mrs King was caused by the driver's side windscreen pillar and roof on the Commodore impacting with the front right corner of the miner's hut. The corner of the hut also impacted with the forehead of Mr Owens causing severe and immediately fatal injuries.

The vehicle travelled under the hut for approximately eight metres with the downward pressure on the Commodore causing the front right wheel to puncture. After disengaging from the load, the Commodore continued along the road for 40 metres in a southerly direction before crossing the road shoulder. Eye witness accounts and a forensic analysis of tyre marks point to continued pressure being applied to the accelerator and no braking. Approximately 150 metres further south from where the Commodore left the road, and 26 metres east of the road shoulder, the driver’s door on the Commodore collided with a pillar supporting a large advertising sign. This spun the Commodore in a clockwise direction and resulted in the rear passenger side of the vehicle impacting a second pillar holding up the sign. This final impact resulted in most of the serious injuries suffered by Mrs Owens and the more minor injuries suffered by Mr King.

Aftermath of the collision

Mr Burton transmitted a message on the UHF radio advising the other vehicles in the convoy that he had been hit by a car. He pulled over immediately although later moved the truck slightly further north to a safer position.

Senior Constable Doust heard a transmission over the UHF radio advising of the collision and immediately performed a u-turn. He was able to do so prior to the vehicle of Mr Lakin reaching him in the southbound lane. He found the wreckage of the Commodore and then called for assistance. It was immediately clear nothing could be done for Mr Owens. Mr Lakin helped to illuminate the scene with his vehicle's headlights and then, with Senior Constable Doust, helped to care for the injured passengers until paramedics arrived via helicopter.

Autopsy results

An autopsy examination of Mr Owens' body was carried out on 18 May 2011 by a forensic pathologist, Dr Eric Donaldson.

Samples were taken for toxicological testing and returned no reading for alcohol or drugs.

After considering the toxicological results and his own observations, Dr Donaldson issued a certificate listing the cause of death as:

> *1(a) Head injuries including fractured base of skull and bilateral subdural and subarachnoid haemorrhage;*
> *(b) Blunt trauma;*
> *(c) Motor vehicle crash (driver)*

Investigation findings

Senior Constable Doust and Mr Burton were breath tested after the collision and found not to be affected by alcohol.

All drivers in the oversize load convoy were appropriately licensed and accredited. All work diary and permit checks were completed correctly by Senior Constable Doust.

The oversize load was projecting at least 1.2 metres and, likely, around 1.5 metres into the southbound lane of the Bruce Highway at the time of the collision.

All warning lights and signs required under the Form 4 guidelines were operating as designed and correctly positioned on the convoy vehicles and the oversize load at the time of the collision. In addition, two fluorescent 'squares' were affixed to the lower, forward facing extremities of the load.

All vehicles in the convoy were positioned correctly when measured against the requirements for spacing set out in the Form 4 guidelines.

The collision occurred at a point approximately 125 metre south of the intersection between Old Gympie Road and the Bruce Highway although the lack of gouge or skid marks makes a precise measurement difficult.

There was no evidence found pointing to environmental or mechanical factors playing a role in the collision.

Mr Owens was appropriately licensed and had undergone medical testing within the previous two years as required under legislation.

The cause of the crash

For the reasons I have detailed in my summary of the relevant evidence, I am satisfied the specifications of the oversize load; the steps taken to ensure it and the escort vehicles were visible; and the passage of the escort itself, all accorded with the requirements set out in what is referred to as the Form 4 guideline and the QPS issued permit.

I am also satisfied the driver transporting the oversize load did so in as safe a manner as was possible given its width. This reflects well on those transporting the load and on Senior Constable Doust who clearly conducted a thorough inspection before the load set off.

There is no evidence the vehicles involved in the crash were speeding or otherwise being driven inappropriately. There is no evidence fatigue degraded the performance of any of the drivers involved in the incident.

Just prior to the point of collision heading south, the fog line extends outward to create a narrow passing lane. This is meant to accommodate vehicles continuing south when another vehicle is turning right into Old Gympie Road and needs to wait for oncoming traffic to pass. Cars travelling south can follow the fog line leading them to the left and around such a stationary vehicle. The fog line then gradually moves back towards the centre line so that the lane returns to its usual width. The effect for a vehicle being steered to follow the fog line is that, at the end of the passing lane, it is directed towards the centre of the road and a gentle movement of the steering wheel to the left is required to resume the straight line of travel. It is possible that for an elderly driver, driving in the dark and approaching an unusual obstacle, that this contributed to the otherwise surprising failure to avoid the load protruding into the southbound lane. That could have been achieved by continuing to drive on or near the fog line in the southbound lane.

It is likely that, notwithstanding the fluorescent markers, flags and side lighting, all designed to mark the extremities of the load, Mr Owens' attention was distracted by the other lights on the prime mover. Ultimately, there is no eye witness account or forensic evidence that allows me to make a finding to the requisite standard as to why Mr Owens was unable to avoid an obstacle that was apparently clear to other drivers.

It is likely in my view that the extremities of the load were rendered less obvious because the load was being carried at night. I will address the safety and preventative aspects arising from the collision leading to Mr Owens' death later in these findings.

Findings required by s. 45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits and the oral evidence given at the inquest, I am able to make the following findings:

Identity of the deceased – The deceased person was Kenneth Roland Owens.

How he died - Mr Owens died when the vehicle he was driving struck a wide load being transported by a truck travelling in the opposite direction on an undivided section of the Bruce Highway.

Place of death – He died at Glenorchy via Maryborough in Queensland.

Date of death – He died on 17 May 2011.

Cause of death – Mr Owens died from head injuries and other blunt trauma caused by a motor vehicle collision.

Part 2: Death of Daniel Arthur Stiller

Introduction

On the morning of 1 December 2010, Sergeant Daniel Stiller, 33, an experienced police motorcycle rider was escorting an oversize load along the Bruce Highway near Mount Larcom. He approached a line of four vehicles travelling in the opposite direction on a two lane section of road. As those vehicles slowed, the fourth in line, a prime mover hauling an empty trailer, jack-knifed. It careered suddenly into the path of Sergeant Stiller. The resulting collision killed him instantly.

These findings:

- Confirm the identity of the deceased; how, where and when he died and the medical cause of the death;

- Establish the cause of the crash; and

- Consider the adequacy of the regulations governing the transport of wide loads, including whether motorcycles should be used for escort duty.

The investigation

The other officer involved in the escort, Sergeant Mark Norrish, was travelling approximately 300 metres behind Sergeant Stiller's motorcycle at the time of the crash. He arrived on the scene within approximately ten seconds of it happening. It was apparent to him Sergeant Stiller had suffered unsurvivable injuries.

Sergeant Norrish dialled 000 and reported the crash and the identity of the victim.

On the morning in question, Senior Constable Michael Thiry was performing traffic patrol. Shortly after 7:00am he was on the Bruce Highway near the Calliope River Historical Village when he heard police radio communications detail a fatal traffic incident a few kilometres north of his location. He went immediately to the scene.

He introduced himself to Sergeant Norrish and set about making preliminary inquiries. He identified Mr John Dodd as the driver of the truck involved in the crash. After warning him of his right to remain silent, he conducted a brief tape recorded interview with the truck driver and breath tested him.

Shortly after Senior Constable Thiry arrived, the District Officer, Inspector Graham Coleman, also arrived on scene. He assumed control of the incident and Senior Constable Thiry was tasked with traffic control on the northern side of the crash site.

The officer in charge of the Mt Larcom Police Station, Senior Constable Alistair Mearns, was advised of the crash in a call from the Gladstone Police Communications Centre shortly after 7:00am. He was told the location of the crash and that it involved a police officer. As it was within his division he proceeded directly to the scene, approximately 15 kilometres south of Mt Larcom.

On arrival, he spoke briefly to Sergeant Norrish and Mr Dodd. Senior Constable Thiry told him he had breath tested the truck driver and this showed zero alcohol. He did not have a digital audio recorder with him and so he wrote contact details of witnesses on a clipboard he carried.

He also spoke with Inspector Coleman and Sergeant Mike Despot who had also just arrived at the scene. Senior Constable Mearns was an experienced police officer who had been sworn in 1985. More recently he had completed a basic traffic accident investigation course and he had investigated approximately 15 fatal crashes. However, he did not consider himself an expert traffic crash investigator and suggested to Inspector Coleman that two others officers who had done the advanced crash investigators course would be better equipped to handle the investigation into the death of Sergeant

Stiller. Senior Constable Mearns was also concerned about the appropriateness of his investigating an incident involving a more senior officer.

Inspector Coleman caused inquiries to be made as to the availability of the other two offices suggested by Senior Constable Mearns. They were general duties officers as there was at the time no forensic crash unit (FCU) in the Central Region. Unfortunately, neither of those better trained officers was available, and so Inspector Coleman told Senior Constable Mearns he would have to take responsibility for the case. He assured the Senior Constable that expert crash investigators from the Brisbane FCU would be detailed to come north to assist him.

Senior Constable Mearns then conducted a further examination of the scene and made a rough sketch plan on a clip board. He marked points of significance on the roadway with yellow spray paint. A Gladstone Scenes of Crime photographer arrived at the scene and photographed the scene. Senior Constable Mearns also took some of his own.

Senior Constable Mearns spoke to some of the people at the scene he identified as the drivers of a cluster of vehicles travelling in close proximity to the truck involved in the crash. He asked some to provide him with statements and took the contact details of others with the intention of having them interviewed at a later stage. He made notes of these conversations. Unbeknownst to him at the time, the leading truck in that group had not stopped at the scene and was not identified until later that day. After that he was not interviewed for some months. Senior Constable Mearns said the delay resulted because the driver left the country in the weeks after the crash and did not return for some time.

The driver of the truck involved in the crash, Mr Dodd, was put into an ambulance soon after Senior Constable Mearns arrived at the scene. The ambulance was preparing to take him to the Gladstone Hospital and so Inspector Coleman instructed another officer, Detective Sergeant Christopher Lindsay, to accompany Mr Dodd and interview him about how the crash occurred.

As they were travelling towards Gladstone that officer activated a digital recorder and took notes in his notebook. He soon became aware his tape recorder had malfunctioned and so he arranged for another officer to attend at the hospital to formally interview Mr Dodd.

That job was detailed to Senior Constable Sparkes who went to the Gladstone Hospital at about 2:50pm in the afternoon. In accordance with the instructions he had been given, he gave Mr Dodd a warning about his evidence being able to be used against him but he was not told of any of the previous versions Mr Dodd had given, or any details of the crash scene.

Senior Constable Sparkes conducted a cursory interview in the presence of Mr Dodd's employer. His lack of relevant background knowledge probably prevented him doing much more.

Senior Constable Sparkes said at the inquest that he didn't particularly want to be involved in the job. A transcript of his conversation with Mr Dodd makes that obvious.

Some months after the fatality it was recommended to Senior Constable Mearns that he review the way Mr Dodd managed fatigue and used the truck's engine brake. When he sought to do this Mr Dodd exercised his right not to be interviewed.

Contrary to Inspector Coleman's initial reassurance, officers from the Brisbane Forensic Crash Unit did not attend Central Region until two days after the crash. They went to the scene and inspected the vehicles at the compound where they were being held. Both vehicles were subsequently also inspected by a QPS vehicle inspection officer.

The senior FCU officer, Sergeant David Stocker, a highly experienced and well qualified crash investigator, said at the inquest that he didn't believe the technical side of the investigation suffered in any way because of his delayed attendance at the scene. He also expressed the view that Senior Constable Mearns adequately preserved the crash scene evidence.

Sergeant Stocker produced a detailed collision analysis report that sought to determine the speed and direction of travel of the two vehicles immediately before, during and after the crash and the factors that led to the loss of control of the vehicle being driven by Mr Dodd.

The day after the crash the regional crime coordinator visited Senior Constable Mearns in Mt Larcom and offered assistance with the investigation plan. It doesn't seem this offer of assistance came to much.

The QPS Metropolitan South Region Health and Safety Coordinator undertook an investigation to determine whether any workplace hazards contributed to the fatality or whether any changes to the way the QPS managed its involvement in wide load escorts could reduce such incidents. The report of that investigation was tendered at the inquest.

In May 2011, Senior Constable Mearns reported the results of his investigation to the QPS Prosecution Section and sought advice as whether the evidence supported criminal proceedings being brought against Mr Dodd.

As a result Mr Dodd was charged with driving without due care and attention. After a three day trial, on 21 September 2012, he was found not guilty on the basis the Crown did not prove beyond a reasonable doubt the particulars they had alleged: namely, that he was driving too fast, failed to adequately heed the warning of the first escort vehicle that a wide load was approaching and

as a consequences had to brake too hard causing his truck to jack-knife into the path of Sergeant Stiller's motor bike.

The various investigations were overviewed by an officer from the QPS Ethical Standards Command (ESC) who concluded the conduct of the officers participating in the escort was in accordance with relevant QPS policies and procedures.

Further inquiries were initiated by those assisting me in connection with the management of wide loads.

As a result I am satisfied that at the inquest I had access to all information relevant to the discharge of my role.

Submissions made on behalf of Mr Stiller's wife pointed to what they considered flaws with the way the investigation was undertaken and managed. They submitted that at the outset the possibility of a dangerous driving causing death charge should have been in contemplation and therefore the scene, witnesses and the suspect should have been preserved, secured and isolated as would normally occur when an indictable offence involving a fatality was being investigated. That did not occur.

Examples of what might be considered sub-optimal practice include the following:-

- Senior Constable Mearns did not tape record his conversations with the various witnesses at the scene of the crash; he did not obtain detailed accounts from any of them on that morning; and he did not have any of them adopt the notes he made of their conversations.

- Key witnesses were allowed to confer at the scene and then to leave, on the understanding they would attend at a police station at a time and place convenient to them to provide a statement.

- It was immediately obvious that if charges were to be preferred, Mr Dodd would be the most likely defendant. He was spoken to by four police officers on the day of the crash but none took a detailed statement or questioned him closely as should have happened in such circumstances.

- Senior Constable Mearns was notionally in charge of the investigation but other officers, including Inspector Coleman gave directions about aspects of the matter without consulting Senior Constable Mearns and they did not ensure he was advised of the outcomes.

- Other officers who were tasked to undertake various inquiries and/or obtain statements were inadequately briefed as to the issues under investigation and the versions supplied by other witnesses, meaning they could contribute little to the investigation.

- The expert investigators from the FCU did not arrive until two days after the crash.

- None of Senior Constable Mearns' superiors adequately supervised his undertaking of the investigation, allowing significant delays to occur.

While these criticisms have some force, as a result of reviewing the investigations of numerous traffic fatalities I am aware that similar practices are common.

Senior Constable Mearns was the officer in charge of a busy division with limited crash investigation training and experience. Nonetheless, in the normal course, he would investigate fatal road crashes in that division, there being at the time no specialist FCU in Central Region. However in this case he was left to undertake a criminal and coronial investigation of a particularly sensitive matter, while other experts undertook discreet investigations or reviews of aspects of the incident. There was limited coordination of the four inquiries and less supervision of Senior Constable Mearns. The outcome was less than perfect, but probably no worse than many investigations regularly undertaken throughout the state.

The crash resulted in the death of an officer undertaking official duty. Commissioners Circular 19/2009 was then in force. It provided that in the event of a death arising from a police related incident, the incident is to be investigated by the ESC. A police related incident is defined as an incident resulting in death that involves an officer acting in the course of his duty. In my view it would have been preferable for the investigation to have been undertaken by the ESC with technical assistance from the Brisbane FCU.

Sergeant Stiller's wife, Julie, is also a police officer. She considers she was not kept appropriately informed during the protracted investigation. She was in the early stages of pregnancy when her husband was killed. Her grief and frustration must have been severe. She has my sincere condolences for her on-going loss.

The QPS is generally very good at providing pastoral care for its members and their families when a member is killed or injured. Because I ruled the way it cared for Mrs Stiller and provided her with information, was an employee relations issue, not within the proper scope of this inquest, I did not seek a response from the QPS to her concerns. I can not therefore pass comment on whether the tragedy was properly managed from that perspective. However, I would encourage a senior officer to review whether appropriate communication and support was at times absent as a result of Sergeant Stiller working in one region, his wife another and the crash happening in a third.

The Inquest

A pre-inquest conference took place on 16 August 2012. Mr Johns was appointed as counsel assisting and leave to appear was granted to representatives for the QPS Commissioner, Mrs Stiller, several police officers

involved in the investigation of the collision and the Department of Transport and Main Roads.

I viewed the scene of the collision with representatives of the parties on 15 October 2012. The inquest commenced in Brisbane on 17 October and continued for three days. Evidence from one further witness was heard on 26 October 2012. During the inquest leave to appear was granted to Mr Dodd.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

Detailed written submissions were received from all those granted leave to appear. They were very helpful.

The evidence

The wide load escort

On 27 November 2010 transport company, NQ Group Pty Ltd applied to the QPS Central Permit Support Unit (CPSU) for a permit to transport a CAT 793F dump truck with cab from Kerry Road, Archerfield to Rolston Mine, Springwood Road, Rolston.

The permit was issued authorising the transit of the wide load between Tuesday 30 November at 12:05am and sunset on Wednesday 1 December via a specified route that included the Bruce Highway.

The permit required the transporters to comply with policies and procedures collectively referred to as 'Guidelines for excess dimension vehicles carrying indivisible articles, special purpose vehicles and vehicles requiring a pilot or escort in Queensland, Form 4'. Understandably, these procedures are usually called the Form 4 Guideline.

Upon becoming aware of the proposed transport, an officer in the CPSU sent a service wide email seeking volunteers among appropriately qualified police officers to participate in the escort of the wide load.

No officers volunteered and so another member of the CPSU staff contacted Sergeant Stiller and Sergeant Norrish and asked them if they were prepared to do the job. Both agreed.

The escort vehicles consisted of one marked QPS sedan with lights and sirens, one marked QPS motorcycle with lights and sirens and two privately operated escort vehicles with rotating orange lights and signs.

Sergeant Stiller was on the police motorcycle and Sergeant Norrish drove the marked police car.

Sergeant Norrish attended at the Hastings Deering storage facility on Kerry Road, Archerfield at about 11:45pm on the evening before the escort was to

commence. He took up with the two wide load escort pilots and checked their licences and pilot accreditation. Sergeant Stiller was also in attendance.

While these preliminary matters were being attended to, it began to rain heavily.

One of the documents Sergeant Norrish commenced was a fatigue management log on which were to be recorded rest periods, travel periods and distances travelled.

The officers inspected the prime mover, trailers and load and measured its dimensions. They noted that it was within the 35 x 7.49 metres specified on the permit.

As the officers undertook these inspections they marked off the details on an oversized load checklist designed for the purpose.

At approximately 12:30am the wide load left the holding yard with the civilian pilot, Bob Martin driving at the head of the convoy. His vehicle had a large sign reading ‘oversized vehicle’ ahead and a rotating orange warning light on its roof. That vehicle was followed by Sergeant Stiller’s motorcycle and then Sergeant Norrish’s marked police vehicle. Both the police vehicles had illuminated rotating blue and red warning lights. Behind the wide load followed the second civilian escort vehicle marked up and illuminated in the same way as the one at the head of the convoy. The wide load and all escorting vehicles could communicate with each other via two way radio.

The speed of the convoy varied according to road conditions from as slow as 15 kilometres an hour up to 70 kilometres an hour. After about two hours the convoy stopped so the load could be checked and if necessary the chains re-tensioned. After 15 minutes the convoy continued.

On open sections of road once the convoy had cleared the metropolitan area, the lead pilot vehicle was up to two kilometres in front of the wide load. Sergeant Stiller was approximately 800 metres in front of it and Sergeant Norrish approximately 500 metres ahead. As the various piloting vehicles came across traffic travelling in the opposite direction it was ushered to the shoulder of the carriageway to allow the wide load to proceed.

The primary role of the pilot vehicles in front of the load is to warn oncoming traffic of the oversized load and to signal them to move over. When other heavy vehicles were encountered, radio communication was used to inform them of the size of the load, how far behind the first pilot vehicle it was travelling and to warn them to pull over.

At 5:30am when the convoy was near the township of Moore another lengthy stop was necessary during which the escort crews took time out to rest. They set off again at 7:30am with the escort vehicles in the same order as when they had left Archerfield.

At 11:00am the convoy stopped for a rest and meal break at Goomeri. At 11:30am they left and continued north along the Burnett Highway again in the same formation.

At about 3:30pm the convoy came onto the Bruce Highway at Booyal. The volume of traffic increased. Along this section the lead pilot vehicle stayed on the left hand side of the road's centre line and motioned for cars to pull over and communicated with heavy vehicles by two way radio. A kilometre or so further back, Sergeant Stiller rode along the centre dividing line also signalling with his hand for cars and trucks to pull over. Sergeant Norrish followed some 300 metres behind him with his vehicle almost all on the incorrect side of the centre dividing line forcing vehicles completely off the carriageway. This was necessary because the wide load, which was about 7.5 meters wide, took up both lanes which were about 7 metres wide in total.

The convoy stopped for about 15 minutes in Gin Gin before continuing north on the Bruce Highway. They stopped for the day at Miriam Vale at about 4:00pm.

The convoy members reconvened at about 4:30am the next morning. It was raining lightly at that time and it was apparent it had rained over night as the ground was wet. Sergeant Stiller was wearing yellow police issued wet weather gear. Because it was raining and overcast the officers decided the convoy should not depart until about 5:30am when more light could be expected.

While they were waiting Sergeant Stiller and Sergeant Norrish discussed in what order they would travel during the day. Sergeant Stiller stated words to the effect '*I would rather be out in front. I don't like getting out in front of trucks when I'm on the bike'.* This referred to the fact that the lead police vehicle usually positioned itself in about the middle of the roadway whereas the second police vehicle was required to move right over to the incorrect side of the road to ensure oncoming traffic got right off the roadway to allow the wide load to pass. Sergeant Norrish readily agreed to Sergeant Stiller's request.

The convoy entered onto the Bruce Highway at about 5:30am in the same formation as previously and headed north. It was still drizzling and the roadway was wet.

A concerning description of the way the escort was being managed was provided by a truck driver travelling south who came upon the wide load just south of the Calliope cross roads.[1] He was driving a B double tipper loaded with 64 tonnes of gravel. He said he was travelling south at about 100 kilometres an hour when he came upon the first pilot vehicle who told him over the UHF radio; '*There's seven and a half metres coming mate'*.

He immediately began reducing his speed. Shortly after the pilot vehicle passed him the driver saw a police motor cycle about 100 metres ahead of

[1] See ex B10 statement of Gourley

him, travelling north in the south-bound lane. This prompted him to brake more heavily. The motorcycle stayed in the truck driver's lane until it was only about 50 metres in front of the truck.

By the time the truck passed the motorcycle, the driver had managed to reduce the truck's speed by between 20 and 25 kilometres an hour. He then noticed approximately 200 metres ahead of him a police sedan also travelling towards him. He could then see the wide load about 100 metres behind the police car. He described his reaction in the following terms:

> *From this point onward it was all emergency go, as I was still travelling at around 80 kilometres an hour with a 64 tonne load. I was able to pull up and stop my truck within 300 yards. I had pulled over about 100 metres before the overtaking lane. I had driven off the road with one wheel riding on the dirt as there was only about 18 inches of dirt outside the bitumen before it dropped off about 6 -7 foot. If the shoulder had given away under my weight I would have rolled over. I wasn't happy with being given very little notification considering the location, being a bend in the road, which didn't allow for too much room on the road and which didn't give the pilot vehicles or the police a great distance of vision to alert other motorists, in particular heavy vehicles.*

Approximately 20 kilometres south of Mr Larcom, due to the road features which had slowed the progress of the wide load, Sergeant Stiller stopped his motorcycle and Sergeant Norrish drove his police car up beside him where they had a light hearted conversation for a few minutes. As the wide load was approaching, but still about a kilometre behind, they both set off again. It was apparent to Sergeant Norrish that Sergeant Stiller was using his mobile phone via a blue tooth connection. Indeed, it seems likely Sergeant Stiller was on the phone when the crash occurred and had been for some minutes before hand.

Shortly after this they came to a section of the highway that expanded to three lanes to allow traffic travelling south to overtake.[2] The escort party took advantage of this to allow traffic caught behind the wide load to overtake it. This involved the two lead escort vehicles stopping southbound traffic, relaying this to Sergeant Norrish who then gave the escort vehicle behind the load the 'all clear' to allow vehicles to pass.

At about the same time, a wide load heading south stopped at the southern extremity of the southbound overtaking lanes so the two wide loads could pass on the three lane section. This had been suggested to the pilot of that vehicle in a radio transmission by the pilot of the load Sergeant Stiller was escorting.

[2] Sergeant Norrish said his statement that the overtaking lane is for northbound traffic (ex B21 para 67) but I conclude he is mistaken. See also statement of Davies (ex B6) which confirms this.

The collision

The crash occurred fifteen kilometres south of Mt Larcom. Approaching the crash site from the south, the Bruce Highway comes over a crest and then runs down a moderate incline in a fairly straight alignment for about a kilometre. For most of that distance it is of three lanes: one for north bound traffic, two for south bound traffic. Just north of where the passing lane for the south bound traffic commences, the highway goes through a dip and then climbs up a short but moderately steep incline into a cutting. Approximately 300 metres further north the road takes a moderate right hand bend to the east. The southbound overtaking lane commences about 300 metres south of the crash scene and the dip where sight of north moving vehicles is obstructed from a south facing vehicle at the crash scene is approximately 500 metres.

John Dodd was a fire officer on extended leave working as a truck driver. Since October 2010 he had been employed by SRT Logistics Queensland Pty Ltd on a casual basis. Initially, he did short haul trips three times per week. By the time of the crash he was driving five nights per week to coastal cities as far north as Rockhampton.

On 30 November 2010, he left Brisbane at about 10:30pm bound for Rockhampton carrying general dry freight. He was driving a 1999 Kenworth prime mover and a 45 foot refrigerated trailer. After a number of short rest stops, he arrived in Rockhampton at about 5.20am. While his truck was unloaded he had a brief rest before he set off for Brisbane at about 6:00am with no freight in the trailer.

There wasn't much traffic on the road. It had been raining, the road was wet and the road verges were soft and muddy.

As Mr Dodd was coming south through the township of Mt Larcom he saw another truck in front of him carrying a load of logs. It is now known it was being driven by Allan Olman. Mr Dodd gained ground on the log truck on the hills so that as he approached the crash site he was approximately three to four truck lengths behind the log truck.

There were two other vehicles in front of the log truck. A Toyota Hilux four wheel drive driven by Charles Curnow and another semitrailer loaded with concrete pipes driven by Leonard Knauth.

The lead escort vehicle proceeded up through the cutting, passed the crash site and went around the right hand bend when it came across those four vehicles. The driver, Mr Martin, said; '*They weren't following too closely but they were close'.* As was his habit he expects he said words to the effect, '*7.5 metre load coming, better find somewhere quick to pull up and stop'*. He believes he heard someone reply *ok* which he assumed came from one of those vehicles.

The driver of the first truck, Mr Knauth recalls the pilot vehicle going past and believes something was probably said over the UHF radio but he doesn't

recall exactly what. He expects he was advised of a wide load coming. He did not hear any response from any of the other trucks travelling nearby him. On seeing the escort vehicle he took his foot off the accelerator which activated his engine brake causing the vehicle to slow slightly.

He was travelling about 85 to 90 kilometres an hour when a police motorcycle with blue and red lights activated came over a rise towards him. It was in the middle of his lane, or at least on the south bound side of the centre line, when Mr Knauth first saw the motorcycle. It was approximately 200 metres away from him. It prompted him to slow the vehicle further by applying the foot brake so that when the bike and the truck passed he estimates the truck to be travelling at only about 10 kilometres an hour and the motorbike going 30 to 40 kilometres an hour. Mr Knauth was aware there was a truck behind him carrying logs but he didn't take much notice of it at the time. He was still slowing down and looking for where he might pull off the highway. He was concerned because he knew it had been raining and that the verges would be soft. He knew that the south-bound overtaking lane was a short distance in front of him and hoped he might be able to get to that point before the wide load reached him.

He commenced to go down the hill towards the overtaking lane when he heard over the radio that a pilot had been hit. When he looked in his rear view mirror he couldn't see the crash site because it was back over the crest but he could see the top of a trailer that was moving across onto the wrong side of the road. After briefly stopping he went on because he considered he had nothing to do with the crash. Later in the day however, after he had dropped his load and was again travelling north, he identified himself to a police officer at a road block that had been set up to keep traffic away from the site.

Travelling behind Mr Knauth as his truck approached the crash site was a four wheel drive Toyota Hilux driven by Charles Curnow. He had left Emerald at 3:00am that morning heading for Brisbane.

He said at the inquest that the trucks were '*a fair distance apart*'. He said he had been travelling in convoy with the trucks for perhaps 100 kilometres and had never been concerned about the distance between the vehicles. However he was conscience they were all moving along and the trucks '*do have tendency to push you a bit*'. He didn't have his car's UHF radio switched on.

He recalled seeing the civilian wide load escort vehicle come past which caused the truck in front of him to slow. A short time later a motorcycle suddenly appeared from beside that truck. Mr Curnow believes the motorbike was 18 inches on his side of the centre dividing line. The motorcycle seemed to cause the truck in front of him to slow further. He looked in his rear view mirror concerned that the trucks behind him might not slow as quickly. On doing so he saw the truck behind the truck immediately behind him jack knife across the north bound lane. He saw the motorcycle plough into the side of it. Mr Curnow expressed concern at the way the motorbike had just suddenly appeared from behind the truck in front of him.

Behind Mr Curnow's four wheel drive was the log truck being driven by Allan Olman. He had left Rockhampton at about 6:00am carrying a load of power poles to the Boyne Valley.

He had been aware of a truck in front of him and a truck behind him for some time and he had noted no one had overtaken when passing lanes provided an opportunity to do so. He concluded the vehicles were all travelling about the same speed.

He recalled just north of the crash site seeing the pilot vehicle. He had earlier heard broadcasts that it was escorting a 7.5 metre load.

He claimed the pilot escort said over the UHF radio words to the effect, '*7 and a half metre wide load coming towards you fellas. You should have time to get down to the three laner'.* He said he took that to mean the pilot wanted them to keep travelling until they got to the south bound overtaking lane at the bottom of the hill 300 or 400 metres south of the crash site.

He thought that was a good idea because he considered in view of the rain it would have been difficult to pull over off the side of the road because it was muddy and boggy.

He said when the pilot vehicle went past, the gap in between the four vehicles contracted – he thought so they could all reach the three lane section before the wide load came by. He said they were travelling about 80 to 90 kilometres an hour at this time. He couldn't say how far Mr Dodd's truck was behind him. He said; '*all of a sudden I saw the brake light of the front truck…come on'.* He said it then started pulling off to the left of the road. There was no skidding of that truck but the initial braking was '*fairly hard*'.

He says as that truck pulled to the left of the road he could see a police motorcycle with its flashing lights activated travelling towards him '*just on our side of the white line in the centre of the road*'. He also braked and pulled to the left. He said, '*I jabbed my foot on the brake for a quick hard brake*'. He felt the power poles on his trailer shift forward as he braked causing him to check the load in his mirrors. As he did so he saw the Kenworth behind him '*go sideways towards the centre of the road. It kept slewing to the right into the north bound lane'*. The police motorcycle went past him in the south bound lane but started to veer back towards the northern lane. The Kenworth kept pushing to the right and the police motorcycle hit it near the two rear drive wheels on the passenger side of the prime mover. The prime mover kept skidding across the road into the drain and came to rest against the cutting, doubled back against the trailer. The rider flew off the motorcycle and the motorcycle also came to rest in the table drain.

Mr Dodd was following behind Mr Olman in the unloaded Kenworth. He thinks that as they approached the crash scene, he was three to four truck lengths behind the log truck. They had been in a convoy for an hour or more keeping a fairly regular distance apart. He was also aware of Mr Knauth's truck further

ahead. He said in accordance with his usual practice he had the engine brake on the highest setting of 3.

He said at the inquest that he doesn't recall the escort vehicle going past, although he made a comment immediately after the crash that was inconsistent with this. He said that shortly before the crash he heard a broadcast over the UHF radio to the effect; '*there's an overtaking lane up there. I'm going to back off and let you around'.* This may be consistent with what Mr Olman said he heard, or it may be more congruent with the broadcasts that occurred when the wide load escort vehicles facilitated north bound traffic getting past the wide load at the earlier three lane section.

In any event, it seems clear that Mr Olman and Mr Dodd concluded that the their group of vehicles was going to try and pass the wide load on the southbound overtaking lanes so that the trucks would not have to try to get off the road onto the sodden verge. Mr Knauth was also intent on doing this.

Mr Dodd has given various accounts as to whether he saw the wide load approaching including that he did, that he didn't and that he saw something that alerted him for the need for caution. I don't accept the sinister construction of this uncertainty urged by counsel for Mrs Stiller. He told the first officer he spoke to straight after the crash that he had seen the wide load; in later versions he changed this to seeing something unusual on the road ahead. By the time he gave his first account there was absolutely no doubt this thing was a wide load. It is natural he would conflate his earlier sighting with his then current knowledge and say he had seen the wide load. As the wide load was some 600 - 800 metres away at the time of the crash, his uncertainty is not surprising.

Mr Dodd's account of the distance between him and the log truck just before the crash has also varied. When Senior Constable Thiry breath tested him immediately after the crash, he wasn't asked about the distance between the vehicles involved in the incident, but in response to the question; '*What happened?'* Mr Dodd recounted hearing the other drivers discussing a manoeuvre in the overtaking lanes so he '*hung back a little'*. Detective Senior Constable Lindsay spoke to him in the ambulance very soon after the crash and asked, '*What distance were you travelling behind the truck?'* He said, '*I don't know, probably a truck length, maybe a bit more'*. He gave a similar account to Senior Constable Sparkes at the hospital later that day and included a similar estimation in notes he made himself the day after. At the trial of the charge brought against him, he said as the trucks left Mt Larcom and travelled south there was the '*normal'* distance between them which he said was about three truck lengths. He also conceded the distance shortened on hills because he was unloaded. At the inquest he said he was three to four truck lengths behind the log truck when he came around the curve before the straight on which the crash occurred.

I conclude Mr Dodd has sought to increase the distance between his vehicle and the log truck in order to minimise his responsibility for the crash. Whatever the precise gap, it undoubtedly shrunk when the vehicles in front of

his slowed in response to their seeing Sergeant Stiller's motorbike coming at them.

Mr Dodd said the next thing he remembers after rounding the curve is the brake lights of the log truck coming on causing him to apply his foot brake. Prior to that, he had been relying on the engine brake which activated whenever he took his foot off the accelerator. He said the log truck braked quite severely requiring him to increase his braking. As he did so he felt his trailer moving to the left. He denied touching the engine brake which was set on three throughout the journey.

After the trailer started sliding, he had no control of his vehicle in the next few seconds as it jack-knifed with the front of the prime mover slewing to the right blocking the north bound lane, leaving nowhere for Sergeant Stiller to go but into the side of it, making contact between the two rear drive wheels of the prime mover.

The prime mover came to rest against the cutting on the western side of the highway facing north, with the trailer jammed against it facing in the opposite direction. Sergeant Stiller and his motorcycle came to rest in the table drain on the western side of the highway, a few metres south of the truck.

Specialist investigation findings

Forensic Crash Unit

Inspection of the road at the crash site, when coupled with eye witness accounts, confirmed the prime mover had jack-knifed into the path of Sergeant Stiller's motorbike.

A jack-knife usually occurs when the drive wheels on the prime mover lose side force due to their losing traction as a result of locking up due to excessive braking.

Examination of the road found the surface was adequate and had not contributed to the crash. The minimum emergency braking distance for a non ABS assisted heavy vehicle travelling at 100km/hr along the relevant section of road was calculated to be 100 metres.

Testing of the brakes of the trailer-mover found they were within relevant braking efficiency tolerances, but four of the six brakes were out of adjustment in a manner that meant their application after activation would have been somewhat delayed. The brakes on the prime mover could not be tested because of crash damage. However, inspection of them suggested that two of the four drive wheel brakes were out of adjustment in the same manner.

The prime mover's engine was equipped with an Engine Control Module which records various data concerning the engine's performance and driver inputs. As a result of analysing data downloaded from that device, the FCU report suggested the truck was travelling at 101 km/hr 13 seconds before coming to rest as a result of the crash.

Over the next three seconds the throttle input was reduced to zero, which would have activated the engine brake, were it on. The speed of the vehicle only reduced slightly during this time suggesting that if the engine brake was on it was at a low setting. The GPS data suggests the truck was at this time about 200 metres from the position it came to rest after the crash.

Between seven and six seconds before coming to rest the truck's speed reduced from 96km/hr to 76km/hr without any apparent application of the foot brake, suggesting to Sergeant Stocker that the engine brake was switched on or its setting increased. The data also indicated the prime mover's drive wheels lost traction at this point. It is significant, however, that the engine braking mechanism was unable to be tested because of damage sustained during the crash.

Between six and five seconds before coming to rest the drive wheels locked up for a second or two under input from the foot brake.

A second later the GPS data indicates the truck would have been in the position where the tyre scuff marks in the northbound lane first commence.

This information allowed the FCU lead investigator, Sergeant Stocker, to conclude the motor bike collided with the left rear wheels of the prime mover when the bike was in the centre of the north bound lane. He calculated the truck was travelling at a minimum speed of 42km/hr at impact. He was unable to make any calculation of the motor bike's speed but the lack of debris north of the impact point suggests it was moving very slowly at impact.

QPS WH&S

A civilian Health and Safety Co-ordinator from the QPS Metropolitan South Region reviewed the incident to ascertain whether any workplace hazards contributed to it.

The review mainly consisted of examining documentation to ensure appropriate QPS policies were complied with.

It concluded that the likelihood of such an incident occurring was *rare* but as the consequences of it were *catastrophic* the overall risk level was *high*.

The report concluded that the policies had been complied with. It recommended QPS members be reminded of their responsibilities concerning the use of mobile phones when driving, and that the Service review the use of motor cycles to conduct wide load escorts.

WH&SQ

WH&SQ officers did not attend the scene or interview any witnesses. As a result of reviewing documentation supplied by the QPS, they concluded the incident did not indicate a contravention of an obligation under the Workplace Health and Safety Act. Accordingly the agency took no further action.

Autopsy results

An external autopsy examination was carried out on 3 December 2010 by an experienced forensic pathologist, Dr Nigel Buxton.

Samples were taken for toxicological testing and no drugs or alcohol was detected.

Dr Buxton considered the toxicological results, a description of events leading to the death as reported by police and his own observations during the autopsy examination before issuing a certificate listing the cause of death as:

> *1(a) Multiple injuries;* due to or as a consequence of
>
> *1(b) Motor vehicle trauma*

Dr Buxton noted the injuries to the head were not survivable and that death would have been instantaneous.

The cause of the crash

The truck with which Sergeant Stiller's motorbike collided was the last in a group of three semi trailers and a four wheel drive which had travelled south in proximity of each other from at least Mt Larcom (the convoy).

As they were carrying different loads the gaps between the vehicles varied with the topography. Mr Dodd was driving a semi trailer at the rear of the convoy. As his trailer was not loaded, he caught up to the other trucks when they were climbing hills. He accommodated this by using his engine brake to slow his vehicle when necessary.

There is no evidence the vehicles in the convoy were speeding or tailgating. There is no evidence fatigue degraded the performance of any of the drivers involved in the incident.

The driver of the pilot vehicle leading the three vehicles in front of the wide load that Sergeant Stiller was also escorting warned on-coming trucks by using UHF radio transmissions. These broadcasts were heard by the trucks he sighted at which they were directed and others on the road.

Shortly before the crash, the lead pilot suggested to the escort of a wide load heading south that it should wait in a three lane section of the highway for the larger northbound load he was escorting to pass. There were also radio transmissions about using that three lane section to allow northbound traffic caught behind the wide load to pass it.

Shortly before the crash the lead escort vehicle passed the convoy. At least two of that group heard reference over the radio to the three lane section and all saw it at about the same time as the wide load also came into view. I think it likely the lead escort vehicle did suggest they try and get to the three lane section before the wide load came by.

While the drivers were separately contemplating whether they should continue to the three lane section, Sergeant Stiller's motorbike suddenly appeared out of a dip in the road, about two hundred meters south of the convoy.

At the point Sergeant Stiller reached the convoy, the trucks could not safely get far enough off the left hand side of the road to allow the wide load to pass because of an embankment and wet and soft road verges.

Because he was riding in the southbound lane, only the driver of the truck at the head of the convoy saw him initially. That driver braked and pulled to the left.

That revealed the motorbike to the driver of the next vehicle. Because it was a much smaller and lighter four wheel drive, its driver had no problem braking and moving out of its way but he expressed concern about the bike's position on the road.

The motorbike caused more problems for the next vehicle – a semi trailer loaded with logs. Its driver had to brake sharply to avoid it and the slowing vehicles in front of him. So much so that some of the logs slid forward and bent the frame of steel pipes fixed to the front of the trailer. He knew the truck driven by Mr Dodd was behind him and was concerned as to how that driver would react.

When he looked in his rear vision mirror the basis of that concern was borne out: Mr Dodd had continued to follow closely behind the log truck after the wide load pilot had passed the convoy and had to apply the foot brakes of his truck so firmly that the back wheels of the prime mover locked up, causing them to slip sideways. As soon as they were out of alignment with the trailer, its continuing momentum caused the prime mover to rotate into the path of Sergeant Stiller's motorbike.

I don't accept the evidence suggesting the engine brake was applied or its setting increased in the few seconds before the jack-knife. It is based solely on an interpretation of downloaded electronic data - the engine brake itself could not be tested – and it is highly unlikely a driver in Mr Dodd's obviously parlous situation would seek assistance from a mechanism he knew would only gradually slow the vehicle when he needed quick deceleration to avoid a crash. Mr Dodd's evidence that he always drove with the engine brake on setting three is corroborated by his employer and is more likely in my view.

I conclude the crash occurred due to a combination of circumstances:

- The radio communications by the lead escort vehicle were potentially confusing in that they were overheard by road users in the vicinity, other than those to whom they were directed. They made reference to the three lane section of highway.

- The trucks in the convoy were not given clear instructions but invited to find a place of their choosing to stop. It is likely this also included a suggestion they make for the three lane section.

- Those escorting the wide load gave insufficient regard to the need for other vehicles to get completely off the road when the highway was only of two lanes and the difficulty this would pose for heavy vehicles.

- The convoy was ushered off the road by Sergeant Stiller driving north in the southbound lane, even though the trucks could not get off the road at that point due to road features. It was apparent he had not heard the suggestion the convoy make for the three lane section, perhaps because he was talking on the phone at the time of that transmission.

- The motorbike suddenly appeared in front of the first truck in the convoy after emerging from a dip in the road and its position in the southbound lane obscured it from the view of the others in the convoy.

- The first truck and then the other vehicles in the convoy had to brake sharply on account of the motorbike's presence.

- Mr Dodd did not slow sufficiently as the convoy approached the wide load, either because he did not see or did not heed the warning of the lead pilot vehicle.

- When Mr Dodd then had to brake quickly, the wet road and his lack of load combined to precipitate the prime mover jack-knifing.

- Sergeant Stiller had no time and no room to avoid the out of control truck.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The deceased person was Daniel Arthur Stiller.

How he died - Mr Stiller died from injuries sustained in a collision between his police motorcycle and a prime-mover travelling in the opposite direction on the Bruce Highway, while Mr Stiller was performing wide load escort duties.

Place of death – He died on the Bruce Highway south of Mount Larcom in Queensland.

Date of death – He died on 1 December 2010.

Cause of death – Mr Stiller died from multiple injuries associated with motor vehicle trauma.

Part 3: Section 46 comments and recommendations

Section 46, insofar 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 circumstances of the deaths investigated at these inquests raise a number of issues which warrant consideration from this perspective.

Introduction

The regulation of the movement of excess dimension vehicles or loads on public roads requires the balancing of complex competing public policy considerations: namely, the impact on the financial interests of individuals or organisations involved in development and heavy industry; the effect on the state's economy generally and the safety of other road users.

Nearly 20,000 excess dimension vehicles traversed Queensland roads last year and with continuing growth in the mining sector and other heavy industries significant growth is expected to continue for the foreseeable future. Accordingly, the risk to public safety associated with this activity will only increase unless it is adequately managed.

Generally part 3 of the Transport Operations (Road Use Management – Mass Dimensions and Loading) Regulation (MD&L) prohibits the use of vehicles on public roads that exceed 2.5 metres in width, unless an appropriate permit has been granted pursuant to part 6 of the regulation.

The Department of Transport and Main Roads (TMR) is responsible for administering these regulations, although QPS members authorised by the Commissioner have power to issue permits.

Until recently, these functions were handled by police officers across the state with input from other agencies as the circumstances required. Last year, the QPS and TMR joined with Queensland Rail and QR National to create a central agency for the management of these issues state-wide - the Heavy Vehicle Road Operations Program Office (HVROPO).

I am persuaded by the evidence put before the inquest that this body is effectively engaging with the complex issues involved in managing these activities and has appropriate interface with other local and national agencies and groups focussed on reform in the area. I acknowledge the expertise of those involved.

However, I also consider more can be done. The load involved in the death of Sergeant Stiller was nearly 7.5 metres wide. The average width of a lane of

the Bruce Highway is 3.5 metres. It is readily apparent that the movement of such loads create very significant risks that require careful management if they are to be adequately mitigated.

Notwithstanding the extensive work that has been done, I consider the analysis of the circumstances of these deaths by this inquest raises issues which warrant further reflection in an effort to enhance safety, namely:

- Limiting the number of wide loads.
- The movement of wide loads at night.
- The use of motorcycles for wide load escorts.
- Managing wide loads.
- The signage on wide loads and escort vehicles.
- Road user's obligations when encountering wide loads.

Limiting the number of wide loads

If all wide loads pose some risk to other road users, the most effective way of reducing this is to limit the number of such loads. As detailed above, last year 20,000 wide load permits were issued in Queensland and this is anticipated to increase significantly in coming years. I accept there may be economic benefit to the state as a result of the development which flows from the use of oversized items transported to remote locations. However, in view of the inherent danger of such transportation it is important that road transport is not used to move these items if other forms of transport are available. Mere cost savings or convenience should not justify increased dangers to other road users. For example, shipping such loads to the ports of Gladstone or Mackay could very significantly reduce the number of wide loads on a very busy part of the Queensland road network and limit damage caused to the roads by overweight vehicles.

Recommendation 1 – Road transport last resort

In view of the risk to other road users and the damage done to the road network by oversize loads, I recommend that permits not be granted to carry such loads if other forms of transport are available.

Permits are only granted if the over dimension load is *indivisible*. It seems from the evidence heard in the Owens inquest this criterion may not always be applied with much rigor. The load in that case was a miner's hut which could readily be manufactured to allow flat packing and on site assembly.

Recommendation 2 – Indivisible load review

To ensure permits are not granted for the carriage of excess dimension loads that could in fact be made smaller and therefore safer, I recommend the Heavy Vehicle Road Operations Program Office (HVROPO) review the basis on which it accepts loads are indivisible.

The movement of wide loads at night

Generally, wide load permits do not allow the movement of wide loads at night. One exception is in the metropolitan area where there are advantages

to negotiating confined intersections when minimal traffic may be expected. As other road users in the metropolitan area can be expected to be travelling at low speed and as street lighting aids visibility this is unobjectionable.

However, the evidence presented during the inquest into the death of Mr Owens suggested transporting a load at night through rural areas when the load protruded across the centre lane into the lane used by traffic travelling in the opposite direction, may have contributed to the crash. The driver of that load said that he had undertaken two night trips and he had been involved in a crash on each occasion and had witnessed many near misses.

Recommendation 3 - Limited night travel.

In view of the obvious dangers of transporting loads that protrude into adjacent lanes on single lane highways in the dark, I recommend that the practice generally be limited to the metropolitan areas and dual lane carriageways.

Use of motorcycle for wide load escorts

The officer in charge of the State Traffic Support Branch was effusive in support for the use of motorcycles as wide load escorts. With one exception, I did not find his evidence persuasive. The exception was that motorcycles could more easily negotiate around wide loads to assist them to negotiate intersections within the metropolitan area.

I am concerned that motorcycles are difficult to see on the highway. In a view undertaken by the court at the scene of the crash which killed Sergeant Stiller, it was apparent that even on a sunny day and with the bike's coloured lights illuminated, it was quite difficult to see it from any significant distance.

Further, it is obvious if oncoming traffic does not see the motorcycle and a dangerous situation develops, it will be more difficult for the bike rider to take evasive action and he or she will have less protection should a crash occur.

Recommendation 4 – Motorcycles for wide load escorts.

I am of the view that the reduced visibility of motorcycles and the increased risk of death or serious injury to the rider should a crash occur make them unsuitable for use as wide load escorts. Accordingly, I recommend that the HVROPO review their continued use.

Managing of wide loads

Three sources of information to this inquest, all experienced 'expert' truck drivers, raise concerns as to whether the management of wide loads is as effective as it could be under current arrangements. The driver involved in the crash that killed Mr Owens told the hearing he had done two wide loads under escort and both had involved crashes and near misses. He indicated he would not participate in any more. The driver of the 4WD travelling with the convoy involved in the crash with Sergeant Stiller worked and regularly travelled around the central Queensland mining region. He said it was a common concern among road users in that region, who discussed the frequency of

near misses and the impending likelihood of a crash. The third witness to express concern was the driver of a heavily loaded B double who only just managed to stop safely when confronted by the wide load Mr Stiller was escorting, just a few kilometres before the fatal incident. That evidence was corroborated by the description of the way that wide load was managed. It seemed the drivers of the five vehicles involved had only a general understanding of their positions relative to each other and the wide load; the escorts gave imprecise information to the vehicles coming the other way – in effect; '*there is a 7.5 metre load some indeterminate distance behind me, you should find some safe place to move over or stop, if you can';* the vehicles hearing that information could not be sure to whom the communication was directed.

I am not suggesting escort operators are cavalier - rather they are engaged in a hazardous and dynamic activity that is very hard to undertake in a controlled manner. I am not persuaded that the small number of fatalities that have resulted – six in the five years 2005 – 2010 – indicate the activity is as safe as could be. Nor do I presume I have sufficient detailed information to make concrete suggestions as to how it could be improved. However, I understand the recently formed and Brisbane based, National Heavy Vehicle Regulator (NHVR) will later this year begin oversight of the Heavy Vehicle National Law (which is yet to come into effect). In that role it will become a 'one stop shop' for a national approach to heavy vehicle monitoring and regulation. Specifically, the NHVR will be responsible for the implementation and oversight of standardised regulations for mass, dimension and loading of heavy vehicles even though state based agencies will remain responsible for the issuing of licences, the registration of vehicles and associated enforcement action. The NHVR would seem to be the appropriate body to address this issue.

Recommendation 5 – Improved management of wide load escorts

In view of the dangers inherent in moving some over sized loads and the increasing frequency with which this will be happening in many parts of Queensland in coming years, it is essential the activity is well managed. The evidence to this inquest indicates there is substantial room for improvements. The National Heavy Vehicle Regulator is the appropriate body to consider how this could best be achieved. Accordingly, I recommend it has regard to the evidence put before this inquest when developing regulations or guidelines for the management of wide loads by escorts.

The signage on wide loads and escort vehicles

Vehicles over 2.5 metres wide are obliged to display a sign *Oversized load*. When escort vehicles are required for a load over 3.5 metres those vehicles are obliged to display a sign *Oversized load ahead*. These signs remain the same even if the load is 7.5 metres wide. The signs provide no information as to the size of the load or what is required of motorists coming upon it.

Recommendation 6 – More explicit signage

I recommend that wording on wide load warning signs be reviewed to ensure they more effectively communicate to other road users the size of the load and what is required of them.

Road users obligations when encountering wide loads

Road users are obliged to give way to wide loads travelling under escort. When the load is as wide as the one involved in the death of Sergeant Stiller road users are in most situations obliged to clear the road and stop. I am concerned this is not widely understood.

Recommendation 7 – Awareness

I recommend that in conjunction with the development of more useful and communicative signs, a public awareness campaign be undertaken to explain the new regime of signs to motorists and make them aware of their obligations when confronted by a wide load.

I close the inquests.

Michael Barnes
State Coroner
Brisbane
15 March 2013