QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jamie Robert Joseph PUNCH**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/324
DELIVERED ON:	12 August 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	12 August 2014
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, police pursuits

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Senior Constable Brad Fullerton	Mr Craig Pratt (Gilshenan & Luton Lawyers)
Queensland Police Commissioner:	Ms Antonietta Kersten (Public Safety Business Agency)

Table of Contents

Introduction

Late on the morning of Australia Day in 2011 Jamie Punch approached a random breath testing site on Logan River Road at Edens Landing. He would have been mindful that he was unlicensed, a warrant for his arrest was in force, and he was in possession of vials of illegal steroids. He would also likely have tested positive for driving under the influence of a drug if the relevant test was conducted. After slowing down and appearing to comply with a police officer's direction to pull over, Mr Punch quickly accelerated away on his Honda CBR900 motorcycle. A short distance later he travelled through a red light, struck another vehicle and sustained injuries that killed him instantly.

These findings:-

- establish the circumstances in which the fatal injuries were sustained;
- confirm the identity of the deceased person, the time, place and medical cause of his death; and
- consider whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force.

The investigation

An investigation into the circumstances leading to the death of Mr Punch was conducted by Acting Detective Senior Sergeant Gregory Bishop and Acting Inspector David Cousins from the Queensland Police Service Ethical Standards Command. It was recognised early that Mr Punch was likely trying to 'avoid being taken into custody' at the time he died and that his death was, therefore, a 'Death in Custody' under the *Coroners Act* 2003 (the Act).

The ESC investigators interviewed those officers on duty at the RBT site and they later examined the scene of the collision. A specialist traffic accident investigator was assigned and a series of photographs of the scene were taken during his examination.

Investigators obtained statements from civilian witnesses to the collision and arranged for a mechanical inspection of both vehicles involved. A urine and breath sample was taken from the officer who had directed Mr Punch to stop at the RBT site.

The analysis of the collision undertaken by accident investigator Senior Constable Simon Whittle was detailed in a report which was tendered at the inquest.

I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

An inquest was held in Brisbane on 12 August 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Oral evidence was heard from one of the investigating officers, Detective Sergeant Bishop, and the police officer who directed Mr Punch to pull over at the RBT site, Constable Fullerton. He and the QPS Commissioner were represented. Mr Punch's partner and mother were both interviewed by the ESC investigators and were notified of the inquest proceedings by my office.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The *Coroners Act 2003* provides in ss 45 and 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These findings will be distributed in accordance with those requirements and posted on the web site of the Office of the State Coroner.

The evidence

Mr Punch

Jamie Punch was born on 18 October 1975 making him 35 years of age at the time of his death. A landscape gardener, he was father to five children. On the evening of 25 January 2011 he stayed at the home of his partner and youngest child at Woodridge. He had a lengthy history of involvement with police, predominantly related to use, and funding the use, of amphetamines, heroin and cannabis.

On 14 January 2011 Mr Punch failed to appear in the Beenleigh Magistrates Court and a warrant was issued for his arrest. On 25 January 2011 his partner told him that a police officer had been trying to contact him by telephone in relation to court appearances. His partner says Mr Punch was aware that a warrant had been issued and that he had expressed a fear of returning to prison.

Mr Punch had not held a valid drivers licence since 2 June 2010.

At around 8:30am on 26 January 2011 Mr Punch set off from his partner's house intending to travel to Browns Plains to visit an associate. It is now known he was in possession of ampoules of illegal steroids at the time.

The RBT site

Constable Brad Fullerton was the most senior of six traffic officers performing random breath testing at a site on Logan River Road on the morning of 26 January 2011. The RBT site was one that, according to Constable Fullerton, had been used many times before without any safety concerns arising. There was a set of traffic lights 400-500 metres from the site that allowed for the

interception of vehicles at regular intervals. He undertook the duty of signalling to vehicles that they needed to pull into the site to be tested by the other officers. A safety plan for the site was in place and Constable Fullerton was wearing a high visibility fluorescent vest over his police uniform.

At approximately 10:45am the motorcycle ridden by Mr Punch approached Constable Fullerton who signalled to pull over for testing. Constable Fullerton says that the rider was initially compliant; indicating, slowing down to walking pace and pulling over into the appropriate lane behind the line of witches hats. As it passed Constable Fullerton he heard the motorcycle rev and turned to see it accelerate quickly between him and Constable Payne and along Logan River Road. He estimates the motorcycle sped up to 100km/h before he lost sight of it although other officers at the scene estimate the speed to be higher still. The speed limit along that stretch of Logan River Road was 80km/h.

Constable Fullerton's evidence at the inquest was that he called the officers at the site together and advised them to try to obtain the motorcycle's registration number. He also advised them not to attempt to pursue the motorcycle because it was not a pursuit matter, there being no imminent threat to life or property. None of the officers was able to take note of the registration number of the motorcycle. A possible partial registration seen by one officer and supplied to police communications resulted in a match to a different vehicle.

There was no attempt to follow, intercept or pursue the motorcycle. All officers remained at the RBT site and continued with their duties until becoming aware of the collision via police radio some 5-10 minutes later. They then packed up the site and proceeded to the scene of the collision to assist with traffic management.

The collision

At a point around 1.4km to the south-east of the RBT site along Logan River Road it intersects with Castile Crescent at a set of traffic lights. Kara and Kevin Quinn had stopped at the intersection while facing a red light. Kara Quinn was in the driver's seat with her vehicle, a Mazda 2 sedan, positioned on Castile Crescent. She was intending to turn right, across the south-east bound traffic (including Mr Punch) so as to head in a north-westerly direction along Logan River Road.

After seeing the green signal for her to turn she proceeded into the intersection and almost immediately had her attention drawn to the motorcycle of Mr Punch. She saw it from around 200m away and noted it to be travelling at high speed and showing no apparent intention to stop at the red signal facing it. Ms Quinn accelerated in the little time she had to react, in order to try to prevent a collision; however, the motorcycle collided with the driver's side of the Mazda 2. It appears that the motorcycle was no longer upright when it hit the Mazda. This was likely the result of Mr Punch losing control as he attempted to brake heavily.

The collision resulted in Mr Punch suffering severe injuries which were almost certain to have been immediately fatal. The Queensland Ambulance Service was called at 10:53am and ambulance officers arrived at the scene at 11am. In the interim, at 10:57am, police from the RBT site arrived. They had been notified by motorists of what was occurring 1.4km to their south-east. It was sadly evident to the police and ambulance officers who arrived at the scene of the collision that nothing could be done to assist Mr Punch.

Investigation findings

An examination of the scene of the collision by Senior Constable Whittle did not allow a precise calculation of the speed of Mr Punch's motorcycle. Eyewitness accounts indicate that he was travelling well in excess of the designated speed limit of 80km/h.

Constable Fullerton's urine and breath samples showed that he was not affected by alcohol or drugs at the relevant time.

A mechanical inspection of both vehicles involved in the collision was conducted. An accurate opinion of the mechanical condition of the Honda motorcycle was unable to be formed due to the extent of the impact damage. However, no mechanical defects were found with either vehicle which would have contributed to the incident.

No defects or deficiencies were found with the road leading up to the point where Mr Punch collided with the Mazda. The road was dry, weather fine and visibility good.

A report was prepared by Dr Gary Hall of the Queensland Health Clinical and Forensic Medicine Unit in relation to the toxicology results of Mr Punch. He considered that the level of cannabis metabolite recorded in the blood of Mr Punch would have impaired his ability to safely control a motorcycle. The impairment would have been increased by the levels of morphine detected.

Autopsy results

A full autopsy examination was carried out on 28 January 2011 by forensic pathologist Alex Olumbe.

A post mortem CT scan was conducted. Samples of blood were taken and subjected to toxicological analysis. These revealed the presence of the psychoactive and inactive metabolites of cannabis as well as morphine and several prescription drugs.

After considering the multiple severe injuries visible at autopsy and all of the other available information Dr Olumbe issued a certificate listing the cause of death as:

> *1(a) Multiple injuries* due to, or as a consequence of
> *1(b) Motorcycle collision (rider)*

Conclusions

I am satisfied that Mr Punch died as a direct result of his own dangerous driving; constituted by his excess speed and failure to stop at a red light while under the influence of illicit drugs.

I am satisfied that Mr Punch's decision to speed away from the RBT site resulted from knowing that, by stopping, he risked being detained either due to his being affected by illicit drugs and/or due to the warrant which had been issued for his arrest.

The evidence establishes quite clearly that the police officers at the RBT site did not take any action to intercept or pursue Mr Punch.

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, I am able to make the following findings:

Identity of the deceased – The deceased person was Jamie Robert Joseph Punch.

How he died - Mr Punch failed to stop as directed by police for a random breath test and sped away on his motorcycle. A short time later he travelled through a red light, struck another vehicle and suffered fatal injuries.

Place of death – He died at Edens Landing in Queensland.

Date of death – He died on 26 January 2011.

Cause of death – Mr Punch died from multiple injuries due to a motorcycle accident.

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.

I am satisfied that in this case there has been no departure by police from the expectations imposed on them by legislation and policy in terms of the operation of the RBT site.

Incidentally, I note for the reasons below, that the QPS pursuit policy would have allowed an officer at the RBT site to follow Mr Punch in a vehicle in order to give a further direction to stop.

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

'Intercept' means the period from deciding to direct the driver of a vehicle to stop until either the driver stops or fails to stop. It includes the period when the police vehicle closes on the subject vehicle in order to give the driver a direction to stop. When an officer on foot has attempted to intercept a vehicle, it has failed to stop and an officer in a vehicle is used to close on the subject vehicle in order to give its driver a further direction to stop, such a scenario is also part of an intercept. In that situation a pursuit is not deemed to commence until it can reasonably be inferred the driver is aware of the mobile officer's direction and ignores it.

I raise this to illustrate my finding that the officers in this case were a long way short of any act which might have been considered a breach of QPS policy.

Nothing else has arisen from the evidence collated in this matter which would allow me to make any useful comments or recommendations aimed at the prevention of future deaths.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
12 August 2014