QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Michael George Parkes**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2016/3141
DELIVERED ON:	12 November 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	12 February 2018; 14-15 June 2018
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in the course of a police operation; vehicle interception sites, motor cycle accident; police hand signals.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Commissioner of Police:	Ms Belinda Wadley
Senior Sergeant Malcolm Lilley:	Mr Troy Schmidt instructed by Queensland Police Union of Employees Legal Group
Parkes family:	Mr Terry Morgans, Fisher Dore Lawyers

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Introduction

1. Michael Parkes[1] died on the afternoon of Sunday, 31 July 2016, at Old Gympie Road, Mount Mellum, as a result of chest injuries sustained in a motor cycle accident. The incident occurred shortly after a police officer conducting traffic enforcement duties in an unmarked police vehicle pulled over another vehicle for the purpose of issuing a traffic infringement notice for speeding. As the intercepted vehicle was re-entering traffic on Old Gympie Road, the driver of a Hyundai Santa Fe was approaching. The police officer signalled to that driver to slow down to facilitate the safe entry of the intercepted vehicle onto the road. The driver of the Hyundai Santa Fe braked heavily in order to slow down or stop.

2. Mr Parkes was travelling on his motorcycle directly behind the Santa Fe at the relevant time. He braked heavily, and his rear wheel locked. His motor cycle slid and clipped the rear left corner of the Santa Fe. The motorcycle continued off the left edge of the carriageway and collided with the rear end of the police vehicle which was parked in a residential driveway at the side of the road. Mr Parkes died at the scene.

3. These findings:

   - confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death; and
   - determine the adequacy and appropriateness of the conduct of persons involved in the traffic incident that occurred at 1.37pm on 31 July 2016 at Old Gympie Road, Mount Mellum, including compliance with relevant QPS policies in place at the time.

The investigation

4. The investigation into the circumstances leading to Mr Parkes' death was carried out by Senior Sergeant Jeffrey Gillam from the Queensland Police Service Ethical Standards Command, Internal Investigations Group (IIG).

5. After he was notified of Mr Parkes' death, Senior Sergeant Gillam attended the scene and an investigation ensued. The investigation was informed by statements and recorded interviews with:

   - police officers involved;
   - persons who were driving other vehicles in the lead up to the death;
   - various forensic investigation officers;
   - owners of properties adjacent to the scene of the incident; and
   - Mr Parkes' next of kin.

[1] Mr Parkes was also known as Michaelangelo. His family expressed a wish that he be referred to as Michael in these findings.

6. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted, and photographs were taken. All of the police investigation material was tendered at the inquest.

7. A full internal autopsy examination with associated testing was conducted by Forensic Pathologist, Dr Beng Ong. Further photographs were taken during this examination.

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

The Inquest

9. Mr Parkes' death was a 'reportable death' pursuant to section 8(3)(h) of the *Coroners Act 2003*. The death was considered by me to be a death that happened in the course of or as a result of police operations.

10. On 8 May 2017, I wrote to Mr Parkes' family advising of my intention to finalise the coronial investigation without holding an inquest. I invited them to request an inquest if they believed one should be held. I received this request on 15 June 2017. The family set out concerns relating to clarifying the events leading up to the accident, and the rules and regulations relating to police officers pulling motor vehicles over on the road side. I subsequently determined it was in the public interest to hold the inquest, consistent with the presumption in s 27(1)(iii) of the *Coroners Act*.

11. The primary purpose of a coronial investigation is to independently investigate a reportable death in order to make the findings required by s 45 of the *Coroners Act* in relation to the identity of the deceased person, the cause of death and how the person died. A coroner is prevented from making any findings in relation to criminal or civil liability arising from the death under investigation. In appropriate cases a coroner can make comments connected with the death in relation to ways to prevent deaths from happening in similar circumstances in the future, public health or safety, or the administration of justice.

12. Coronial findings are required to be based on proof of relevant facts on the balance of probabilities, in accordance with the principles set out by the High Court in *Briginshaw v Briginshaw*.[2] Coroners should not make comments or findings that are adverse to an individual unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

[2] (1938) 60 CLR 336

13. The inquest was held in Brisbane over 14-15 June 2018. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. I accepted the submission from the counsel assisting at the pre-inquest conference, Mr Bartlett, that all evidence be tendered, and that oral evidence be heard from the following witnesses:

    - Senior Sergeant Jeffrey Gillam;
    - Mary Gibney;
    - Christopher Williams;
    - Senior Sergeant Malcolm Lilley;
    - Andrew McLaren;
    - Sergeant Sharon Klump;
    - Chris Loveday; and
    - Senior Sergeant Jacquelin Honeywood.

14. I consider that the evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the requisite findings.

The evidence

Personal circumstances

15. Michaelangelo George Parkes (known as Michael) was born on 12 June 1950. He was 66 years of age at the time of his death. Mr Parkes had four adult children and lived alone on a rural property at Booroobin, west of Beerwah. The mother of his children had passed away some fourteen years prior to his death. Mr Parkes was described by his sister as being close to his family, keeping in touch regularly. A letter to Mr Parkes written after his death was tendered at the inquest. It sets out the strong bond he had with his children and grandchildren, and the profound sense of loss they have experienced after his death. I express my sincere condolences to Mr Parkes' children and extended family.

16. Mr Parkes owned a Kawasaki GT750 motorcycle and had been riding motorcycles for most of his life. At the time of his death Mr Parkes had retired from truck driving and building truck and bus bodies. He also had a love of horses and was a ceremonial member of the Maleny Light Horse Regiment.

17. Mr Parkes' medical records were tendered at the inquest and confirmed that he had undergone surgery for tonsillitis at the Sunshine Coast University Hospital on 29 July 2016.

18. On 30 July 2016, after leaving the hospital, he drove to his sister's home at Woodford. After sharing a meal with his sister, he stayed the night. He left at around 8:20am on 31 July 2016, telling his sister that he would return later to have dinner. It is believed he then returned to his home where he collected his motorcycle.

Events leading to death

19. Senior Sergeant Malcolm Lilley is the Officer in Charge of the Landsborough Road Policing Unit. He has been in this role for approximately 8 years. At the time of Mr Parkes' death, Senior Sergeant Lilley had over 28 years continuous policing experience, with 20 of those years performing duties as a traffic officer/road policing officer.

20. Senior Sergeant Lilley was interviewed by police investigators after the incident[3], and also gave evidence at the inquest. On 31 July 2016, he was performing traffic enforcement duties, with his dashboard camera activated. He told investigators that he was travelling southbound on Old Gympie Road, when he detected a Toyota Yaris, driven by Mary Gibney, speeding in a 60km/hr zone. Ms Gibney was aged 70 years at the time of the incident.

21. Senior Sergeant Lilley subsequently performed a U-turn to intercept Ms Gibney's vehicle, which pulled into the driveway of 3051 Old Gympie Road, some 60m from the intersection with Clarkes Road.[4] Just before the intersection with Clarkes Road was a road warning sign indicating that a crest was approaching and advising a 40km/hr speed through that crest.[5]

22. At the inquest Senior Sergeant Lilley said that he had detected Ms Gibney's vehicle travelling at 76 km/h. He then activated his emergency lights in order to draw attention to oncoming vehicles and to attempt to intercept Ms Gibney's vehicle. He said that he reached 90 to 91 km/h as he drove to intercept Ms Gibney. He considered this to be justified as 'urgent duty driving', and he was required to leave his warning lights activated under the relevant QPS policy.[6] When asked if he had considered deactivating his lights, Sergeant Lilley said that once he drove over the crest, he could see that Ms Gibney had driven off the road and into a driveway. He said that it was his standard practice to intercept vehicles with his lights flashing continuously.

23. Senior Sergeant Lilley said that he was very familiar with Old Gympie Road and that the safe locations to pull vehicles over on this road included driveways and intersections. He said that some vehicles take a while to stop, and that the intercepted vehicle is generally in control of the location they pull over. He said that he had no concerns with the interception spot selected by Ms Gibney and that there was no need to move to another location.

[3] Exhibits B5-B5.1; Exhibit E2.
[4] Exhibit C1, page 4
[5] Exhibit B5.1, page 5 onwards.
[6] OPM 15.3.3 no longer requires warning lights to be activated when accelerating a police vehicle to catch up to and attain positioning behind a vehicle to be intercepted, so as to give the driver of the vehicle a direction to stop.

24. At the inquest, Senior Sergeant Lilley was questioned in relation to how the selection of the interception location complied with Chapter 10.4.2 of the Traffic Manual[7], which states "*If possible, avoid stopping over the crest of a hill or in an area where visibility of the police vehicle is impeded*".

25. Senior Sergeant Lilley said that although Ms Gibney had elected to stop at that location in order to comply with his direction, he continued with the intercept. He said that if he was not happy with the location he could have waited or moved to a safer location. Prior to intercepting Ms Gibney, he had intercepted a motorcycle but waited until the motorcycle reached Landsborough before doing so for safety reasons. Senior Sergeant Lilley said that the site that Ms Gibney had pulled over was a residential driveway servicing two houses and was not overgrown with vegetation.

26. Ms Gibney was interviewed by police after the event[8], and also gave evidence at the inquest. Ms Gibney had driven to Beerwah and was on her way home to Maleny. Ms Gibney said that she first noticed the flashing lights on the police vehicle while it was travelling in the opposite direction. She said that the police vehicle then came behind her with flashing lights and she pulled over. It had taken a while for her to pull over because she had not travelled on that road for some time and was conscious of hidden driveways. Ms Gibney said that she thought the location where she had pulled over was safe because it was a driveway.

27. After Ms Gibney stopped in the driveway Senior Sergeant Lilley asked her to move her vehicle forward so he could, in turn, move his vehicle off the roadway. Senior Sergeant Lilley then issued a traffic infringement notice to Ms Gibney. When asked why he did not simply post the infringement notice to Ms Gibney without pulling her over, he said that a direction had issued from the Assistant Commissioner, Road Policing Command, to not issue infringement notices by mail for offences detected with mobile radar devices. Senior Sergeant Lilley spoke of the benefit of issuing an 'on the spot' fine as a form a specific deterrence.

28. At the inquest, Ms Gibney said that after she was spoken to by Senior Sergeant Lilley, she was informed that she would receive the "ticket in the mail". Ms Gibney said that as she drove away the road was clear. As she drove off, she saw Senior Sergeant Lilley waving someone else down in her rear vision mirror. At this point she also saw a motorcyclist coming over the crest of the hill with his "hands wobbling". Ms Gibney thought that Senior Sergeant Lilley was waving the second vehicle off the road for the purpose of booking him. She did not see the crash involving Mr Parkes take place.

[7] Now OPM 15.4.2
[8] Exhibit B1.

29. Senior Sergeant Lilley said that as he directed to Ms Gibney to continue on her way, he heard another vehicle approaching from the south. Senior Sergeant Lilley told investigators that he felt, from the previous manner of Ms Gibney's driving, she had been a little slow to enter the traffic. With this in mind, he moved to the road edge at the rear of his vehicle, intending to indicate to the approaching vehicle to slow down.[9] At the inquest he said that he wanted Ms Gibney to return safely to the roadway, having regard to her age and the type of vehicle she was driving.

30. The approaching vehicle was a Hyundai Santa Fe, driven by Christopher Williams. Mr Williams was interviewed by police after the event[10], and also gave evidence at the inquest.

31. Mr Williams was travelling home from his brother's property at Peachester and was heading north on Old Gympie Road. As soon as Mr Williams appeared over the crest, Senior Sergeant Lilley signalled to him to slow down by waving his hand in a downward motion. Mr Williams told ESC investigators that he was uncertain what the signal was, so he decided to stop. He is heard on Senior Sergeant Lilley's field recorder to say "*sorry, I thought you were telling me to pull up*". Sergeant Lilley responded that he was indicating to slow down.

32. At the inquest, Mr Williams said that he lived on Old Gympie Road and was very familiar with it. He said there were steep drains to the left of the road and numerous driveways. In particular, he said that the driveway which Ms Gibney had pulled into was used by the owner of B-double trucks which entered the roadway from that point.

33. Mr Williams' evidence was that he reduced speed to approximately 40 km/h as he went over the crest near the intersection with Clarkes Road. At this point he saw the police vehicle with flashing lights and a blue car pulling out slowly onto the roadway. He did not recall seeing Mr Parkes' motorcycle in his rear vision mirror at that point in time.

34. Mr Williams said that when he was halfway between the crest of the hill and the driveway from which Ms Gibney was entering the roadway, he saw Senior Sergeant Lilley motioning with his palm facing down. He interpreted Senior Sergeant Lilley's motion as a direction to slow down but he was not certain. He was familiar with the signal as he frequently saw it at roadworks.

35. Mr Williams said that, in response, he slowed to approximately 5 km/h and was bringing his vehicle to a gentle stop when he saw Senior Sergeant Lilley suddenly run away from the edge of the road. He then saw in his rear vision mirror Mr Parkes skidding with his brakes locked and then colliding with the rear of the QPS vehicle, where Senior Sergeant Lilley had been standing. Mr Williams said that although he needed to slow down, he would have been able to avoid a collision with Ms Gibney's vehicle in the absence of any direction from Senior Sergeant Lilley.

[9] Exhibit B5.1, page 12 onwards.
[10] Exhibit B4; Exhibit E5.

36. Senior Sergeant Lilley told investigators that he saw Mr Williams' vehicle's front end dip as a result of the braking.[11] At the inquest he said that Mr Williams had braked abruptly but he did not see him stop. At the same time, Senior Sergeant Lilley saw the motorcycle being ridden by Mr Parkes immediately behind Mr Williams' vehicle, already under heavy braking with the handlebars shaking and skidding directly towards him.

37. Senior Sergeant Lilley told investigators that he then ran around to the front of his vehicle to avoid any impact with the motorcycle. As he was running, he heard the impact of Mr Parkes' motorcycle colliding with the police vehicle and subsequently ran back. He saw Mr Parkes lying on the ground near the rear end of the police vehicle. Senior Sergeant Lilley immediately contacted police communications by radio and requested an ambulance.[12]

38. Senior Sergeant Lilley commenced CPR with the assistance of Mr Williams. Senior Sergeant Lilley continued CPR with the support of Mr Williams until paramedics from the Queensland Ambulance Service (QAS) arrived and took over.[13] Mr Parkes was subsequently declared deceased by QAS at the scene.[14]

Autopsy results

39. A full internal autopsy examination was conducted on 3 August 2016 by senior forensic pathologist, Dr Beng Ong. A copy of Dr Ong's report was tendered at the inquest.[15]

40. Dr Ong explained that the examination showed evidence of injuries to the torso, most severely to the chest including underlying fractures of the ribs and sternum. There was an extensive amount of haemorrhage present in both thoracic cavities, but most severely on the right-hand side. There were contusions to both lungs, and the pericardium was ruptured. There were perforated lacerations to the heart, and traumatic atrial septal defects. Dr Ong also noted some abdominal injuries, namely that the spleen was ruptured. There were minimal other injuries seen on Mr Parkes' body.

41. Toxicology testing showed the presence of celecoxib, paracetamol and tramadol all at non-toxic levels. They were not likely to have affected Mr Parkes, or contributed to his death, in any way.

42. Dr Ong ultimately determined the cause of death to be from 'chest injuries, due to, or as a consequence of a motor vehicle collision (motorcyclist).'

[11] Exhibit B5.1, page 10 onwards.
[12] Exhibit B5.1, page 7 onwards; Exhibit E1.
[13] Ibid.
[14] Exhibit D1.
[15] Exhibit A4.

Investigation findings

43. The ESC investigation reviewed the circumstances leading to the accident and Mr Parkes' death. Senior Sergeant Gillam's report incorporated a report from the QPS Forensic Crash Unit (FCU), prepared by Sergeant Sherryn Klump, Officer in Charge of the Nambour Forensic Crash Investigation Unit, who attended the scene and gave evidence at the inquest.

44. A copy of Sergeant Klump's report was also tendered at the inquest.[16] By way of summary, that report concluded the following key matters:

- The incident occurred on Old Gympie Road, Mount Mellum, on 31 August 2016 at 1:40pm when the road was dry and conditions clear;
- Mr Parkes died at the scene as a result of injuries sustained after losing control of his motorcycle and colliding with the rear end of the stationary police vehicle;
- The loss of control was a result of a series of events which commenced with Senior Sergeant Lilley signalling the driver of the Hyundai Santa Fe to slow down to allow the intercepted Toyota Yaris driven by Ms Gibney to re-enter traffic;
- The Hyundai Santa Fe braked heavily in response to that signal and slowed rapidly;
- As Mr Parkes' motorcycle traversed the crest of the hill, he encountered the Hyundai Santa Fe travelling much slower than anticipated, and applied emergency braking to avoid collision;
- It is likely Mr Parkes' motorcycle was not travelling at excessive speed or too close to the Santa Fe;
- The distance from the crest of the hill to the start of the skid was 22m;
- It is possible there was reduced braking available to the front wheel of the motorcycle. New brake pads were not fully bedded in and may have contributed to Mr Parkes' extended skidding distance and thereby contributed to his death;
- A motorcycle travelling at 60km/hr with 100% braking efficiency would have required 25m to reach a complete stop if the rider had been able to remain upright;
- The motorcycle skidded for 28m before leaving the bitumen surface and then slid a further 11m to the point of impact with the QPS vehicle;
- The police vehicle was clearly visible and readily identifiable; and
- There have been no criminal offences detected in the investigation of the incident.

45. At the inquest I heard evidence from Andrew McLaren, a Vehicle Inspection Officer with the QPS. A statement from Mr McLaren was also tendered.[17] Mr McLaren inspected Mr Parkes' motorcycle, Mr Williams' vehicle and Senior Sergeant Lilley's unmarked police vehicle.

[16] Exhibit C1.
[17] Exhibit B2.

46. With respect to Mr Parkes' motorcycle, Mr McLaren's written report indicated that it was in a satisfactory mechanical condition, however new brake pads had been fitted. He thought they were not fully bedded-in, which may have caused a reduction in front brake efficiency and this condition may have contributed to the cause of the incident.[18]

47. At the inquest a repair invoice[19] was produced which indicated that the motorcycle's brakes had been replaced one year prior to this incident. Mr McLaren readily conceded that where a motorcycle had been operated so that the brakes were heated sufficiently, the surface of the brakes is 'taken off' and the brakes' efficiency is not diminished. Accordingly, the condition of the brakes would not have hampered Mr Parkes' capacity to effectively stop the motorcycle on 31 July 2016.

48. No defects were found during inspection of Mr Williams' vehicle or the police vehicle which might have contributed to the cause of the incident.[20] In particular, the brake lights on Mr Williams' vehicle were found to be working.

49. Sergeant Klump's evidence was that the QPS vehicle could be seen clearly from the crest of the hill. The QPS vehicle was also clear of the travel line on the roadway.

50. Sergeant Klump observed a single skid mark which indicated that the rear tyre of Mr Parkes' motorcycle was locked and was braking. Consistent with this, she also observed a flat spot on the rear tyre of the motorcycle. Sergeant Klump's analysis was that the motorcycle was travelling between 46 km/h and 73 km/h. Her evidence was that although the Santa Fe utility driven by Mr Williams may have blocked Mr Parkes' view of the QPS vehicle, there was enough distance to bring the motorcycle to a stop without colliding with either vehicle, taking into account an initial distance of 25m travelled during "perception reaction time" before he likely applied his brakes. Her evidence was that the camber of the road caused the motorcycle to leave the bitumen road surface when it was skidding.

51. The ESC report reviewed the events and information available from independent witnesses and police officers. The investigation identified a number of contributing factors to the accident. These factors included:

    - the decision by Senior Sergeant Lilley to intercept a vehicle for a traffic infringement;
    - the position at which by Ms Gibney chose to pull off the road;
    - the time at which Mr Williams' vehicle travelled over the crest toward their location;
    - the manner of braking of Mr Williams' vehicle after he saw the police vehicle;

[18] Exhibit B2, page 3.
[19] Exhibit C12
[20] Exhibit B2, pages 4-5.

- the time at which Mr Parkes travelled over the crest behind Mr Williams' vehicle; and
- Mr Parkes' evasive action in order to prevent a collision with Mr Williams' vehicle and the subsequent collision of Mr Parkes' motorcycle with the police vehicle.[21]

52. The ESC investigation found that Senior Sergeant Lilley responded appropriately in rendering immediate first aid at the scene.[22]

53. The investigation found that there was no evidence to support any criminal charges against any of the persons involved in the incident. No issues were identified by ESC investigators in relation to the design or the condition of the road, nor were any other issues identified which needed to be addressed in order to prevent any future fatalities of a similar kind.

54. The ESC investigation did not identify any suspicious circumstances associated with Mr Parkes' death. Further, there was no evidence to indicate any breaches of discipline or misconduct by any member of the QPS.

QPS policy and procedure relating to stopping vehicles for prescribed purposes

55. The investigation found that the actions of Senior Sergeant Lilley complied with relevant QPS legislation, policy and procedures. There was no evidence to suggest that Senior Sergeant Lilley did not comply with the legislative requirements in the *Police Powers and Responsibilities Act 2000* ('PPRA') relating to stopping vehicles for prescribed purposes (section 60).

56. At the time of Mr Parkes' death, the policy relating to vehicle interceptions was contained within s.10.4.2 and s.10.4.5 of the QPS Traffic Manual ('the Manual'). It stated a number of considerations which an officer must take into account when intending to intercept a vehicle. This included taking appropriate safety precautions and not unnecessarily exposing themselves, or any other persons, to danger. I have extracted the relevant policy, as follows:

> *"10.4.2 Considerations prior to interception*
>
> *PROCEDURE*
> *Officers intending to intercept motor vehicles should ensure:*
> *(i) they do not unnecessarily expose themselves or any other persons, to danger; and*
> *(ii) appropriate safety precautions are taken.*
>
> *Prior to giving a direction to the driver of another vehicle to stop, officers should:*

[21] Exhibit A6.
[22] Exhibit B5.

(i) consider the reason for the interception and what action can be taken if the driver of the vehicle refuses to stop, see s. 10.5.2: 'Justification for pursuit' and s. 10.4.4:
'Abandoning an attempted interception' of this chapter;
(ii) consider whether to stop the vehicle immediately or call for assistance. This consideration should include whether the vehicle is being driven in a manner dangerous to road users, the offence suspected of having being committed, the number of persons in the vehicle and whether the officer is attempting the interception is alone;
(iii) whenever practicable, inform the local police communications centre of their intentions prior to attempting to stop the particular vehicle; and
(iv) select a suitable interception site. Where practicable, the interception site should be well lit and located on a level stretch of roadway so that both the police vehicle and the intercepted vehicle are visible from a distance. If possible, avoid stopping over the crest of a hill or in an area where visibility of the police vehicle is impeded. (Emphasis added)

10.4.5 Procedures after interception

PROCEDURE
Before leaving the police vehicle to speak to the occupants of the intercepted vehicle, officers should:
(i) notify the local police communications centre of the interception and the exact location as well as any other information regarding the description of the intercepted vehicle and its occupants;
(ii) if time permits, record on the activity log or elsewhere, information about the intercepted vehicle and its occupants;
(iii) continue to operate the flashing warning lights;
(iv) observe the occupants of the intercepted vehicle for any unusual movement, e.g. change of seating positions, attempts to dispose of anything or attempts to leave the scene unexpectedly either in the vehicle or on foot;
(v) avoid standing between the police vehicle and the intercepted vehicle; and
(vi) conduct a threat assessment using the POP process (Person Object Place) and, if safe to do so, approach the intercepted vehicle in accordance with the 'Dealing with motorised offenders' Good Practice Guide (available on the Service Intranet)."

57. Senior Sergeant Lilley's evidence was that he received instruction during his pre-service training at the Queensland Police Academy on how to provide prescribed police hand signals to stop and proceed in accordance with the *Traffic Regulations 1962*.[23] He clarified that these hand signals are now located within Schedule 7 of the *Police Powers and Responsibilities Regulation 2012*.

[23] Exhibit B5.

58. Senior Sergeant Jacquelin Honeywood is stationed at the QPS Recruit Training Centre, and gave evidence at the inquest about the training provided to police officers relating to traffic control.[24] A copy of Schedule 7 was tendered at the inquest, as part of the Recruit Training Program Manual Traffic Control Learning Guide (the Learning Guide).[25] Notably, the prescribed hand signals provide for a 'stop' signal, a 'proceed' signal, and a signal for a person to 'stop at a place as indicated'. The 'slow down' hand signal as used by Senior Sergeant Lilley is not included in Schedule 7. The Learning Guide stipulates that an officer may use their own hand signals. However, the signals have to be appropriate (s 17 *Police Powers and Responsibilities Regulation 2012*); and be carried out in such a way as to eliminate misunderstanding (s 1.6 of the Traffic Manual).

59. Section 1.6 of the Traffic Manual is as follows:

> *PROCEDURE*
>
> *Officers performing duty which involves regulating traffic should:*
> *(i) give definite signals, directions, or orders to drivers in such a way as to eliminate any misunderstanding;*
> *(ii) as far as practicable, stand in the centre of any intersection and see that vehicles, etc., proceed in their turn in a proper manner at a reasonable rate of speed;*
> *(iii) ensure that traffic control light signals at any intersection where it is necessary for police to regulate traffic are turned off or are turned to flashing amber; and*
> *(iv) ensure that any signals, directions or orders given to drivers do not create a dangerous situation for the officer or other road users.*

60. Senior Sergeant Lilley's evidence was that throughout his service he has provided traffic direction utilising hand signals thousands of times and has also observed other officers doing so.[26] He explained that the signal he was using with Mr Williams in the lead up to the accident (described as pushing one hand with the palm down repeatedly), was an attempt to advise Mr Williams to slow down. It is a hand signal that Senior Sergeant Lilley has used successfully many times over many years in an attempt to slow drivers who are approaching a hazard. He has also observed other police officers using the same hand signal.

61. Senior Sergeant Gillam was satisfied, in this instance, that Senior Sergeant Lilley intercepted the vehicle for a detected speed infringement. Senior Sergeant Lilley activated the emergency lights of his unmarked police vehicle and intercepted Ms Gibney.

[24] Exhibits B6 – B6.5.
[25] Exhibit B6.2, pages 260 – 262.
[26] Exhibit B5.

62. Senior Sergeant Gillam accepted that operational police are not always able to obtain a suitable safe place to intercept vehicles. Further, the intercepted vehicle may not always pull off the roadway in the position where the intercepting officer intended or would prefer them to stop. In this case Ms Gibney pulled into a residential driveway adjacent to a 60km/hr road. This left limited room for Senior Sergeant Lilley's police vehicle to park behind her vehicle. Senior Sergeant Lilley subsequently instructed Ms Gibney to move her vehicle forward, thus enabling Senior Sergeant Lilley to move his vehicle completely off the roadway.

63. Senior Sergeant Gillam also conducted inquiries with the occupants of properties in the vicinity of the accident. The occupant of the property whose driveway was used by Ms Gibney to pull over stated that he had lived there for 13 years. He had not observed any other traffic crashes in the vicinity during this time and raised no issues with the roadway. However, two other neighbours indicated that the road was 'dangerous'. One neighbour stated the intersection of Clarkes Road was a 'blind rise', and that you cannot see vehicles coming in either direction when travelling down the hill, and want to turn into Clarkes Road. She believed the road should be levelled to make vision clearer.

Submissions on behalf of the Parkes family

64. Comprehensive and helpful written submissions were provided on behalf of Mr Parkes' family. It was submitted on their behalf that the following points may be considered central to the inquest:

    a) The decision to intercept Ms Gibney rather than forwarding an infringement notice to her in the mail;
    b) The decision to intercept the vehicle driven by Ms Gibney at the location used;
    c) The decision of Senior Sergeant Lilley to use his own hand signal and whether or not such was done in a way to eliminate misunderstanding.

65. The family submitted that Senior Sergeant Lilley had a discretion to issue an infringement notice by post and that the Traffic Manual did not require him to intercept Ms Gibney's vehicle before issuing the infringement notice.

66. It was also submitted by Mr Parkes' family that Senior Sergeant Lilley failed to follow the procedure required by section 10.4.2 of the Traffic Manual in that he failed to ensure that he did not unnecessarily expose himself or another person to danger and take appropriate safety precautions.

67. It was submitted that it was possible to stop Ms Gibney in a location other than over the crest of a hill, and that it would also have been practicable to have allowed Ms Gibney to have continued travelling in her vehicle until such time as she approached a suitable interception site. It was unsatisfactory to say that if a single vehicle travelled over the crest, immediately prior to the interception site, that it could technically stop in time.

68. The family submitted that Senior Sergeant Lilley's evidence that he always left his lights flashing during an attempted intercept meant that vehicles being followed would not be certain about the signal being given by the following police vehicle.

69. It was also submitted that Senior Sergeant Lilley should have:

    a) Activated his lights/and or siren only if he considered Ms Gibney's speed to be a serious risk to road users;
    b) Deactivated his lights following the U-turn and when he was accelerating the police vehicle to catch up to and attain positioning behind Ms Gibney;
    c) If still intending to intercept Ms Gibney's vehicle, ensure he did not unnecessarily expose himself or any other persons to danger; and that he took appropriate safety precautions;
    d) Considered the reason for the interception and selected a suitable interception site.

70. The family submitted that Senior Sergeant Lilley's hand signal was not necessary, having regard to Mr Williams' evidence that he saw Ms Gibney pulling out and did not need to take any action in response, "except to back off a little". It was submitted that Mr Williams' interpretation of Senior Sergeant Lilley's hand signal as a direction to stop created a dangerous situation for the officer and other road users.

71. Mr Parkes' family submitted that his death was contributed to by the combination of circumstances which occurred on 31 July 2016. The danger created by such circumstances had been previously identified by those who have formulated and amended the OPM and Traffic Manual which apply to QPS officers. It was submitted that had the appropriate procedures been followed, the contributing combination of circumstances would not have occurred, and it is likely that Mr Parkes would not have lost his life as he did.

Conclusions

72. I agree with the submission on behalf of Mr Parkes' family that his death was contributed to by the combination of circumstances which occurred on 31 July 2016. I accept that his driving ability was not impaired in any way at the time of the crash, and that his motorcycle was not suffering from any defects that contributed to the incident.

73. While it could be argued with the benefit of hindsight that Senior Sergeant Lilley might have approached the interception of Ms Gibney's vehicle in the manner suggested above by Mr Parkes' family, I accept the submission of counsel assisting that he acted in accordance with his training and relevant operational procedures in force when he intercepted Ms Gibney on 31 July 2016. He was entitled to intercept Ms Gibney's vehicle in the way that he did for a speeding offence. At no time was he in pursuit of Ms Gibney's

vehicle. I consider that he acted within the scope of the discretion afforded to him by the relevant QPS policies and procedures.

74. It may have been hypothetically possible for an infringement notice to have been issued to Ms Gibney via the post. However, Senior Sergeant Lilley did not detect the speeding offence on a camera device. This means it would have been necessary for him to attempt to proceed to engage in urgent duty driving to follow or intercept Ms Gibney's vehicle to obtain the registration details for her vehicle. However, I accept that he acted in accordance with QPS policies in intercepting her vehicle for traffic enforcement purposes. I accept his evidence that it was not QPS policy to issue infringement notices by mail for offences detected with mobile radar devices.

75. I accept that the location where Ms Gibney elected to stop was a driveway leading to two properties which was regularly accessed by prime movers. The road markings adjacent to the driveway indicated that vehicles could turn in both directions from the driveway.

76. I also find that the QPS vehicle and Ms Gibney's vehicle were both clear of the carriageway at the time of the incident leading to Mr Parkes' death, and that the QPS vehicle was clearly visible from the crest of the hill at the Clarkes Road intersection. I accept the evidence of Sergeant Klump that there was sufficient time and distance for Mr Parkes to have avoided the collision, if he had been able to maintain control of his motorcycle, either by stopping or driving around the hazard presented by Mr Williams' vehicle. On that basis, I find that the site was suitable for the interception of Ms Gibney's vehicle, noting that the requirement of s 10.4.2 to "*avoid stopping over the crest of a hill"* was imposed in circumstances where that that is possible.

77. In using the 'slow down' hand signal with Mr Williams, Senior Sergeant Lilley acted in accordance with his training and extensive experience. He was permitted to use hand signals apart from the regulated signals. He had previously used the same hand signal successfully to require vehicles to slow down on many occasions. I am satisfied that there was no reason for Senior Sergeant Lilley to believe that its use on this occasion would have produced a different response.

78. I do not consider that Mr Parkes' death could have reasonably been prevented in the circumstances. I consider that his death was caused by a combination of factors. Primary among those was Mr Williams' misinterpretation of the hand signal given by Senior Sergeant Lilley. Mr Williams' decision to stop suddenly rather than slow is likely to have contributed to Mr Parkes' decision to brake heavily in order to avoid a collision with Mr Williams' vehicle. This resulted in his rear wheel locking. His motorcycle came into contact with Mr Williams' vehicle before entering an uncontrolled slide off the road surface into the QPS vehicle. I am not critical of the response of Mr Williams or Mr Parkes in the circumstances. I

consider that most drivers alter their manner of driving when they encounter a police officer in uniform or a QPS vehicle at the side of the road.

79. I am satisfied that the investigation conducted into Mr Parkes' death by the Ethical Standards Command was thorough, and covered all relevant areas of investigation. I am satisfied that the protocols established to investigate deaths in custody in accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

Findings required by s45

80. 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 the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Michaelangelo George Parkes (also known as Michael).

How he died - Mr Parkes died when he took evasive action on his motorcycle in order to prevent a collision with another vehicle which had slowed suddenly. That vehicle had reduced speed after the driver interpreted a hand signal from a police officer, intended to signal to the driver to slow down, as a signal to stop. Mr Parkes applied his brakes and lost control of his motor cycle. After clipping the vehicle that had slowed, the motor cycle slid off the road and Mr Parkes came into contact with a stationary police vehicle parked in a driveway at the side of the road following a vehicle interception. This collision resulted in fatal chest injuries.

Place of death – Mr Parkes died at Old Gympie Road, Mount Mellum in the State of Queensland.

Date of death – He died on 31 July 2016.

Cause of death – Mr Parkes died as a result of chest injuries sustained in a motorcycle collision.

Comments and recommendations

81. Section 46 of the *Coroners Act*, 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.

82. Counsel assisting submitted that consideration might be given to recommendations for a public awareness campaign in relation to the use of police hand signals, or amendments to Schedule 7 of the *Police Powers and Responsibilities Regulation* to incorporate a 'slow down' signal. However, I am not satisfied that that there is a widespread lack of understanding of the signal employed by Senior Sergeant Lilley which would warrant either response.

83. Mr Parkes' family submitted, among other matters, that I make the following recommendation in relation to the prevention of deaths in similar circumstances:

- *That officers not familiar with the requirements of the OPMS/Traffic Manual as they pertain to vehicle interceptions be required to undergo training to ensure that any direction made to a driver to stop a vehicle is made in circumstances where the direction to stop is clearly communicated to the driver (such as positioning the police vehicle in close proximity to the vehicle to be intercepted prior to giving a direction to stop);*

84. I consider that current arrangements already cover officer training on these requirements. Chapter 15 of the OPM relates to the driving of service vehicles. Communication of the direction to stop is subject to 15.4.3 which states:

> "*Once an officer has decided to intercept a vehicle, a direction to stop is to be given as soon as practicable after:*
> *(i) an officer's vehicle is appropriately positioned in relation to the vehicle to be intercepted; or*
> *(ii) observing the subject vehicle being driven in a manner which poses a risk to road users."*

85. I have been advised that training of QPS officers in relation to the interception of vehicles is contained in the following online training packages:

- QPS Police Pursuits OLP; and
- Queensland Police Service Safe Driving Policy

86. Officers are required to undertake 'on the road' training in relation to these practices as part of QPS Driving Courses, with changes to legislation and policy communicated to all officers in the form of state-wide notifications and compulsory online learning products.

87. Road Policing Officers are also issued with Axon body worn cameras that are continuously buffering. Once activated, the device automatically captures the preceding 30 seconds. The device cannot be tampered with by an officer and is downloaded to a secure server. Current policy requires an officer to activate the device when exercising a power or function of the service. Any vehicle interception should be recorded and can be reviewed to ensure compliance with policies and procedures.

88. Mr Parkes' family also submitted that the following recommendation be made:

- *That the now section 15.4.2 of the OPM be amended to include at (iv) - That consideration should be given to not intercepting a vehicle where the interception is not immediately necessary for road safety and where the interception site is uncertain or not visible to oncoming traffic from 100 metres away.*

89. I do not consider that QPS officers should be limited to intercepting vehicles in circumstances where interception is 'immediately necessary for road safety'. The evidence at this inquest was that the mobile and visible enforcement of road safety legislation, including speeding laws, is an essential component in the deterrence of breaches of those laws.

90. However, having regard to the variable nature of road conditions and vehicle stopping distances, I agree that consideration should be given the second aspect of the suggested recommendation.

Recommendation 1

I recommend that the Queensland Police Service give consideration to the inclusion in section 15.4.2 of the Operational Procedures Manual more specific guidance to officers with respect to the safe location of interception sites, including the need to have regard to the distances required for vehicles to stop safely when travelling at the speed limit for the relevant section of road.

91. During the course of investigating Mr Parkes' death, it also came to my attention that an independent Speed Limit Review was conducted for the Sunshine Coast Council on the relevant section of road. A copy of that review, completed by Cardno, was tendered at the inquest[27], in addition to crash data obtained from the Department of Transport and Main Roads ('DTMR') for the relevant section of road.[28] The review found that, based on the speed limit review process, the speed limit should be posted at 70km/hr, rather than the current 60km/hr.[29]

92. The review examined relevant crash data, and suggested that further on-site investigations were required to reduce roadside hazards and improve

[27] Exhibit C11.
[28] Exhibits C9.13-9.14
[29] Exhibit C11, page 12.

road safety. The location of single vehicle run-off road crashes suggested to the review team that additional treatments such as signage, line marking and clearing of vegetation may reduce the risk and severity of crashes along the road. The review recommended that a road safety audit be conducted to identify deficiencies and suggest improvements.

93. At the inquest I heard evidence from Chris Loveday, the A/Manager of Transport and Infrastructure Management at the Sunshine Coast Council. Mr Loveday confirmed that the independent speed limit review had been received by Council. He explained that before any higher speed limit is implemented, it required approval from the Speed Management Committee (SMC). The SMC comprises of representatives from the Council, QPS, and other emergency services, Transport and Main Roads and the Royal Automobile Club of Queensland.

94. With respect to the recommendation for an independent safety audit, Mr Loveday gave evidence that Council was procuring the audit, which could raise engineering issues which may need to be addressed before any increase in the speed limit. Mr Loveday explained that it was expected that the Council would receive the Road Safety Audit results in June 2018. The audit would also consider treatments such as signage and line marking, together with funding requirements for those, and the issue would be referred back to the Speed Management Committee.

95. On 5 November 2018 Mr Loveday advised my office that the Speed Management Committee will review the recommendations of the "Speed Limit Review – Old Gympie Road Segment, Beerwah to Landsborough", together with my findings, at a future meeting.

96. This inquest focussed on an incident occurring in the immediate vicinity of the intersection of Old Gympie Road with Clarkes Road, without the benefit of the findings of the road safety audit. As such, it would not be appropriate for me to make any recommendations with respect to speed management on the entire Beerwah to Landsborough segment of Old Gympie Road. However, I make the following recommendation:

Recommendation 2

I recommend that the Sunshine Coast Council Speed Management Committee consider the issues identified in these findings with respect to the segment of Old Gympie Road in the vicinity of its intersection with Clarkes Road at Mt Mellum, including the capacity for vehicles travelling at 70km/h to avoid collisions with vehicles accessing the road from adjacent driveways.

97. I consider there are no other recommendations I could reasonably make to prevent a death from occurring in similar circumstances in the future.

Section 48

98. Section 48 of the *Coroners Act* provides that a coroner must give information to the Director of Public Prosecutions or to the chief executive of the Department in which legislation creating an offence is administered if the coroner suspects a person has committed an offence.

99. A coroner may give information to an appropriate disciplinary body such as the Crime and Misconduct Commission or the Commissioner of Police in the case of corrupt police conduct or police misconduct. I have considered submissions on the question of a referral under s 48 consistent with the State Coroner's Guidelines.

100. There will not be a referral under s 48 in this matter.

101. I close the inquest.

Terry Ryan
State Coroner
Brisbane
12 November 2018