CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 9th of April, 16th and 17th of August and the 4th of September 2001, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of George Spencer Chester.

I, the said Coroner, find that George Spencer Chester, aged 18 years, late of 36a Yallum Terrace, Kilkenny, South Australia, died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 10th of May 2000 as a result of multiple injuries. I find that the circumstances of the death were as follows:

1. Introduction

1.1. At about 8:35pm on Tuesday, 9 May 2000 a Toyota Landcruiser four-wheel-drive ('4WD') vehicle was being driven in a south-easterly direction along Decres Bay Road at Ceduna, South Australia, when it failed to negotiate a left-hand bend on the road, left the northern side of the carriageway and rolled over several times.

1.2. The driver of the vehicle, George Spencer Chester, aged 18 years, was ejected from the vehicle and suffered injuries which caused his death on Wednesday, 10 May 2000.

1.3. The vehicle Chester was driving had been stolen earlier that evening, by a person or persons unknown. Shortly before the incident, Detective Senior Constable Peter Martin Hore had been following the stolen vehicle in his unmarked police Toyota Landcruiser.

1.4. For that reason, the Deputy Commissioner of Police directed that the incident be investigated by Inspector R S Bubner of the Traffic Operations and Investigation

Section Traffic Support Branch of the South Australia Police ('SAPOL'), locally known as a Commissioner's Inquiry.

1.5. It is arguable whether Mr Chester's death constitutes a 'death in custody' within the meaning of Section 12(1)(d)(a) of the Coroner's Act 1975. A protocol for investigation into deaths in custody, developed between my office and the Commissioner of Police, treats such cases as deaths in custody. Since I decided that an inquest into the death was desirable in the public interest, the strict definition is somewhat academic in the circumstances of this case

2. Circumstances of the accident

2.1. The circumstances of the theft of the Toyota 4WD are not clear. Its owner left it in the Ceduna Area School carpark, with the keys in the centre console, hidden under some compact discs, at 9:45am that morning. The owner was not aware that the vehicle had been moved until after the accident had occurred.

2.2. At about 7:50pm, Ceduna police received an anonymous report that two vehicles were being driven in a 'disorderly manner' in the vicinity of the tennis court and bike track area near Talbot Street. A patrol consisting of Constables Puckridge and Larkins was tasked to the area.

2.3. Puckridge and Larkins attended in the Talbot Street/Chandler Crescent area in response to the tasking. As they arrived, the Toyota was seen leaving the area along Handke Drive. They located the other car, a yellow Toyota hatchback, near the tennis courts, and towed it to a safer place.

2.4. Larkins said that he spoke to Hore on the radio and advised him that he thought the 4WD on Smith Street could be a stolen vehicle. Soon afterwards, he heard Hore say that he had seen the vehicle and was following it on Smith Street, and that it was failing to stop. They followed to back up Hore.

2.5. Puckridge said that he heard Hore advise that the stolen vehicle was travelling at about 80 or 90 kilometres per hour, and that 'there's no dramas' (T28). Larkins said he saw Hore's vehicle about 500 metres ahead of them as it went onto the dirt, and 'disappeared into the dust' (exhibit C23, p3).

2.6. Hore was returning to Ceduna on the Eyre Highway when he heard reports of these activities on the radio. He drove to the general area to assist. He said that when he

arrived at the area, the air was still thick with dust, it being a still night, but the cars had gone.

2.7. Hore drove to the school and made enquiries in regard to another vehicle that had been tampered with. He then resumed patrols and, while travelling east on Smith Road, he saw the stolen 4WD travelling west. He performed a U-turn and followed the vehicle, which was travelling at 60 kilometres per hour. He activated the flashing light in his vehicle.

2.8. The vehicle turned left into Decres Bay Road, followed by the police vehicle. Hore said he activated the siren on his vehicle. He saw a puff of smoke from the exhaust, and the vehicle accelerated to about 80 kilometres per hour. He said this happened in the vicinity of 'Cheryl's house' (T134).

2.9. Ms Cheryl Nicholls is an Administrative Assistant at the Ceduna Police Station, and lives on Decres Bay Road near the intersection with Belts Street. She states that she and her husband went outside when they heard the siren, and saw the two vehicles on Decres Bay Road, and then a police Commodore sedan, travelling at a much faster speed, also went past (this was the vehicle in which Puckridge and Larkins were travelling). She said:

> 'It (the Toyota) wasn't travelling at a high speed, it was just as though the vehicle was refusing to pull over.'
> (Exhibit C26a, p3)

2.10. When the stolen Toyota reached the end of the bitumen on Decres Bay Road, a large cloud of dust came up from the compacted limestone surface. Hore said that he was blinded by the dust, and slowed to about 40 kilometres per hour.

2.11. As he progressed down Decres Bay Road, Hore advised his colleagues of his movements on the police radio. I will describe these transmissions shortly.

2.12. Hore described his speed and that of the other vehicle at that stage as 'moderate' (exhibit C24a, p10).

2.13. Hore said he continued carefully down the road until he saw the car stopped on the side of the road. It was on its wheels, but damaged as if it had rolled. He stopped, then turned his vehicle towards it. He took his torch and ran to the vehicle, looking for the driver. He noticed that the driver's door was open. There was no-one in the

vehicle, so he went over to a fence, shining his torch, looking for the offender whom he assumed had 'decamped' (exhibit C24a, p13).

2.14. Soon afterwards, Puckridge and Larkins heard Hore advise that he had located the vehicle, and that it had rolled. They drove to the scene. As they arrived, Larkins saw a male person lying face-down on the ground in their headlights, about 7 metres from the rolled vehicle. He also saw Hore looking over the fence with his torch (T89).

2.15. Puckridge and Larkins immediately went over to where the man was lying on the ground. Larkins said that he turned the man over into the coma position. He checked the airway, and noted that the breathing was shallow and laboured. He shook the man's shoulder but there was no response. He pinched the ear but there was no response to painful stimulus, either. The man was deeply unconscious.

2.16. An ambulance was called, and the record (part of exhibit C25) indicates that the call was received at 2035 (8:35pm), and the ambulance crew arrived at the scene at 2045, a commendably prompt response, particularly for a volunteer crew.

2.17. In the meantime, Puckridge and Larkins remained with the injured man throughout. They put something under his head to make him comfortable. Larkins said it was a folded rain jacket, Puckridge said it was folded leather gloves – it is not important who is right. Larkins said they also put a rain jacket over the man to keep him warm (T106). The man continued to breathe until the ambulance arrived.

2.18. Ambulance Officer, Kristina Borgas attended the scene with her colleague, Paul Warmington. Ms Borgas said that Puckridge and Larkins were still kneeling on the ground close to the person when they arrived. When she examined the person he was unconscious, cold to the touch and his breathing was shallow. His pupils were fixed and dilated and his foot was rotated through 90º indicating a leg injury.

2.19. When the man's breathing stopped, a mask was applied and his breathing was assisted by 'bagging' on the way to Ceduna Hospital (exhibit C7a).

2.20. On arrival at Ceduna Hospital, the man was seen by Dr John Tedders. He was noted to be deeply unconscious, with a Glasgow Coma Scale reading of 3, which is close to death. He was peripherally shut down, meaning that he had lost much of his peripheral circulation. A retrieval team from Adelaide was called and arrived at about 12:30am. In the meantime he had been intubated and ventilated, and haemacel was

administered intravenously. He did not receive a blood transfusion until the retrieval team arrived 'due to the lack of appropriate blood' (exhibit C8a, p2).

2.21. During this period, the injured man was identified as George Spencer Chester, born 27 October 1981, of 36a Yallum Terrace, Kilkenny.

2.22. The retrieval team arrived at the Royal Adelaide Hospital at 4:11am on Wednesday, 10 May 2000. On examination, Mr Chester was cold to touch, his pupils were fixed and dilated and he had no pulse (this had stopped at 3:52am). Dr Jeremy Abbott pronounced life extinct (exhibit C5a).

3. Cause of death

3.1. A post-mortem examination of the body of the deceased was performed by Dr John D Gilbert, Forensic Pathologist, at the Forensic Science Centre at Adelaide. Dr Gilbert's report is exhibit C18a.

3.2. Dr Gilbert noted:

> 'General
> There was marked paucity of blood in the heart and major vessels.
> The collections of blood in the pleural and peritoneal cavities were obviously diluted by intravenous fluids.
> A faint odour of alcohol was noted about the body. The gastric contents showed a quite distinct odour of beer.'
> (Exhibit C18a, p2)

3.3. There was also an acute subdural haematoma measuring 2 to 3 mms in thickness over the convexity of the left cerebral hemisphere. This was confirmed by Professor P C Blumbergs, who also noted patchy subarachnoid haemorrhage, cerebral contusions (bruising) and petechial (pinpoint) haemorrhages within the white matter of the brain and brain stem (exhibit C20a).

3.4. In addition to the brain injuries, Dr Gilbert found:

> 'Skeletal System
> The following recent injuries were identified:
> 1. Undisplaced fracture of posterior aspect of the left 10th rib. Overlying parietal pleura intact.
> 2. Separation of left sacro-iliac joint and symphysis pubis. Associated fractures of the left inferior and superior pubic rami were noted radiologically at Ceduna Hospital. Associated injuries included complete avulsion of the mid portion of the left psoas

major muscle adjacent to the left sacro-iliac joint, extensive soft tissue bruising of the pelvic soft tissues and subcutaneous fat over the lower abdomen and adjacent left upper thigh was well as a large scrotal haematoma.

No skull, vertebral or limb fractures were identified.'

(Exhibit C18a, p4)

3.5. Dr Gilbert commented:

'1. Death appeared to be due to sustained blood loss resulting from the pelvic fractures and a closed head injury (see separate neuropathology report).

2. The toxicology results were not to hand at the time of this report. It should be noted that, because of extensive blood loss from the pelvic injuries, a large volume of intravenous fluids had been administered. No admission blood samples were taken at the Ceduna Hospital or the Royal Adelaide Hospital. It will therefore be difficult, if not impossible, to determine likely blood alcohol and drug levels at the time of the vehicle accident.

3. There were no injuries or other markings on the body to indicate the involvement of another person in the death. In particular, there were no injuries indicative of an assault on the deceased at around the time of the vehicle accident.

4. No natural disease that could have caused or contributed to the death was identified at autopsy.'

(Exhibit C18a, p5)

3.6. In conclusion, Dr Gilbert diagnosed the cause of death as 'multiple injuries', a conclusion which I accept.

4. Analysis of the accident

4.1. Senior Sergeant Andrew Mitton, now retired, attended the accident scene with Constables Hancock and Atkins at about 1:30pm on Wednesday, 10 May 2000. There had been some confusion the night before about whether the Major Crash Investigation Section ('MCIS') of SAPOL would be involved, but nothing turns on this for present purposes. The scene had been marked out and preliminary observation taken by Senior Constable Sowerby the night before (exhibit C4a), and the vehicles were still in-situ and the scene was still being guarded by the time the MCIS personnel arrived.

4.2. After conducting a detailed technical analysis of the tyre marks left on the road, the coefficient of friction of the road surface, and the behaviour of the vehicle when rolling, the speed of the stolen vehicle was estimated at between 73 and 84 kilometres per hour (exhibit C27, p10).

4.3. Senior Sergeant Mitton commented:

> 'The reason for the vehicle's initial loss of control has not been positively determined. The vehicle's light switch was found in the 'off' position and it is possible that the driver of the vehicle turned the lights off to evade the following Police vehicle. If that was the case, and given the nature of the road surface, it could not be considered unusual that control was lost.
>
> It is apparent that the driver of the Land Cruiser was not wearing the seat belt provided. The integrity of the vehicle's cabin remained relatively intact and I believe that, had he not been ejected from the vehicle, there is a strong possibility that any injuries he received may have been relatively minor.'
>
> (Exhibit C27, p10)

4.4. A similar analysis of the tyre marks of the police vehicle indicated that it had been travelling at 44 kilometres per hour before Hore applied the brakes heavily and skidded to a stop (exhibit C27, p11).

4.5. I accept Senior Sergeant Mitton's conclusions, which were admitted by consent (exhibit C27).

4.6. A mechanical inspection of the stolen vehicle was performed by Mr E C McDonald of MICS, a qualified mechanic and experienced Vehicle Examiner.

4.7. Mr McDonald found that the headlight switch was in the 'off' position. When turned on, the lights operated correctly, on high beam.

4.8. Mr McDonald noted that the tyres on the vehicle were in poor condition, with minimal tread remaining, but apart from that, the vehicle had been in generally good condition (exhibit C16a, p4).

4.9. In particular, there is no evidence that there had been any form of collision between the vehicle driven by Mr Chester and the police vehicle (see also the statement of Senior Constable Mylchreest, the crime scene examiner [exhibit C17a]).

4.10. The evidence is sufficient for me to make a finding that Mr Chester was alone in the car at the time of the accident. Several young men, youths for the purposes of the Young Offenders Act, had been involved in the initial theft of the vehicle, and the driving of it around Ceduna. There is conflicting evidence about the role played by some of the young men involved, but it is not necessary for my present purposes to analyse this any further. However, by the time that Hore sighted the vehicle, I find that Mr Chester was alone, driving the vehicle.

5. Issues arising at the inquest

5.1. Urgent duty driving

This is defined in SAPOL General Order 5810.14 as 'driving in a manner which, when compared with normal risks, substantially increases the risk of injury to police, the public or suspects, or of damage to property …'.

5.2. The General Order provides:

- 'the urgent duty driving should not be disproportionate to the circumstances;
- risk must be continually assessed in terms of the potential danger to all and the risk of damage to property;
- police have a duty of care not to endanger other road users and must exercise an extreme level of awareness and caution.

…

Urgent duty driving may only be undertaken:

- in response to an emergency involving obvious danger to human life; or
- in the detection of a very serious crime.

In all cases, the known reasons for the urgent duty driving must justify the risks involved.'

Considerations for institution/continuation

Before commencing and while engaged in urgent duty driving the senior member and the driver must consider:

- the seriousness of the emergency or crime;
- the degree of risk to the lives or property of police, the public or the suspect/s;
- whether the driver holds the appropriate driving permit;
- whether immediate apprehension is necessary (if in pursuit);
- the availability of other police assistance;
- the capability and type of police vehicle or forthcoming assistance;
- the practicability of using other stopping devices such as road spikes;
- environmental and climatic conditions;
- police driver competence and local knowledge.

If the urgent duty driving involves a pursuit it must be terminated when:

- the necessity to immediately apprehend is outweighed by obvious dangers to police, the public or the suspects if the pursuit is continued; or
- the apprehension can be safely effected later (eg, the identity of the owner/occupants of the vehicle is known)
- instructed by supervisor, State Duty Officer of Communications Senior Sergeant.

> If the urgent duty driving involves an emergency response it must be terminated when the necessity to attend urgently is outweighed by obvious dangers to police or the public.'
>
> (Appendix 4)

5.3. In light of those criteria, I see nothing inappropriate in the way Hore conducted the pursuit that evening. He had reason to believe that the Toyota vehicle was stolen. He pursued it at moderate speed. He did not approach it to an inappropriate extent. He discontinued the pursuit when it became unsafe to continue, because of the dust. Apart from the fact that his presence may have led Mr Chester to turn off the headlights of the stolen vehicle at some stage, Hore's manner of driving did not contribute to the accident.

5.4. First aid

I accept that Hore had not seen Mr Chester before Puckridge and Larkins arrived at the scene. Once there, they all approached him to ascertain his condition. Once this was established, an ambulance was called promptly, and they did their best to keep Mr Chester comfortable until the ambulance arrived. There is no significance in the fact that Puckridge and Larkins remained closer to Mr Chester than Hore did – he was busy calling the ambulance and noting what had happened. There was no need to try and resuscitate Mr Chester at that stage, since he was still breathing. They had placed him in the coma position, checked his airway, and monitored his breathing. He was not bleeding externally.

5.5. One issue which does emerge is that Puckridge admitted that the officers' first-aid training was not up-to-date at the time of the incident (T162). It is also clear that the officers had little idea of the contents of their first-aid boxes in the police vehicles. It seems that the boxes did not contain a 'space blanket' to keep the injured person warm until the ambulance arrived (see the evidence of Larkins at T105, Hore at T145 and Puckridge at T158).

5.6. In view of Mr Chester's catastrophic injuries, there is no suggestion that these issues would have affected the outcome in this matter. I therefore do not consider it appropriate to make a formal recommendation pursuant to Section 25(2) of the Coroner's Act, 1975.

5.7. However, it is trite to observe that the need for police officers to have up-to-date first-aid training, and appropriate equipment, particularly in remote areas, is vital. There would be few more frustrating experiences for a police officer than to face an

emergency situation such as this without adequate training and equipment. I draw this to the attention of the Commissioner of Police.

5.8. In this context, I note that Senior Constable Larkins, as a result of his experiences in this case, has since joined the Ambulance Service as a volunteer, and has undergone appropriate training. I understand that a number of police officers in country areas have done the same thing. For this, they are to be commended.

5.9. I agree with the comments of Mrs Atkins, Counsel Assisting, that Senior Constable Larkins should also be commended for his efforts in taking Mr Chester's mother to the scene, and showing her the damaged car, thereby trying to help her understand and hopefully come to terms with the tragedy of her son's death.

Key Words: *Police, Urgent Duty Driving; Death in Custody; Training; Aboriginal Deaths; Motor Vehicle Accident; Reckless Driving; Stolen Vehicle*

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 4th day of September, 2001.

……..……
Coroner

Inq.No. 6/01 (1095/2000)