MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Sarah Jane Paino

Find, pursuant to section 28 (1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Sarah Jane Paino;

b) Ms Paino died as a result of injuries sustained by her in a motor vehicle crash in the circumstances set out further in this finding;

c) The cause of Ms Paino's death was neck and chest injuries; and

d) Ms Paino died at Davey Street, Hobart, Tasmania on 22 January 2016.

Finding

Sarah Jane Paino died in a terrible motor vehicle crash in the early hours of 22 January last year. The vehicle she was driving, in which her two year old son Jordan was a passenger in a booster seat in the rear, was rammed in central Hobart by a speeding stolen vehicle driven by an unlicensed 15-year-old driver who ran a red light. Ms Paino was 33 weeks pregnant. She had dropped her partner, Daniel Stirling, off at his workplace and was returning home.

Ms Paino and Mr Stirling were excited about the impending birth of their second child. It is quite clear that they were a happy family and she a loving and devoted mother.

Ms Paino suffered massive injuries to her neck and chest as a result of the crash. The Tasmanian State Forensic Pathologist, Dr Christopher Lawrence, who later performed an autopsy on Ms Paino's body, said the injury to her neck would have been rapidly fatal and was completely unsurvivable.

Emergency services personnel were on the scene almost immediately after the crash. Ms Paino was noted to still have some cardiac output. Jordan was pulled from the car. Ms Paino was extracted from the vehicle by Tasmania Fire Service personnel and rushed to the Emergency Department of the nearby Royal Hobart Hospital by ambulance. Nothing could be done for Ms Paino but an emergency Caesarean section was performed in the Emergency Department of the hospital, whilst CPR was still in progress, to deliver her baby. All resuscitation attempts ceased shortly after the baby, another son, Caleb, was delivered.

The driver of the other vehicle fled the scene and caught a taxi to his grandmother's home in a southern suburb of Hobart. He was quickly apprehended. A blood test subsequently taken from him at the Royal Hobart Hospital returned a positive reading for cannabis.

The crash and its aftermath understandably received widespread publicity. The driver of the vehicle involved in the crash was charged with, and pleaded guilty to, the manslaughter of Ms Paino. On 9 August last year he was convicted and sentenced to imprisonment for five years.

The completion of the criminal proceedings is not the conclusion of all legal proceedings arising out of the crash. Specifically, the conclusion of the criminal proceedings does not conclude the function of the coroner in relation to this, or any other similar death.

The jurisdiction of a coroner arises under the terms of the *Coroners Act* 1995 by reason of Ms Paino's death being unexpected and having resulted directly from an accident or injury (see section 3 and the definition of 'reportable death'). If a death is reportable, and Ms Paino's was, an obligation arises under the *Coroners Act* 1995 for the matter to be reported to the coroner. Section 21 of the same Act gives a coroner jurisdiction to investigate a death if it appears to the coroner that the death "is or may be a reportable death". The coroner's role involves in the immediate aftermath of a reportable death, amongst other things, safe custody of the body of the deceased person, formal legal identification of the body, making any necessary decisions as to whether or not an autopsy should be performed, considering any objection to autopsy by the senior next of kin, and making any necessary directions with respect to the manner in which an autopsy is to be performed and authorising the subsequent release of the body for burial, cremation or the like.

If a person is charged in relation to a death, the *Coroners Act* 1995 (see section 25) provides that in the absence of a reason to the contrary, any inquest is to be adjourned until the conclusion of any proceedings with respect to the charges. Relevantly, upon resumption of an inquest section 25 (4) provides "if in the course of the criminal proceedings a person has been charged on indictment, the inquest, on each resumption, must not contain any finding which is inconsistent with the determination of the matter by the result of those proceedings".

Whether or not an inquest is held depends on the circumstances of each case. Section 26 gives a coroner a discretion as to whether or not to hold an inquest. If a decision is made by a coroner not to hold an inquest the decision must be recorded in writing, reasons given and the senior next of kin of the deceased person notified as soon as practicable of the decision and the reasons for it.

In this matter notice was duly given pursuant to section 26 of the decision not to hold an inquest. The reasons for not holding an inquest included that the matter had been the subject of careful consideration by a Supreme Court judge, that it had been comprehensively investigated by an experienced Tasmania Police traffic crash investigator (and all the material from that investigation was available to me), and that to re-agitate the matter publicly would simply serve to increase the grief and distress of Mr Stirling and other members of Ms Paino's family with no discernible public benefit arising. Importantly, specific regard was had to the fact that Mr Stirling did not wish for an inquest to be held. As a consequence, the coronial investigation of Ms Paino's death was concluded without an inquest.

My formal findings set out at the beginning of this finding are those required to be made by section 28 of the *Coroners Act* 1995. It is important to understand that it is no part of the role of the Coroner to punish or impose any penalty – that is for the criminal courts (and has occurred in this

case already). The section 28 findings are based on the material provided to me as a result of the investigation. That material included, as has already been mentioned, a comprehensive and detailed crash investigation report prepared by Senior Constable Kelly Cordwell, formal evidentiary material dealing with identification of Ms Paino's body and certifying her life extinct, the report of Dr Lawrence, the State Forensic Pathologist, as to his findings at autopsy, a Death Report to the Coroner from the Royal Hobart Hospital, Ambulance Tasmania records, the results of toxicological analysis of samples carried out at the Forensic Science Service Tasmania laboratory, a detailed and extensive report from Mr Paul Ralph Wells, a Transport Inspector, who examined both vehicles involved in the crash, and affidavits and statements from responding emergency service personnel and eye witnesses.

In addition, I was furnished with all the material which formed the brief prepared by the Office of the Director of Public Prosecutions.

I am satisfied to the requisite legal standard that Ms Sarah Jane Paino died as a result of massive injuries sustained by her in a motor vehicle crash that occurred at 1.02am on Wednesday, 22 January 2016 at the intersection of Argyle and Davey Street, Hobart. The crash occurred when, as was outlined at the beginning of these findings, a stolen Black Rav 4 was driven through a red light by an unlicensed 15-year-old male youth at least twice the permissible speed limit of 50 km/h. The Rav 4 struck the Nissan Tiida driven by Ms Paino. Such was the speed of the Rav 4, Ms Paino's vehicle was pushed nearly 40 metres beyond the point of the crash. The Rav 4 caught fire. The driver of the Rav 4 fled the scene.

Nothing about the road or weather conditions or the mechanical state of either vehicle caused or contributed to the crash. Nothing about the manner of Ms Paino's driving caused or contributed to the crash either.

The evidence is that Ms Paino died almost instantly but due to the outstanding efforts of the emergency service responders and medical staff at the Royal Hobart Hospital her baby was able to be safely delivered. All those emergency service responders - police officers, fire service personnel and ambulance paramedics - and medical staff are responsible for the fact that Caleb was able to be brought safely into the world.

Comments and Recommendations

The circumstances of Ms Paino's death do not call for any recommendations pursuant to section 28 (2) of the *Coroners Act* 1995.

I thank Senior Constable Kelly Cordwell for her highly competent investigation and report.

I extend my sincere condolences to Ms Paino's family and loved ones on their loss.

Dated 12 June 2017 at Hobart in the State of Tasmania.

Simon Cooper
Coroner