QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

AMENDED FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Anthony Michael Charlwood and Krystal Renee Evans**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2022/5952, 2022/5955
DELIVERED ON:	18 June 2025
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 March 2025
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, deaths in custody and in the course of police operations, motorcycle crash, attempted interception, pursuit policy.

REPRESENTATION:

Counsel Assisting:	Ms S Ford, Coroners Court of Queensland
Charlwood and Evans Families:	Mr M Rawlings, instructed by Caxton Legal
Sgt Lyons:	Service Ms A Waite, Gnech and Associates
Commissioner of Police:	Ms T Boettcher, QLS Legal Unit

Contents

Introduction

1. Anthony Michael Charlwood[1] (Tony) and Krystal Renee Evans[2] (Krystal) died in a motorcycle crash at Helensvale in the early hours of 26 November 2022. They were aged 36 years and 35 years, respectively.

2. At approximately 1:30am on 26 November 2022, A/Sgt Lyons from Coomera Police was carrying out patrols when he saw a motorcycle leave the driveway of a house known to police. Tony was the rider of the motorcycle and Krystal was the pillion passenger.

3. Following a QPRIME check of the motorcycle's registration plate, A/Sgt Lyons attempted to intercept the motorcycle for traffic offences. After becoming aware that he was being followed by police, Tony accelerated at high speed and went out of sight. A/Sgt Lyons determined to abandon the attempted intercept after 21 seconds.

4. Shortly after, while looking for somewhere to safely stop, A/Sgt Lyons saw the riderless motorcycle on its side on Helensvale Road. He got out of his vehicle and located Tony and Krystal, both deceased, approximately fifty metres east of the motorcycle. Both had suffered traumatic life ending injuries after colliding with a light pole at speed.

The inquest

5. The deaths of Tony and Krystal were reportable deaths under the *Coroners Act 2003*. They occurred in the course of, or as a result of, police operations.[3] Their deaths were also violent/unnatural deaths.[4] As Mr Charlwood was trying to avoid being arrested his death was also a death custody and an inquest was required.[5]

6. The primary purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including when, where and how the person died and what caused the death.

7. A coroner may also comment on ways to prevent deaths from happening in similar circumstances in the future. A coroner is not able to include in the findings or any comments or recommendations any statement that a person is, or may be, guilty of an offence or civilly liable.

8. Where a coroner suspects that a criminal offence has been committed, they can make a referral to the Director of Public Prosecutions or relevant prosecuting authority. Information about a person's conduct in a profession can be given to the disciplinary body for that profession if the coroner believes the information might cause the body to inquire into or take steps in relation to the conduct.

[1] DOB: 3 July 1986.
[2] DOB: 17 April 1987.
[3] *Coroners Act 2003*, s8(3)(h).
[4] *Coroners Act 2003*, s8(3)(b).
[5] *Coroners Act 2003*, s27(1)(a)(i).

9. The following issues were investigated at the inquest, which was held at Brisbane on 19 March 2025, following a view of the crash site on 18 March 2025:

    1. The findings required under section 45 of the Coroners Act 2003, namely the identity of the deceased persons, when where and how they died, and the causes of their deaths.

    2. The appropriateness of Acting Sergeant Lyons' actions in attempting to intercept the motorcycle.

    3. The adequacy of the Queensland Police Service investigation into the circumstances surrounding the deaths.

    4. Whether there are any further recommendations that can be made which could prevent deaths from happening in similar circumstances in the future.

10. At the inquest oral evidence was heard from Det Sgt Spinks of the Ethical Standards Command (ESC), SC Hutchinson from the Forensic Crash Unit (FCU) and A/Sgt Lyons.

11. I found the evidence of each of these witnesses to be credible and reliable. Their evidence was corroborated by the objective evidence as contained in the BWC footage, CCTV footage, radio transmissions, and the QLITE download.

12. Evidence was also heard from Mr Semmens who was the only witness present at the time of the crash.

The investigation

Forensic Crash Unit[6]

13. Senior Constable Hutchinson of the Coomera FCU conducted an investigation into the crash and produced a report dated 8 June 2023. He was one of the first responders on 26 November 2022. He also assisted at a view of the scene of the crash site by the Court on 18 March 2025 and gave evidence at the inquest.

14. SC Hutchinson told the inquest that he was sworn into the QPS in 1991. He has conducted over 100 investigations, including aviation and industrial incidents as well as car and motorcycle crashes.

    <u>The motorcycle[7]</u>

15. A mechanical inspection of the motorcycle was conducted by the QPS Vehicle Inspection Unit (Vehicle Inspection Officer Major). It was found to be in a satisfactory mechanical condition, with no defects that could have contributed to the crash. The motorcycle had been in fifth gear and there was no evidence of wheel lock-up.

[6] C2 (FCU report/Supp F1).
[7] C2 (FCU report/Supp F1), p 9.

Scene examination[8]

16. Helensvale Road is a sealed bitumen carriageway in good condition. There were no defects, potholes or foreign substances present that could contribute to the cause of the crash.

17. The FCU Report noted that, in terms of tyre marks, there was evidence of contact damage on the concrete kerbing (on the side of the road).[9] This was understood to have been caused by the front wheel striking the gutter at a shallow angle and the motorcycle then continuing in an upright position. This would have caused the handlebars to rotate to the right, effectively causing a counter-steering effect – the consequence being that the motorcycle would violently tip left (as if making a left turn) and in turn, position the rider and pillion directly in the path of the light pole at high-speed.[10]

18. Preceding the contact damage, and approximately 17.5 metres from the light pole, was a single tyre mark. According to Officer Major, it:

> *…shows a cleansed appearance of the concrete surface rather than a black "skid" type tyre mark as is usually observed when a tyre skids across the concrete surface after a wheel lock caused by the braking system achieving maximum force application.*

19. The FCU Report indicated that there may be several reasons the wheels did not reach maximum brakeforce to lock one or both wheels. These included rider skill, a faulty or overheated braking system, exceeding the weight capacity of the motorcycle, a high level of friction created between the tyre compound and the road surface, and no application or minimal force braking by the rider.

20. Inspection of the carriageway also revealed two other tyre marks. The first was located approximately eighty metres from the front tyre striking the gutter. This tyre mark was positioned to the right side of the right lane adjacent to the centre traffic island. The second was approximately thirty-two metres from the gutter strike to the left side of centre of the left lane.

21. SC Hutchinson said the position of these two marks may be consistent with a motorcycle travelling at high speed and drifting wide in a right turn. However, the investigation could not conclude that the marks related to this incident.

Cause of the crash[11]

22. SC Hutchinson opined that the cause of the crash was a combination of, but not limited to, the following factors:

- *Rider inexperience – No formal training and assessment of competency in applying "Roadcraft."*
- *High speed operation.*
- *Consumption of drugs.*

[8] A10 (FCU report/Supp F1), pp 4 - 6.
[9] F5
[10] A10, p 6
[11] A10 (FCU report/Supp F1), pp 6 – 9, 11.

- *Conscious decision by the rider to evade police apprehension due to possessing a stolen motorcycle and prohibited drugs.*
- *Poor Roadcraft*

23. SC Hutchinson was unable to establish the motorcycle's speed at the time of impact with the light pole. However, where the motorcycle came to rest approximately 50 metres from the pole, and where there was evidence of contact damage both on the pole and the motorcycle, using the 'slide to stop formula', a minimum speed of the motorcycle at the commencement of the slide after contact with the light pole could be calculated.

24. SC Hutchinson's speed valuations are such that the motorcycle may have *slid* at a speed of between 66km/h to 96.6km/h following impact with the pole[12] - meaning it would have been travelling at significantly faster speed before collision. The speed limit at this location was 60km/h.

25. Ultimately, SC Hutchinson determined the likely cause of incident to be as follows:

> *Collision with kerb and fixed road furniture (light pole). Impaired decision making (rider). Significant contributions speed, drug consumption by rider, operating stolen motor vehicle, possession of dangerous drugs. Rider inexperience - Poor Roadcraft.*

26. SC Hutchinson clarified at the inquest that he was not qualified to indicate the precise impact the presence of drugs in Tony's blood on the crash. He said that 'roadcraft' included matters such as speed management, positioning of the motorcycle and the approach to corners.

27. SC Hutchinson said that while there was no evidence Tony had completed formal rider training in Queensland, it was apparent that he was capable of riding a motorcycle. However, his approach to the corner leading into the incident was not consistent with approaches recommended in the Queensland Motorcycle Riders' Guide.

28. He agreed that apart from the factors he had identified the cause of the incident may have been something completely different that was solely within Tony's knowledge.

29. SC Hutchinson told the inquest that Mr Semmens' vehicle was inspected, and while it had some scratches there was no panel displacement. There was no evidence Mr Semmens had collided with the motorcycle. He noted Mr Semmens' consistent evidence was to the effect that, at the time, he saw a riderless motorcycle as he executed a right turn from Helensvale Road into the Ampol service station.

30. SC Hutchinson also said while there was nothing to negative the evidence of Mr Semmens, there was also nothing to rule out the possibility that he performed a U-turn that interfered with the path of the motorcycle.

[12] These calculations are subject to the friction value of the road at the time.

Ethical Standards Command

31. An investigation into the circumstances of the deaths was also conducted by Detective Sergeant Spinks of the QPS Internal Investigations Group ESC.

32. Det Sgt Spinks' investigation was informed by versions given by Mr Semmens (civilian witness) and A/Sgt Lyons, body-worn camera footage, Government Wireless Network data ('GWN') obtained from A/Sgt Lyons' radio, and CCTV footage from nearby premises.

ESC investigation Conclusions[13]

33. In his report of 26 February 2024, Det Sgt Spinks concluded A/Sgt Lyons had complied with QPS policy and procedure.

34. Det Sgt Spinks determined that at no time did A/Sgt Lyons consider or engage in a pursuit. As for the intercept, A/Sgt Lyons was authorised to attempt it, and in doing so, he complied with sections 15.3.1, 15.4.3, and 15.4.4 of the QPS Operational Procedures Manual (OPM).

35. Other relevant findings/conclusions included the following:

- In accelerating to close the distance between his vehicle and the motorcycle, A/Sgt Lyons was:

  > *…performing a function of the Police Service pursuant to s.2.3 of the Police Service Administration Act 1990 (PSAA) and the exemptions provisions of s.305 of the Transport Operations (Road Use Management-Road Rules) Regulation 2009 apply. Additionally, his is afforded an exemption for exceeding the speed limit pursuant to s.144, of the Transport Operations (Road Use Management) Act 1995*

- On positioning himself to conduct the intercept, A/Sgt Lyons activated the vehicle's warning flashing lights and sirens, indicating to the motorcycle to stop. The motorcycle increased speed and A/Sgt Lyons attempted to match the speed for a short distance constantly assessing his situation, surroundings, and ability to intercept the vehicle.

- On deciding to abandon the intercept, A/Sgt Lyons slowed his speed, de-activated his lights and sirens, attempted to contact the Police Communications Centre (PCC), and began making an assessment on a safe place to stop his police vehicle in compliance with OPM 15.4.4, 'Vehicle Interceptions'. Upon visual observations in front of him, A/Sgt Lyons re-assessed the location to stop his vehicle.

- The total time in which A/Sgt Lyons attempted to intercept the motorcycle was 21 seconds. A further 18 seconds elapsed before he stopped his vehicle in front of the motorcycle. Det Sgt Spinks told the inquest that the GWN data can plot a map of the vehicle's movement and verified the account given the A/Sgt Lyons.

[13] A8 (ESC report), part 16, p 23.

- A/Sgt Lyons appeared to maintain sufficient distance between himself and the motorcycle to avoid a dangerous situation or possibility of collision. CCTV footage from a child care centre around 400m from the crash site indicated that A/Sgt Lyons' vehicle was likely 4-5 seconds behind the motorcycle.

ESC Recommendations[14]

36. The ESC investigation concluded that A/Sgt Lyons' conduct did not give rise to any criminal offences or breaches of discipline. As such, no disciplinary or criminal action was recommended.

37. However, the investigation recommended the use of 'dash-cam' video recording devices be extended to unmarked police vehicles.

The evidence

Personal histories

Mr Charlwood[15]

38. Tony moved to Oxenford from New South Wales in 1989. He lived there with his mother and siblings until his death. He was the youngest of four siblings.

39. Family statements were provided to the court by Tony's brother, Peter, and his mother, Kerry. Tony struggled with learning difficulties at school and enjoyed working outdoors as a landscaper and labourer. He clearly had a strong bond with his mother and siblings and is missed by them. They stressed that his memory should not be defined by the events leading up to his death.

40. Tony was regularly prescribed Atomoxetine (an ADHD drug) and Quetiapine (used to treat psychosis and depression). Otherwise, his medical history was unremarkable.

41. Tony's criminal history included property, assault and drug offences. His traffic record dated back to 2002 when he was first fined for driving unlicensed. His history included repeated unlicensed driving offences, driving under the influence of drugs and alcohol, speeding (including by exceeding 20km per hour), and failing to stop.

42. At the time of his death, Tony was not licensed to ride a motorcycle.

[14] A8 (ESC report), part 17, p 24.
[15] A8 (ESC report), parts 9 and 11; C2 (criminal history); C6 (traffic history).

Ms Evans[16]

43. Krystal spent most of her life living in and around the Gold Coast. At the time of her death, she was living in Upper Coomera with her son and her mother. She was an only child and had a close bond to her mother.

44. Krystal's health records reveal that she had significant health issues. Krystal also had criminal and traffic histories including unlawful use of motor vehicles, dangerous operation of motor vehicles and breach of bail.

45. Statements provided to the court by her aunt and friend indicated that Krystal was a devoted mother and a cherished friend.

46. I extend my condolences to Tony and Krystal's families and friends.

Day of deaths - 26 November 2022

Sighting of motorcycle[17]

47. On 25 November 2022, A/Sgt Lyons[18] (of Coomera Police Station) was rostered to perform shift supervisor duties within the Coomera division from 9:00pm until 6:00am on 26 November 2022.

48. His duties included single officer patrols in an unmarked silver Toyota sedan police vehicle with call sign GN205. The vehicle was fitted with covert emergency red and blue lights, and a siren. It was not fitted with a dashcam video system.

49. A/Sgt Lyons told the inquest that the annual Schoolies festival was on at the time of this incident and it was a very busy time for police on the Gold Coast.

50. At approximately 1:30am, A/Sgt Lyons was patrolling on Discovery Drive, Helensvale. This is an area known to police because residents had previously been involved in disturbances and drug-related activities.

51. As he drove past the intersection of Discovery Drive and Lindfield Road, A/Sgt Lyons observed a parked motorcycle, with a rider and a pillion passenger, facing up the road with its headlights on. He slowly drove past the motorcycle.

52. The motorcycle pulled out of the driveway and proceeded along Discovery Drive behind A/Sgt Lyons, travelling in the same direction. A/Sgt Lyons believed the motorcycle overtook his vehicle at the speed limit, but then increased speed. He did not believe Tony or Krystal would have identified him as a police officer at that point.

53. A/Sgt Lyons stopped and used his QLiTE device to conduct checks on the motorcycle's registration plates.[19] The QPRIME report noted 'false plates'. The Transport and Main Roads ('TMR') report which was generated also showed up as 'blue' – indicating the plates had been cancelled, and the motorcycle was uninsured or unregistered, or the driver was unlicensed.

[16] A8 (ESC report), parts 9 and 11; C3 (criminal history); C7 (traffic history).
[17] B3 (statement of Lyons); A8 (coronial report).
[18] Registered number 30746.
[19] Being 342ME.

54. A/Sgt Lyons was aware that, in accordance with QPS policy, these matters were 'non-pursuable' (insofar as pursuits and urgent duty driving). Accordingly, he decided to attempt to intercept the motorcycle for traffic-related offences. In conducting his risk assessment, he determined that if the rider attempted to evade the intercept, he would not pursue it.

55. A/Sgt Lyons pulled back onto the road. He estimated the motorcycle to be 'about' 200 metres ahead of him. He radioed the Police Communications Centre ('PCC') at 1:33am and reported:

> *"Urgent, I've got a motorbike, high speed southbound Discovery Drive. False plates. Two persons on board. They've just left number 16 Helensvale Road…*
>
> *Yeah, well over 120 in a 60 zone. I haven't activated lights and sirens. I'm in an unmarked vehicle."*

56. This was acknowledged by PCC.

Attempted intercept

57. On pulling back onto the road, A/Sgt Lyons activated his body-worn camera and followed the motorcycle. He also increased his speed to close the gap (to 124km/h). He told the inquest that factors relevant to his decision-making were that the conditions were dry and there were few vehicles on the road.

58. By this stage (at the Roundabout at the intersection of Discovery Drive and Helensvale Road) A/Sgt Lyons intended to intercept the vehicle for the following reasons:

    i. the number plates were false;
    ii. the rider was potentially unlicensed;
    iii. the motorcycle had been exceeding the speed limit; and
    iv. the motorcycle had departed a house connected with unlawful activities.

59. A/Sgt Lyons closed the distance between his vehicle and the motorcycle. He considered he was close enough to safely attempt the intercept and activated his red and blue lights and his siren – signalling to the motorcycle to pull over.

60. After the lights and sirens had been activated, A/Sgt Lyons observed the motorcycle slow down. This led him to believe Tony, aware police were directing him to pull over, was about to pull over and stop. However, the motorcycle suddenly accelerated off into the distance.[20] This was the first indication that Tony was attempting to evade A/Sgt Lyons.

61. A/Sgt Lyons increased speed (to 136km/h) and continued following the motorcycle for a short distance. In undertaking a risk assessment, however, he decided to abandon the attempted intercept. This occurred at 1:35am. The total duration of the attempted intercept was 21 seconds.

62. A/Sgt Lyons slowed down, deactivated his siren and lights, and searched for somewhere safe to pull over. He had intended to pull over and contact PCC to

[20] The motorcycle's acceleration can be heard clearly on the body-worn camera audio.

report the evade police offence. Meanwhile, the motorcycle continued to travel at high speed and eventually, A/Sgt Lyons lost sight of it.

63. As A/Sgt Lyons approached Shepparton Street, where he intended to pull over, he observed a red light at the intersection of Helensvale Road and Siganto Drive. Instead of pulling over, he continued towards the intersection to see whether the motorcycle was within sight. Upon doing so, he observed a 'plume'/cloud of smoke (or dust).

The crash

64. A/Sgt Lyons decided to inspect the source of the smoke/dust. On further approach, he observed the motorcycle, lying on its side, in his direction of travel. It appeared to have been involved in a collision.

65. Tony and Krystal were not within sight, but a black Commodore was stationary in the right turn lane at the intersection. The driver of the black Commodore was Mr Semmens.

Steps taken following the crash

66. As he could not see anyone near the motorcycle, A/Sgt Lyons believed Tony and Krystal had decamped on foot. At 1:35am, he contacted PCC and advised the operator of the situation:

> *"205 urgent. 205 urgent. Traffic crash…*
>
> *Yeah. Corner of Siganto and Helensvale. That motorbike, high speed. I'm trying to find them now."*

67. A/Sgt Lyons then exited his vehicle to search for Tony and Krystal. He located their bodies approximately 50 to 60 metres from the motorcycle, next to a light pole. It was obvious they were both deceased and had suffered very significant injuries.

68. A/Sgt Lyons notified PCC and requested assistance. Numerous police attended at the scene, including ESC and FCU investigators.

Mr Semmens

69. Mr Semmens, when speaking to Det Sgts Spinks and Bradley at the Southport Watchhouse after the incident, volunteered the following information:

- At approximately 1:30am, he had been travelling along the Pacific Motorway. Needing to refuel, he decided to pull into the Helensvale Service Depot. Having 'overshot' the entrance, he proceeded down Helensvale Road and then did a U-turn at a break in the traffic island dividing the north bound and south bound lanes.

- As he was returning to the intersection of Helensvale Road and Siganto Drive, he heard an engine and observed a riderless motorcycle travel past him in the curb side lane of the south bound lanes, eventually falling on its side as it lost momentum.

- Prior to seeing the motorcycle, he had not heard any sirens.

- Mr Semmens performed a U-turn at the intersection and observed an unmarked police car driving toward the intersection from the southbound lanes. It did not have its emergency red and blue lights activated.

70. Det Sgt Spinks told the inquest that there was no evidence that Mr Semmens was responsible for the crash.

71. Mr Semmens told the inquest he was travelling from Elanora to see his cousins at Waterford West. He usually drove at that time of night. He exited the M1 to get fuel from the Ampol at Helensvale but went past the entry point.

72. Mr Semmens initially said that he could not recall where he carried out a U-turn on Helensvale Road after exiting the M1. He then agreed he may have performed the U-turn at the intersection with Shepparton Road and was in a turn lane closer to that location (at the rear of the Ampol) than at Siganto Road. He said there was no traffic on the road at the time.

73. Mr Semmens' evidence was that he saw the motorcycle tumbling or cartwheeling in the air while he was stopped in the turn lane to drive into Siganto Drive waiting for the light to turn green. He did not see Tony or Krystal. He could not recall any other vehicles. He then parked and went to see if he could assist. He heard sirens briefly (likely from the M1) but was not sure where they came from. He did not recall seeing any red or blue lights before the incident. He agreed that he was intoxicated at the time.

74. It is implausible that he was turning into the rear driveway of the service station when he saw the motorcycle sliding past him given the location of the crash point with the light pole was adjacent to Siganto Drive.

75. Mr Semmens denied that his actions had any influence on the motorcycle or that his driving caused the motorcycle to take evasive action.

76. Mr Semmens did not present as a reliable witness at the inquest. He agreed that he did not have a clear recollection of the incident and I consider the account he gave in close proximity to the crash should be preferred.

77. After considering all of the evidence, I am not satisfied on the balance of probabilities that Mr Semmens' actions played any role in causing Tony to lose control of the motorcycle.

78. However, having regard to the concessions made by SC Hutchinson it is possible that, in addition to the factors SC Hutchinson had identified as the cause of the incident, Tony was required to take some evasive action prior to the intersection of Helensvale Road and Siganto Drive as he encountered the red traffic signal.

Relevant QPS policies

79. The QPS policies and procedures concerning the operation of QPS vehicles are contained in Chapter 15 of the Operational Procedures Manual ('OPM'). The version that applied at the time of the deaths became effective on 7 October 2022.[21] The latest version, released on 2 September 2024, contains no amendments.

80. In relation to safe driving generally, section 15.1[22] notes:

> *Officers in the course of their duty have a responsibility to drive with due care and attention without exposing members of the public or themselves to unjustifiable risk. A primary role of the Service is to protect the safety of the public. Driving vehicles in a manner causing unjustified risk is against this primary role.*

81. Section 15.3 deals with 'Urgent Duty Driving' (i.e. driving a service vehicle to perform a duty which requires prompt action). That section permits officers to engage in urgent duty driving when intercepting or attempting to intercept a vehicle, or when involved in a pursuit.

82. Urgent duty driving may include the use of flashing warning lights and/or the siren to obtain priority travel, and driving in a manner that, if not justified, would ordinarily constitute an offence.

Vehicle intercepts

83. Police officers are also entitled, where lawful, to intercept a vehicle. Section 60 of the *Police Powers and Responsibilities Act 2000* provides that a police officer may require the person in control of a vehicle to stop the vehicle for a prescribed purpose, including for enforcing a Transport Act and to check whether the vehicle complies with a Transport Act.

84. OPM section 15.4 provides the policy, procedures and guidelines relating to the interception of motor vehicles:

- 15.4.2 provides that officers intending to intercept motor vehicles should ensure that they do not unnecessarily expose themselves or any other persons, to danger; and appropriate safety precautions are taken. Before giving a direction to the driver of another vehicle to stop, officers are required to consider the reason for the interception, and what action can be taken if the driver of the vehicle refuses to stop, including whether a pursuit would be justified.

- 15.4.3 stipulates that 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 risk to road users.

[21] C11.
[22] At page 3.

- Officers should also:

    - be alert to the possibility that the vehicle may suddenly stop, reverse, or make a U-turn (15.4.3(ii));

    - position the police vehicle to the rear of, and at a safe distance from, the vehicle to be intercepted. This may include exceeding the speed limit to catch up to the vehicle of interest prior to activating the flashing warning lights and siren (15.4.3(iii)); and

    - activate the flashing lights and siren to give the driver a direction to stop (15.4.3(iv)).

- If 'the vehicle fails to stop as soon as reasonably practicable, and the officer believes on reasonable grounds the driver of the subject vehicle is intentionally attempting to evade police', officers can, if appropriate, commence a pursuit in accordance with section 15.5, or abandon the attempted interception (15.4.3(viii)).

  An attempted intercept must be abandoned if a pursuit is not justified. In such cases the officer must turn off the flashing lights and siren, pull over and stop the police vehicle at the first available safe position and provide details to the local police communications centre (15.4.4).

Pursuits

85. The OPM at section 15.5 provides:

> ***Definition:***
>
> *A **pursuit** exists when an officer driving a police vehicle continues to follow another vehicle after:*
>
> (i) *an officer in a police vehicle gives a direction to the driver of another vehicle to stop and the vehicle fails to stop as soon as reasonably practicable; and*
>
> (ii) *the officer believes on reasonable grounds[23] that the vehicle driver is attempting to evade police.*
>
> *A pursuit is to be abandoned immediately if it:*
>
> (i) *is a non-pursuable matter; or*
>
> (ii) *creates an unjustifiable risk to the safety of any person.*

86. A pursuit is not to be commenced or continued unless officers can justify the need to pursue a vehicle to immediately apprehend an occupant, who officers reasonably believe:

    1. will create an imminent threat to life; or
    2. has or may commit an act of unlawful homicide or attempt to murder; or
    3. has issued threats to kill any person and has the apparent

[23] The reference to 'believes on reasonable grounds' means the question is not determined by the subjective views of the pursuing officer. As with most aspects of law enforcement, officers must align their conduct with what a reasonable officer would do or believe in the circumstances: Findings into the death of Paul Michael Low, as cited in the findings into the death of Damian Lawton.

capacity to carry out the threat; or

4. has committed an indictable offence prior to an attempt by police to intercept the vehicle.

Autopsy results

87. On 29 November 2022, forensic pathologist, Dr Tse, performed autopsies on Tony and Krystal. The autopsy reports were provided on 25 January 2023 and 15 February 2023.

Mr Charlwood[24]

External postmortem and CT scan

88. Dr Tse noted that external examination of the body and postmortem CT scan showed significant catastrophic injuries to the head and torso. The injury pattern was in keeping with the described incident. The nature of this injury was such that death would have been rapid and inevitable.

89. Toxicological analysis showed presence of amphetamine, methylamphetamine, diazepam and cannabis metabolite. This is in keeping with prior exposure to these illicit and prescribed drugs/medication.

Toxicology

90. During autopsy of Tony, Dr Tse took blood and urine samples which were forwarded to Queensland Forensic and Scientific Services for targeted drug and alcohol analysis.

91. On 19 January 2023, a certificate of analysis was completed. Tony tested negative for alcohol, however the following quantities of targeted drugs were present:

- Amphetamine – 0.09mg/L
- Methylamphetamine – 0.69mg/L
- Diazepam - 0.02mg/L
- Tetrahydrocannabinol - 0.014mg/L

92. As the post-mortem interval here was three days, post-mortem changes (including redistribution of the drugs) would undoubtedly have occurred. This means that the concentrations of these drugs as reflected in the toxicology report, are unlikely to accurately reflect the concentrations at the time of Tony's death. Consequently, it is not possible to accurately assess the quantities of the drugs in Tony's system at the time of the crash and in turn, any impairments they may have caused.

93. Dr Tse determined cause of death as:

1(a). Multiple injuries *due to, or as a consequence of*
1(b). Motor vehicle collision.

[24] A6 (autopsy report dated 25/01/2023); A2 (toxicology report).

Ms Evans[25]

External postmortem and CT scan

94. Dr Tse noted that the external examination and postmortem CT scan of the body showed significant catastrophic injuries to the head and torso. This included facial fracture with pneumocephaly, left sided haemothorax and multiple rib fractures and compound comminuted pelvic fracture. The injury was in keeping with a high energy impact as described in the circumstances above. The nature of these injuries was such that death would have been rapid and inevitable.

95. Toxicological analysis showed a range of prescribed, over the counter and illicit medications, and no alcohol detection. This is indicative of prior exposure to these drugs and medication prior to the collision and death.

Toxicology

96. As occurred with Tony, during Krystal' autopsy, Dr Tse took blood and urine samples for targeted drug and alcohol analysis.

97. A certificate of analysis was completed on 19 January 2023. The same observations can be made in relation to the impacts of post-mortem changes on the accuracy of the drug concentrations listed in the toxicology report.

98. Toxicology revealed the presence of the following quantities of targeted drugs:

- Amphetamine – 0.26mg/L
- Methylamphetamine – 2.6mg/L[26]
- Diazepam - 0.02mg/L
- Tetrahydrocannabinol - 0.003mg/L
- Duloxetine – 0.05mg/L
- Ephedrine/Pseudoephedrine – 0.05mg/L

99. The level of methylamphetamine is likely to be within the toxic range for most people. Krystal tested negative for alcohol.

100. Dr Tse determined cause of death as:

1(a). Multiple injuries *due to, or as a consequence of*
1(b). Motor vehicle collision.

[25] A7 (autopsy report dated 15/02/2023); A3 (toxicology report).
[26] This appears to be well-above the toxic level for methylamphetamine. However, I note that tolerance may be a relevant factor.

Conclusions on Inquest Issues

Findings required by s. 45

101. I am required to find, if possible, who the deceased persons were, how they died, when and where they died and what caused the deaths.

102. As a result of considering all the material contained in the exhibits and the evidence given by the witnesses at the inquest, the material parts of which I have summarised above, I am able to make the following findings.

Identity of the deceased –	Anthony Michael Charlwood
How he died –	Mr Charlwood died as a result of injuries sustained in a motorcycle crash while attempting to evade a police officer who was trying to intercept him for traffic offences. While he was riding the motorcycle at high speed he collided with a light pole.
Place of death –	Helensvale Road HELENSVALE QLD 4212 AUSTRALIA
Date of death–	26 November 2022
Cause of death –	1(a). Multiple injuries *due to, or as a consequence of* 1(b). Motor vehicle collision.

Identity of the deceased –	Krystal Renee Evans
How she died –	Ms Evans was the pillion passenger on a motorcycle ridden by Mr Anthony Charlwood. She died as a result of injuries sustained in a motorcycle crash after Mr Charlwood rode the motorcycle at high speed while attempting to evade a police officer who was trying to intercept him, and collided with a light pole.
Place of death –	Helensvale Road HELENSVALE QLD 4212 AUSTRALIA
Date of death–	26 November 2022
Cause of death –	1(a). Multiple injuries *due to, or as a consequence of* 1(b). Motor vehicle collision.

Appropriateness of Acting Sergeant Lyons' actions in attempting to intercept the motorcycle

103. Det Sgt Spinks examined A/Sgt Lyons' actions with reference to the applicable QPS policies and procedures governing the operation of QPS vehicles. Those policies and procedures are contained in Chapter 15 of the Operational Procedures Manual.

Pursuit

104. Det Sgt Spinks firstly considered whether A/Sgt Lyons' actions constituted a pursuit for the purposes of the QPS pursuit policy as found in Chapter 15.5 of the OPM.

105. That policy defines a pursuit as existing when *an officer driving a police vehicle* ***continues*** *to follow another vehicle after:*

    (i) *an officer in a police vehicle gives a direction to the driver of another vehicle to stop and the vehicle fails to stop as soon as reasonably practicable; and*
    (ii) *the officer believes on reasonable grounds that the vehicle driver is attempting to evade police.*

106. Det Sgt Spinks found that at no time did A/Sgt Lyons consider or engage in a pursuit of the motorcycle. I accept that conclusion.

107. After conducting a risk assessment and establishing that only traffic-related offences were involved, A/Sgt Lyons' determined this was a non-pursuable matter. He formed the intention to attempt an intercept only.

108. After the motorcycle failed to stop when directed to by A/Sgt Lyons. He believed that it was attempting to evade police and then elected to abandon the attempted intercept. Although he continued drive a short distance, he deactivated his lights and siren, and significantly decreased in speed.

109. This evidence, and Det Sgt Spinks' finding, is consistent with the body worn camera footage.

Intercept

110. In relation to the attempted intercept, the OPM section 15.4 outlines the policy, procedures and guidelines relating to the interception of motor vehicles.

111. Relevantly, that section stipulates that before giving a direction to the driver of another vehicle to stop, officers are required to consider the reason for the interception (OPM 15.4.2). The evidence before the Court was that A/Sgt Lyons checked the motorcycle's registration plates on his QLITE device before deciding on a course of action. The results indicated that traffic-related offences had been committed.

112. Accordingly, A/Sgt Lyons was authorised to intercept the motorcycle to enforce a transport Act pursuant to s60(3)(a) of the *Police Powers and Responsibilities Act 2000*.[27]

[27] Stopping vehicles for prescribed purposes

113. The OPM states, relevantly, that 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 (OPM 15.4.3). I heard that once A/Sgt Lyons was satisfied he was in an appropriate position to do so, he activated his vehicle's lights and siren. This constituted a direction to stop.

114. An attempted intercept must be abandoned if a pursuit is not justified. In such cases the officer must turn off the flashing lights and siren, pull over and stop the police vehicle at the first available safe position and provide details to the local police communications centre (OPM 15.4.4).

115. The evidence before the inquest was that about three seconds after issuing the direction, the motorcycle increased speed. A/Sgt Lyons attempted to match the speed for a short distance. He was constantly assessing his situation, surroundings, and ability to intercept the vehicle.

116. On forming a decision to abandon the intercept, A/Sgt Lyons slowed his speed, de-activated his emergency lights and siren, and began making an assessment on a safe location to pull over and stop.

117. I also accept that A/Sgt Lyons was authorised to engage in urgent duty driving while attempting the intercept. Section 15.3 of the OPM[28] permitted him to use flashing warning lights and the siren to obtain priority travel and to exceed the speed limit. He reached a maximum speed of 136km/h for only a brief period.

118. Det Sgt Spinks concluded that A/Sgt Lyons complied with policy and procedure, and that his actions were lawful. There were no grounds for either disciplinary or criminal referrals.

119. After considering the evidence of A/Sgt Lyons and the relevant QPS policies and procedures, as well as Det Sgt Spinks' conclusions, I am satisfied that A/Sgt Lyons' actions in attempting to intercept the motorcycle were, at all times, appropriate.

Adequacy of the Queensland Police Service investigation into the circumstances surrounding the deaths

120. The deaths of Anthony and Krystal were investigated by the Coomera Forensic Crash Unit and, separately, the Ethical Standards Command.

121. In relation to the Forensic Crash Unit investigation, I accept that SC Hutchinson had the necessary qualifications, skills and experience to carry out that investigation.

122. SC Hutchinson's investigations started immediately after the crash. In forming his opinions, he undertook thorough scene examinations, produced annotated maps, performed speed calculations, reviewed the evidence obtained by other investigators, and considered a wide-range of factors that may have caused the crash. I found his evidence to be credible and reliable.

[28] Urgent Duty Driving

123. Following the FCU investigation, Det Sgt Spinks, who has more than 20 years' policing experience, produced the ESC report in February 2024.

124. Det Sgt Spinks' investigation included obtaining witness versions, CCTV footage, BWC footage, government wireless network data, and radio transmissions. He also considered the investigations undertaken by the FCU. I accept that Det Sgt Spinks' investigation pursued all relevant lines of enquiry.

125. I also accept the submission from Counsel Assisting that both investigations were appropriate. They were of significant value in establishing the cause and circumstances of the deaths.

Comments and recommendations

126. Section 46 of the Coroners Act 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.

127. Det Sgt Spinks' report recommended that the QPS install dash cams into all unmarked police vehicles. This was in the circumstance that no dash cam footage was available at the time of the incident leading to Tony and Krystal's deaths.

128. I obtained information from the QPS about this issue from Acting Assistant Commissioner Weatherly. He holds executive responsibility for the QPS organisational capability command.

129. Acting AC Weatherly explained that the QPS is in the progress of fitting two channel dash cam into new operational vehicles fitted with lights and sirens. This will include both marked and unmarked vehicles.

130. With respect to this matter, I acknowledge that it is unlikely that the use of dash cam footage at the time of this incident would have had any impact on the outcome or that its availability would have resulted in a different investigation outcome.

131. However, the technology will be of assistance to police officers charged with the investigation of vehicle crashes, including those involving QPS vehicles. The installation of the product described by the AC Weatherly will be of benefit to the QPS.

132. Noting the progress that is being made in this regard, and the fact that the use of dash cam in relation to this incident is unlikely to have changed the outcome, I accept that there are no recommendations I could make which would prevent similar deaths from occurring in the future.

133. I close the inquest.

Terry Ryan
State Coroner
BRISBANE