



CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION: Inquest into the passing of Aaliyah Te Paa, Rayvenna Coolwell; Barefoot; and Cayenne Robertson.

TITLE OF COURT: Coroners Court

JURISDICTION: Townsville

FILE NO(s): 2020/2361, 2020/2364, 2020/2367 & 2020/2369

DELIVERED ON: 15 February 2024

DELIVERED AT: Brisbane

HEARING DATE(s): 29 September 2022, 29-30 November 2022

FINDINGS OF: Terry Ryan, State Coroner

CATCHWORDS: Coroners: inquest, death in police operations, whether there was a pursuit, cultural concerns, unlawful use of motor vehicles, youth crime.

REPRESENTATION:

Counsel Assisting: Ms S Lio-Willie

Sanaa Liddle: Mr P O'Connor i/b Caxton Legal Service

QPS officers: Mr S Zillman i/b Gnech & Associates

Commissioner of Police: Ms E Kennedy, QPS Legal Unit

Dept of Children

Youth Justice and

Multicultural Affairs: Ms K Carmody i/b DCYJMA Legal Unit

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Introduction

1. In the early hours of 7 June 2020, two SUVs were driving through the streets of suburban Townsville. Members of the public reported hooning and dangerous driving to the Queensland Police Service. Officers were tasked to be on the lookout for the vehicles.
2. After police saw one of the vehicles, a white Kia Sorento, they tried to identify a registration number. The Kia Sorento was driving along the incorrect side of the road at speeds approaching 130km/h. The 14 year old driver, Master QTS, failed to negotiate the roundabout at Duckworth Street and Bayswater Road. He lost control and the vehicle rolled and struck two street signs and a traffic light pole. The vehicle disintegrated on impact.
3. The vehicle contained five children. Master QTS managed to crawl out of the wreckage. Tragically, all four passengers were ejected from the vehicle and had injuries that were obviously incompatible with life. They were:
 - a. Aaliyah Te Paa, aged 17 years
 - b. Cayenne Muriel Robertson, aged 14 years
 - c. Rayvenna Tyrone Coolwell, aged 14 years
 - d. Barefoot¹, aged 13 years
4. The passing of the four children was caused by the actions of another child. He was a small boy with a significant criminal history. He was in charge of a vehicle travelling at excessive speed for over 38 minutes. He drove on the wrong side of the road, went through red lights, and numerous vehicles took evasive action. It is surprising that persons other than the passengers in the vehicle were not harmed. The passing of the four children has caused immeasurable harm to their families. I extend my sincere condolences to them.
5. I also acknowledge that the police officers whose actions were the subject of this coronial investigation have also suffered ongoing trauma as a consequence of the horrific scene they confronted.
6. Police in the Townsville District have the unenviable task of responding to increasing numbers of unlawful use offences. There was a 62 per cent increase in burglaries and unlawful use offences in that community between 2019 and 2020. The passing of these children and other similar incidents resulted in significant and ongoing community concern about youth crime, particularly unlawful use of motor vehicle offences following burglary and stealing.

¹ Barefoot was the name used by Lucius Hure-Hill's family and friends when he passed. He is referred to by that name in these findings.

The Inquest

7. As the passing of the four young people happened in the course of a police operation, an inquest was required by s 27(1)(a)(iii) of the *Coroners Act 2003*, unless I was satisfied the circumstances did not require the holding of an inquest.
8. Following a pre-inquest conference on 29 September 2022, the following issues were investigated at the inquest which was held in Townsville from 29 November to 30 November 2022:
 - a. The findings required by s 45(2) of the *Coroners Act 2003*;
 - b. The adequacy and appropriateness of the actions of the Queensland Police Service on 7 June 2020;
 - c. The adequacy of the Queensland Police Service investigation into the circumstances surrounding the deaths.
9. The following witnesses gave oral evidence:
 - Detective Sergeant Green, ESC investigating officer
 - Constable Sharp (Unit TW701), first on scene
 - Constable Forrest (Unit TW442)
 - Acting Sergeant McCulloch (Unit TW700)
 - Senior Constable Garrod (FCU Investigator)
 - Mr Olsen, Regional Director, DCYJMA
 - Detective Inspector Shepherd, Townsville Police District
 - Assistant Commissioner Scanlon

Events Leading to the Passing of the Children

10. The following timeline is based on a review of all the video footage (CCTV, traffic camera, BWC, dashboard camera) and is consistent with the timeline provided by Ethical Standards Command investigator, Detective Sergeant Green.

6 June 2020

11. After 9:30pm on 6 June 2020, a white Kia Sorento was stolen from Eastlake Avenue, Idalia. The car was reported stolen at 4:58am by the occupier of that residence,² who woke up some time after 4:00am to the sound of her refrigerator beeping. She observed the refrigerator was open and her handbag was missing. She checked the driveway to find that her rental car was also missing.
12. At 11:52pm, a red Mitsubishi Outlander was stolen from Arthur Street, Aitkenvale by a group of four to five juveniles.³ The Outlander was reported stolen at 3:22am.⁴ The Rapid Action and Patrol (RAP) crews on duty were aware of this report but were not aware that the Kia was stolen.

7 June 2020

13. At 3:03am, police crew TE307 observed a white Kia and red Mitsubishi outbound on Ross River Road travelling past the Sun Hotel.

² Ex C1 – QP2001179725

³ Ex E17 – E17.3 – CCTV footage from Arthur Street, Aitkenvale

⁴ Ex C1 – QP2001179548

14. At 3:52am, the red Mitsubishi and white Kia were captured on CCTV in Brookside Close, Idalia. The occupants of the vehicles appeared to attempt to enter houses in the street through front doors.⁵
15. At 4:10am, the Kia was captured on CCTV travelling with the Mitsubishi turning from Leeds Street into Cambridge Street, Gulliver.⁶
16. At 4:11am, police received a report from a resident on Kent Street, Gulliver about two cars, believed to be stolen. The informant reported:

*"two cars full of teenagers. Two cars, quite expensive...speeding and doing burnouts, beeping horns, carrying on like dickheads. They're going to ... Kent Street, which is across the road, that's where all their little posse hangs out... They're driving erratically, they're going to have a car accident, they're going to drive into someone's fucking house... It's every night, they've been here every single night...one is black and one is white."*⁷
17. At 4:18am, police crews were advised of the hooning job in Kent Street, Gulliver.⁸
18. At 4:20am, police communications assigned the job to police unit TW702, containing Senior Constable Corbett and Constable Pagett, who reported they were patrolling for the two cars.⁹ Police communications broadcast to the crews to be on the lookout for (BOLF) the vehicles.¹⁰
19. At 4:23am¹¹, the Kia was captured on CCTV and police crew TW700's dashboard camera, turning from Hodges Crescent into Palmerston Street and into Ronan Street, Vincent. Police crew TW700 contained Acting Sergeant McCulloch, Senior Constable Corbett and Constable Andreini.
20. At 4:24am, TW700 reported '*white vehicle travelling inbound on Nathan Street at high speed, possibly turned into Tregaskis Street*'. They were unable to obtain a registration number.¹²
21. Unit TW442, containing Senior Constable Smith and Constable Forrest, were travelling along Cambridge Street towards the intersection of Palmerston Street, Vincent, when they observed the Kia about 800 to 900m away. The Kia then conducted a U-turn (2 or 3 point turn), in the direction of the T-section.¹³ At this time unit TW701 (SC Seymour and Constable Sharp) turned left into Cambridge Street. The Kia drove past TW701, and turned left into Palmerston Street, followed by unit TW442 about 5 seconds behind.¹⁴

⁵ Ex E18 and E18.1 – CCTV footage of Brookside Close, Idalia

⁶ Ex E20 at 4:10.51am, at 21.18mins

⁷ Ex E40 – CAD Recordings – Wall-Baxter

⁸ Ex C22 – CAD Recordings, line 147

⁹ Ex C22 – CAD Recordings, lines 147 - 153

¹⁰ Ex C22 – CAD Recordings, line 153

¹¹ Ex E24.1 – TW700 Dashcam – see tail lights in the distance.

¹² Ex C22 – CAD Recordings, line 157 at 4:24:38am

¹³ Ex E11 – ROI of SC Smith; Ex E11.1 – Interview with map by SC Smith

¹⁴ Ex 25 – TW701 Dashcam – Kia passed at 4:25.49am and TW442 passed at 4:25.53am

22. As the Kia passed unit TW701, SC Seymour was able to identify a registration number and reported it to police communications, at the same time as Constable Andreini from unit TW700.¹⁵
23. At 4:26.16am, TW442 continued along Palmerston Street, the Kia was not visible on TW701's dashcam at this time. All three vehicles passed marked police van Unit TW700, that was in the opposite lane and had pulled over near the intersection with Symons Street.¹⁶
24. At 4:26.31am, TW701 turned right into Tregaskis Street.
25. The Kia turned right at the T-Section onto Fulham Road. When it reached the intersection of Fulham Road and Nathan Street, which was maintained by traffic lights, it turned right onto the incorrect side of Nathan Street.¹⁷ Nathan Street was four lanes divided by a cement median strip. TW422 travelled through the intersection 25 seconds later.¹⁸
26. The Kia was captured driving past the Vincent Village Shopping Centre on the incorrect side of Nathan Street.¹⁹ TW442 was captured travelling on the correct side of Nathan Street, 32 seconds behind the Kia.²⁰
27. Police unit TW701 exited Tregaskis Street [4:26.58am] and crossed the median strip onto the correct side of Nathan Street. Just as they crossed, the Kia travelled past police at speed on the incorrect side [4:27.07am].
28. As the Kia approached the intersection of Nathan Street and Dalrymple Road, it drove through the red light and continued straight onto Duckworth Street [4:27.17am], causing other vehicles travelling through the lights to take evasive action to avoid it.²¹ TW701 drove at a speed between 60 and 78km and slowed down for the red light, which turned green on approach.²²
29. At 4:27am, the Kia was captured on CCTV footage from the Toyota Dealership on Duckworth Street, still travelling at speed on the incorrect side of the road. CCTV captured the Kia travel through a set of lights, Unit TW701 was captured travelling past the same set of lights about 20 seconds later. From 4:27.45am, the Kia is not visible on the Dashcam of TW701. Unit TW701 advised police communications that they could no longer see the Kia.²³
30. The Kia continued on the incorrect side of Duckworth Street. It failed to negotiate the roundabout at the intersection with Bayswater Road and crashed into a traffic light pole. The business on the corner where the crash occurred, "Konnect Time", captured the headlights of the Kia as it approached the roundabout. Around

¹⁵ Ex E8 – Initial version of SC Seymour; Ex E1 – ROI Constable Andreini, Ex C22 – CAD Recordings at lines 163 – 165.

¹⁶ Ex 25 – TW701 Dashcam at 4:26.19am

¹⁷ Ex E14 – TMR CCTV – Kia proceeds turns right onto Nathan Street at 26.41mins

¹⁸ Ex E14 – TMR CCTV – TW442 reaches the intersection at 27.06 mins

¹⁹ Ex E21.6 – Vincent Village CCTV, Part 7 – Kia travels past at 4:26.51am

²⁰ Ex E21.6 – Vincent Village CCTV, Part 7 – TW442 travels past at 4:27.23am

²¹ Nathan Street turns into Duckworth Street through the intersection

²² Ex E25 – Dashcam of TW701 at 2.58minutes; E25.1 – Dashcam of TW701 part 2

²³ C22 – CAD Recordings Timeline, line 174 at 4:27.47am

seven seconds later the headlights are seen swerving, and a second later a flash of light, inferred to be the point of collision.²⁴

31. At 4:28.08am, TW701 drove along Duckworth Street and observed the crash site. Unit TW702 was driving along Bayswater Road and was approaching the roundabout as unit TW701 drove through it on Duckworth Street.²⁵
32. Senior Constable Seymour and Constable Sharp ran to the scene and saw Master QTS crawling out from the wreckage. Constable Sharp yelled at him to get on the ground, and observed the bodies of the four children clearly deceased on the road.²⁶ He advised police communications the Kia had crashed and it was on its roof.²⁷
33. SC Seymour walked Master QTS away from the crash and towards a building. She comforted him and told him not to look. Master QTS had blood on his face. He was visibly shaken and scared. He asked if his friends were OK. When he was told that they were dead and there was nothing he could do, he started crying and said, *"I want to kill myself"*.²⁸
34. Master QTS cooperated with police, and admitted he was the driver. He provided the names of the other children in the car. He initially thought there were only three passengers.
35. Queensland Ambulance Service (QAS) paramedics arrived on scene and removed Master QTS to an ambulance to be treated. He was taken to the Townsville University Hospital for assessment and observation.²⁹
36. All four children were declared deceased at the scene. None of them could be positively identified at the scene due to the severity of their injuries.

Autopsy

37. On 9 June 2020, Forensic Pathologist, Dr Botterill, conducted an autopsy of Rayvenna Coolwell. On 10 June 2020, Dr Botterill conducted an autopsy of the other three children. All four autopsies consisted of external examinations and toxicology testing.
38. The cause of death for each child was multiple injuries sustained by a passenger in a motor vehicle collision.

²⁴ Ex E23 – Konnect Time CCTV

²⁵ Ex E26.1 – TW702 Dashcam at 4:28.07am; [2.04mins]

²⁶ Ex E37 – BWC of Constable Sharp

²⁷ C22 – CAD Recordings Timeline, line 175 at 4:28.15am

²⁸ Ex E36 – BWC of SC Seymour

²⁹ Ex D2- eARF

Forensic Crash Unit Investigation³⁰

39. The evidence at the scene indicated the Kia was travelling too fast for the intersection of Duckworth Street and Bayswater Road. The vehicle failed to negotiate the roundabout and lost control. The driver attempted to regain control but oversteered. This caused the vehicle to leave the roadway and mount the curb, becoming airborne, rotating and impacting two road signs and a traffic light pole.

Vehicle examination

40. The Kia wagon was a hire vehicle. The vehicle sustained unrepairable damage and was unrecognisable after the crash. It was effectively split in half horizontally.
41. On 22 June 2020, the vehicle was mechanically inspected by a QPS Vehicle Inspection Officer. The inspector found that the vehicle was in a satisfactory mechanical condition. No mechanical defects were found which would have contributed to the cause of the incident. However, the front disc brake rotors exhibited evidence of extensive overheating. This condition was due to the manner of operation prior to the crash, and may have caused a reduction in the efficiency of the braking system.³¹
42. The examination of the seatbelts indicated that the driver was wearing his seatbelt. The front passenger seatbelt was torn during impact. It could not be determined if the front passenger was wearing their seatbelt. The three rear passenger seatbelts were flush against the seat, indicating they were not worn.³²
43. Data obtained from the vehicle's electronic control module (ECM) showed a pre-crash speed five seconds before the crash at 128 km/hr. The speed recorded at the time of impact was 111 km/hr.
44. The ECM download also provided a record of steering input. This showed that the driver steered right initially to go around the roundabout on the incorrect side and then attempted to steer back to the left. This over-correction caused the vehicle weight to shift and begin to rotate clockwise. The vehicle subsequently overturned with the passenger side impacting with the traffic pole.³³

Scene examination

45. Forensic Crash Unit Investigators excluded the weather, roadway and visibility as possible contributing factors to the crash. The roadway was constructed of sealed bitumen and was in good condition. The area was clearly lit, and there was an unobstructed view. At the time of the crash the road was dry, it was not raining but the night was overcast.³⁴ Duckworth Street had a signed speed limit of 70km/hr.

³⁰ Ex C4 – Supplementary Form 1 - FCU Report

³¹ Ex C4 – Supplementary Form 1 - FCU Report, p10

³² Ex C4 – Supplementary Form 1 - FCU Report, p7

³³ Ex C4 – Supplementary Form 1 - FCU Report, p8

³⁴ Ex C4 – Supplementary Form 1 - FCU Report, p11

FCU Conclusions

46. The investigators concluded that the vehicle was travelling at an excessive speed and failed to negotiate the roundabout with oversteering causing it to flip and become airborne. The vehicle impacted with a traffic light pole causing the roof and passenger side to peel away, and resulting in the four passengers being ejected from the vehicle.
47. The investigators identified that speed and Master QTS' driving inexperience were the main contributing factors to the crash. There was no evidence to suggest any suspicious circumstances existed.
48. The FCU investigators attended the post-mortem examinations of the deceased. From their injuries and the damage to the vehicle they were able to establish that Barefoot was in the front passenger seat and Miss Te Paa was in the rear left passenger seat. The positions of Miss Coolwell and Miss Robertson could not be positively determined.

Ethical Standards Command Investigation

49. Detective Sergeant Green of the Internal Investigations Group, Ethical Standards Command investigated the circumstances surrounding the passing of the children. A coronial report was provided in October 2020 with various annexures, including witness statements, recorded interviews, BWC recordings, dashboard camera, CCTV and QAS records.
50. The ESC investigation concluded there was no evidence to support a finding that any of the police units attempted to intercept or pursue the Kia. The police on shift that morning did not know who the occupants of the Kia were.
51. The ESC investigation found no evidence to support a criminal offence against any police officer. There was no evidence to support any breach of discipline or misconduct against any police officer regarding the passing of the children.
52. A review of the video footage makes it apparent that none of the police units following the Kia had activated their lights and sirens.
53. The police officers in units TW442, TW700 and TW701 all participated in interviews with ESC investigators. Each officer advised investigators they had formed the intention to attempt to identify the registration details of the Kia.

Unit TW442 – SC Smith and Constable Forrest³⁵

54. Unit TW442 was a marked Toyota Camry, and was conducting patrols on Cambridge Street, Vincent. SC Smith was the driver. They heard the broadcast in relation to two SUV's driving dangerously
55. There was no other traffic around when they encountered the white Kia. At that point, no other units had obtained a registration number, confirmation if the Kia was stolen, or was the vehicle mentioned in the BOLF.

³⁵ Ex E11 – ROI SC Smith; and Ex E3 – ROI Constable Forrest

56. SC Smith said when they came up behind the Kia at the intersection of Cambridge and Palmerston Street, he did not pull in too close in case it was a stolen vehicle.
57. He was aware that drivers of stolen vehicles could be unpredictable. He wanted to give the vehicle room so the driver did not do something that would endanger others.
58. About 400m from the intersection of Cambridge Street, SC Smith disengaged and decided not to identify the vehicle.
59. SC Smith did not see the Kia again until he reached the intersection of Palmerston Street and Fulham Road, where he saw the tail lights of the Kia turn right into Nathan Street. This was the last time TW442 saw the Kia. He heard the broadcast that the Kia was travelling on the wrong side of the road. He was aware that a marked police van was ahead of them on Nathan Street (TW701).
60. Constable Forrest's evidence at the inquest was consistent with SC Smith's account. He told the inquest that after the Kia took off at speed they decided not to engage, returned to normal speed and lost sight of the vehicle on a dogleg. Unit TW442 did not activate lights and sirens. They activated lights after they heard the broadcast of the crash, and proceeded to the scene. Constable Forrest saw Master QTS sitting down and recognised him from prior dealings.

Unit TW701 – SC Seymour and Constable Sharp³⁶

61. Unit TW701 was a marked police van, attached to RAP. Constable Sharp was the driver of this vehicle. At the commencement of shift they were conducting curfew checks.
62. Constable Sharp told the inquest they were advised that a red or burgundy Outlander had been stolen from the Aitkenvale/Annandale area. They were in Aitkenvale and conducted slow patrols but did not see the Outlander. After hearing a radio broadcast of a black SUV and a white SUV doing burnouts in Kent Street, Gulliver they travelled to Gulliver. They conducted slow patrols, with the windows down to listen out for burnouts.
63. They then heard a broadcast that the white SUV was sighted at Palmerston Street and drove in that direction, when they saw the headlights of a vehicle coming towards them on Cambridge Street and then observed a marked police sedan about 100m behind.
64. They drove along Palmerston Street. SC Seymour recalled the Kia was not driving at a speed that concerned her at that time. Constable Sharp guessed that the Kia might travel to Nathan Street, and he turned right on Tregaskis Street to meet up with Nathan Street.

³⁶ Ex E11 – ROI SC Smith; and Ex E3 – ROI Constable Forrest

65. When they reached the intersection with Nathan Street, Constable Sharp realised headlights were coming towards them in the wrong lane, because the nose of the police van was already in the lane. Constable Sharp drove across the lanes and over the median strip to get into the correct lane. When the Kia passed, they did not observe any vehicle behind it. SC Seymour estimated the Kia was travelling at about 170km/hr.
66. They then observed the Kia run a red light at Duckworth and Dalrymple Road. They lost sight of the vehicle just past the intersection. As Constable Sharp drove through the roundabout with Bayswater Road, he saw the Kia on its roof and pulled over and ran to render first aid. He said that after Master QTS exited the vehicle, he thought he was the only occupant. However, his attention was drawn to the deceased passengers. It was an horrendous scene.
67. Constable Sharp said that they never engaged in a pursuit, attempted an intercept, or activated lights or sirens.
68. They discussed the possible use of a stinger but SC Seymour said they did not discuss a specific plan. Her understanding was they would try to find a safe location to put the stinger out. At that time they did not know that the Kia was stolen.

Unit TW700 – A/Sgt McCulloch, SC Corbett and Constable Andreini³⁷

69. Unit TW700 was a marked police van, attached to the RAP. A/Sgt McCulloch was the driver, Constable Andreini was the front passenger, and SC Corbett was the rear passenger. They were aware of a stolen red car and a white SUV travelling together. They observed the white Kia on Palmerston Street and obtained a registration number and transmitted it over the radio. This was at the same time Unit TW442 was following the Kia, and Unit TW701 also followed and then turned right into Tregaskis Street
70. After obtaining the registration, Constable Andreini believed the next step was to confirm if the vehicle was stolen and identify a safe tyre deflation site and obtain authorisation to deploy the stinger. They continued to drive around the area and heard the transmission about the crash. They then travelled lights and sirens to the scene.
71. Constable Andreini recognised Master QTS at the scene. The crew attended to traffic management. He was aware that the DDO would apply the QPS policy in relation to vehicle pursuits.

Master QTS – Driver of the vehicle

72. Master QTS aged 14 years and 1 month at the time of the incident. He admitted to police at the scene that he was the driver of the vehicle. At the hospital he told the treating doctor that he was *“going too fast, and I tried to slow down but the car, the brake warning thing... and then it just kept rolling, and rolling, and it was going really fast, and I tried to turn, and it went like that and hit the pole.”*³⁸

³⁷ Ex E1 and B6 – ROI of Const. Andreini; E2 – ROI SC Corbett; E4 and B5 – ROI of A/Sgt McCulloch

³⁸ Ex E32.1 – BWC of Constable Hughes

73. Master QTS was visibly distressed at the scene and at the hospital. He did not participate in a record of interview with the ESC investigators. At the time of this incident, Master QTS was on bail, and had appeared in the Townsville Childrens Court 18 days earlier.
74. On 1 October 2021 Master QTS was sentenced in the Childrens Court of Queensland to 5 years detention for dangerous operation of a vehicle causing death while excessively speeding, burglary and stealing, and unlawful use of a motor vehicle. He had spent 491 days in pre-sentence custody. He was aged 15 years and 4 months at the time of sentence. He had a relevant criminal history including entries for burglary and unlawful use of a vehicle, and had been sentenced to various orders including probation and a conditional release order.
75. The sentencing judge acknowledged that Master QTS's offending behaviour was the product of low socio-economic background, lack of a male role model, bad decision-making, and trauma from significant life events. At the time of sentencing, Master QTS had not engaged with any counselling and was on suicide watch.

Last known movements of the children

76. Miss Coolwell lived with her mother, Pamela, who last saw her at 11:00pm on 6 June 2020 at home. Miss Coolwell was last seen with Miss Te Paa at about 3:00am on 7 June 2020.
77. Miss Robertson was last seen by her mother, Beverly, at 4:00pm on 6 June 2020 at the family home. She said she was going to her aunt's house but did not go there.
78. Miss Te Paa lived with her father, James. He returned home from work at 1.30am on 7 June 2020 and saw his daughter and Miss Coolwell. At 3:00am, Miss Te Paa said she was going out.
79. Barefoot lived with his grandmother. She last saw Barefoot at her home on 4 June 2020, in the company of two other juveniles. She arranged a taxi for the three boys to take them to an aunt's house.
80. Two brief Instagram conversations were provided to the Coroners Court. They are recordings from Miss Te Paa's Instagram account to two different people or group conversations. The conversations are voice memos between the participants. In the voice memos Miss Te Paa said, "*we're getting chased*."³⁹
81. Even though police had not activated lights and sirens, they were about 5 to 30 seconds behind the Kia at any given time. However, they were not actively pursuing or attempting to intercept the Kia. The children were obviously aware of the presence of the marked police vehicles and perceived that they were being chased.

³⁹ Ex E39 and E39.1 – Instagram recordings

Family Statements and concerns

82. Ms Liddle, Barefoot's maternal grandmother said that he was a Wakka Wakka and Wulli Wulli boy. Ms Liddle said the day she was notified of Barefoot's passing she had been denied her *"right to do my cultural practice surrounding the passing of an immediate family member. Traditions are vital to my wellbeing and the respect to myself and my cultural practices were never carried out that day"*.
83. Ms Liddle said there was a lack of understanding of how important cultural practices are to Aboriginal people. As a grandmother to Barefoot, she would have liked to have had the people who informed her of her grandson's passing to have had access to a member or elder of the Aboriginal community who knew cultural connections *"rather than a systems approach"*.
84. Rayvenna Coolwell's mother, Pamela, said that her daughter (known as Rayray) was not a street kid and had never been in trouble with the police. She had worked hard at school but fell in with the wrong crowd before her passing. She had many siblings and was loved by all. Her passing caused significant upheaval for her siblings and parents, and the family subsequently relocated to another town.

Conclusions on Inquest Issues

Findings required by s. 45

85. I am required to find, as far as is possible, who the deceased children were, how they passed, when and where they passed and what caused their passing. As a result of considering all the material contained in the exhibits and the evidence given by the witnesses, the material parts of which I have summarised above, I am able to make the following findings.

Identity of the deceased – Aaliyah KiriKowhai Te Paa

How she died – Miss Te Paa was a passenger in a stolen vehicle driven at high speed by a 14 year old boy which crashed on a roundabout in Garbutt. She was ejected from the vehicle and died instantly.

Place of death – Intersection of Duckworth Street and Bayswater Road Garbutt, Queensland

Date of death– 7 June 2020

Cause of death – 1(a) Multiple injuries
1(b) Motor vehicle collision (passenger)

Identity of the deceased – Rayvenna Tyrone Elizabeth Coolwell

How she died – Miss Coolwell was a passenger in a stolen vehicle driven at high speed by a 14 year old boy which crashed on a roundabout in Garbutt. She was ejected from the vehicle and died instantly.

Place of death – Intersection of Duckworth Street and Bayswater Road
Garbutt, Queensland

Date of death– 7 June 2020

Cause of death – 1(a) Multiple injuries
1(b) Motor vehicle collision (passenger)

Identity of the deceased – Cayenne Muriel Robertson

How she died – Miss Robertson was a passenger in a stolen vehicle driven at high speed by a 14 year old boy which crashed on a roundabout in Garbutt. She was ejected from the vehicle and died instantly.

Place of death – Intersection of Duckworth Street and Bayswater Road
Garbutt, Queensland

Date of death– 7 June 2020

Cause of death – 1(a) Multiple injuries
1(b) Motor vehicle collision (passenger)

Identity of the deceased – Lucius Hure-Hill

How he died – Barefoot was a passenger in a stolen vehicle driven at high speed by a 14 year old boy which crashed on a roundabout in Garbutt. He was ejected from the vehicle and died instantly.

Place of death – Intersection of Duckworth Street and Bayswater Road
Garbutt, Queensland

Date of death– 7 June 2020

Cause of death – 1(a) Multiple injuries
1(b) Motor vehicle collision (passenger)

Other inquest issues

The adequacy and appropriateness of the actions of the QPS on 7 June 2020

86. The police units happened upon the white Kia by chance on Cambridge Street, Vincent. They had been tasked to be on the look out for two SUVs that were hooning around suburban streets, and only began looking for the white Kia in the 15 minutes immediately preceding the crash. They maintained a safe distance and tried to obtain a registration number. At the time of the crash, police did not have information about who or how many occupants were in the car, and were not aware the car had been stolen.
87. The Instagram voice memos from Miss Te Paa's Instagram account indicated that the children were aware of the police presence on the roads and it is likely Master QTS was speeding to evade police. There was evidence before the court of voice messages sent from Aaliyah to other associates telling them in an animated voice that the police were '*chasing*' them.
88. I accept that was a belief held by the driver and/or the occupants of the Kia Sorento given the decision to carry out a U-turn when they first saw Unit TW442 on Cambridge Street, and then speed off with two police units following.
89. However, while it may have been understandable for a group of young teenagers to believe they were being 'chased' in the circumstances, that belief was mistaken. At no time did any of the police vehicles activate lights or sirens or signal to Master QTS to stop. What he may have thought was an exciting game of cat and mouse with police ended in the unnecessary loss of the lives of his four young friends.
90. The protracted following of a vehicle committing a driving offence, or conducting overt acts to avoid detection, may also constitute a pursuit. However, there is also no evidence that the Kia was followed for a protracted period by any of the police vehicles.
91. As soon as the Kia started accelerating at speed, Constable Forrest's unit withdrew from following as it was "unsafe" for the occupants of the Kia Sorento, for the police officers involved, and for other members of the public.⁴⁰
92. I am satisfied that none of the police vehicles or the drivers of those units engaged in a pursuit of the Kia. The officers acted in accordance with the relevant QPS Operational Policies by withdrawing from following the Kia after it was clear it would be unsafe after the Kia took off at speed.
93. It was evident from the footage before the court that SC Sharp and SC Seymour ran to the crash site when they realised what had happened. After SC Seymour recognised the gravity of the situation, she immediately shielded the driver from the scene and attempted to comfort him until paramedics arrived.
94. I accept the submissions from Counsel Assisting and Mr Zillman that no adverse comments can be made about the actions of the police officers on 7 June 2020.

⁴⁰ B2.3, p16

The adequacy of the QPS investigation into the circumstances surrounding the deaths

95. I consider that the investigation by Det Sgt Green was comprehensive and professional.
96. Concerns were raised at the inquest about the notification of the passing of the children to their families, particularly by Barefoot's family. Det Sgt Green said that ESC relied on the region at the beginning of the investigation to coordinate matters such as FCU engagement, notify families and prepare the Form 1 Report of the Deaths to the Coroner.
97. Det Sgt Green said that ESC does not investigate the manner of the notification to the family by regional officers or Police Liaison Officers, unless relevant to the issues to be investigated. Det Sgt Green said that PLOs were engaged by ESC when meeting with families on the night the children passed.
98. Barefoot's family also raised some concerns about the content of the Form 1 and the lack of interface between that form and QPrime. For example, the record of the 2:09pm notification given to Ms Liddle was not apparent on QPrime.
99. There was limited evidence before the court of the QPS training and policies in June 2020 in relation to such notifications, the training or guidance provided in relation to delivering notifications, or cultural capability training to equip officers to do so.⁴¹
100. The evidence of the police witnesses called during the inquest indicated that officers were aware of the relevant chapter in the OPM, but had not been required to undertake training or refresher training in specific culturally appropriate ways to notify families of a passing, with respect to First Nations or any other cultures. As noted below, this issue is being addressed and is now the subject of specific training to police recruits and other officers.

Comments and recommendations

101. Section 46 of the *Coroners Act*, as far 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.

Notification of the passing of First Nations People

102. Submissions from Barefoot's family focused on the giving of messages by Queensland Police Service officers to First Nations families about the passing of a loved one. It was submitted that the manner of giving such a message can lead to healing if delivered appropriately. However, if the message is not delivered appropriately further damage and trauma can result.

⁴¹ OPM, Chapter 8.4.7 Advising relatives

103. Barefoot's family submitted that officers should engage in dialogue with families in relation to whether they have specific cultural needs. It was submitted that there was no single point of reference for officers to access to ensure that the notification of a passing has been made. In the absence of this information, assumptions can be made about the notice having been given, resulting in miscommunication.
104. It was submitted there was also confusion about the role of Police Liaison Officers (PLOs) in this process and the PLO's presence may not assist where they lack sufficient knowledge of the needs of the family.
105. It was also submitted that officers should simply ask whether the family has any cultural needs, together with an undertaking to facilitate any requests by the family relating to cultural practice. This should be embedded in the relevant OPMs. Barefoot's family felt aggrieved that his mother was not informed of her son's passing by his grandmother. Other matters of concern to the family included the facilitation of smoking ceremonies in public spaces and other cultural practices in relation to the body of a person who has passed.
106. In the August 2020 *Findings of the inquest into the death of Master Carr and Jaylen*, Coroner Clements made the following recommendation:

Issues raised by family members expressed their elevated distress due to the police, health and coronial procedures not recognizing or attempting to accommodate cultural sensitivities. It is recommended that Queensland Police undertake a review of the Operational Procedures Manual regarding deaths reported to the coroner, and coronial investigations. The review is aimed to develop, amend, incorporate and train police, including the Ethical Standards Command, with respect to Aboriginal and Torres Strait Islander culture, especially concerning death. Such review requires consultation and inclusion of Aboriginal and Torres Strait Islander people. Reference is made to "Sad News, Sorry Business, Little Gungallida Girl" and the "Sorry Business" Guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people. Additional reference is made to the requirements of the Human Rights Act 2019.

107. The evidence before this inquest was that there is work being done in relation to this issue. While a guide is being developed for operational police, Barefoot's family submitted that First Nations culture was too diverse to enable officers to know all local protocols and a rigid framework is unlikely to assist. Consultation with individual families is required.
108. The Commissioner submitted that the issue of the notification of the passing of First Nations people was a complex task for officers, and will be addressed in the ongoing review of Chapter 8 of the OPM with input from the First Nations and Multicultural Affairs Unit within the QPS, informed by lived experience. A range of matters needs to be considered, including resourcing, and the fact that giving messages about the passing of individuals is not a task many operational police are required to carry out frequently.⁴²

⁴² The response to this recommendation on the Coroners Court's website from September 2023 notes that *Queensland Police Service Coronial Support Unit are continuing to progress the review of Chapter 8 'Coronial Matters' of the Operational Procedures Manual. The QPS First Nations cultural capability training is currently being developed and intended to be*

109. I was provided with a statement from AC Mark Kelly, Executive Officer with the People Capability Command (PCAP).⁴³ AC Kelly said that training on the delivery of notifications of the passing of a family member to next of kin is covered twice in the Recruit Training Program as part of PCAP-led instruction in the topic Sudden Death, and then in training provided by the Coronial Support Unit (CSU).
110. This specifically includes a death messaging component where cultural issues are addressed. Officers are encouraged to refer to the *Religious and Spiritual Diversity Guide for Operational Police* developed by the Australian and New Zealand Policing Advisory Agency.
111. AC Kelly said that after graduation from the Recruit Training Program, officers enter the First Year Constable Training Program. That Program requires officers to complete and demonstrate competence in identified key tasks or areas including a Workplace Activity in relation to Coronial matters which requires them to demonstrate competence in coronial matters including sudden passing notifications.
112. The November 2022 Report of the Commission of Inquiry into Queensland Police Service responses to domestic and family violence – *A Call for Change* contained a detailed analysis of broader cultural capability issues within the QPS. The Report contained a raft of recommendations designed to enhance its training and responsiveness to First Nations Peoples and communities.
113. Following the implementation of recommendations from the Commission of Inquiry the First Nations Unit has been established as separate division headed by an Executive Director in an identified position. I have been advised that the QPS has also enhanced training throughout the organisation with over 900 recruits receiving two days cultural capability training. By the middle of 2024, all QPS officers will undertake focussed cultural capability training, including officers from the Ethical Standards Command.
114. The Coroners Court has also enhanced its capacity to respond to the needs of First Nations families with the recent engagement of a Cultural Capability Manager who is able to directly support families, as well as coroners in their investigation and review of the passing of First Nations people. The position also provides training for coroners and court staff and provides expert advice and assistance for relevant reportable deaths. The Cultural Capability Manager is also available to consult with QPS officers seeking guidance on appropriate cultural protocols.
115. Having regard to the previous recommendation from Coroner Clements, and the ongoing work in response to that recommendation, I am not satisfied that an additional recommendation is required on this topic.

delivered to recruits commencing mid-2023. In line with the review of chapter 8, community consultation is in progress with an update expected at a later date.

⁴³ Ex B12.1

Unlawful motor vehicle use

116. The evidence in this inquest also highlighted issues associated with young persons and unlawful motor vehicle use. The children who passed in this incident were each from loving homes. They made a decision to get into a stolen vehicle and go driving around the streets of Townsville in the early hours of the morning. That decision had the most tragic consequences.
117. There is clearly an acknowledgement by the community and government agencies that tragedies of this nature continue and require an intensive multi-agency response.
118. Assistant Commissioner Scanlon gave evidence in her capacity as head of the Youth Justice Task Force. AC Scanlon had over 16 years' policing experience in Townsville, including as the Regional Crime Coordinator. Following three separate tragedies between June 2020 in February 2021 the Premier announced a suite of reforms targeting serious repeat youth justice offenders including the establishment of the multi-agency Youth Justice Task Force which reports to a Youth Justice Cabinet Committee.
119. AC Scanlon said that while the unlawful use of motor vehicles by young persons was not a new issue, there was an increasing trend of breaking and entering dwellings to steal keys. The serious repeat offender cohort comprised less than 400 young people across the State, and there was a need for greater engagement with the families of these young people to address the root causes of crime.
120. AC Scanlon also identified issues in relation to siloed approaches by Queensland Government Departments and lack of information sharing between agencies. A number of legislative changes have been introduced including a presumption against bail for young people charged with serious offences, and the introduction of electronic monitoring devices. Those changes have resulted an increase in the number of young persons in custody, including police watch houses. However, as AC Scanlon noted the problem will not be solved by simply arresting young people.
121. AC Scanlon said that policy initiatives which have been progressed include the introduction of youth coresponder teams involving police and youth justice workers to respond to youth crime and monitor young people on bail.
122. Intensive bail support for young people and families has been introduced in five locations delivered by First Nations organisations. There has also been a focus on discouraging the use of social media by young offenders to post criminal conduct online.
123. Detective Inspector Shepherd from the Townsville District Crime Services Group provided evidence in relation to activities within the Townsville District relating to vehicle crime. From 1 January 2022 to 26 October 2022, 264 adult offenders and 798 juvenile offenders were charged in relation to property crime. He said that the QPS has also adopted innovative approaches to monitor stolen vehicles that minimise the need for officers to follow and attempt to intercept those vehicles.

124. Detective Inspector Shepherd said that the Townsville Stronger Communities Early Action Group was a collaborative group lead by the QPS. This group aims to identify young people aged between 8 and 16 in the early stages of involvement in the criminal justice system who are disengaged from education but not subject to youth justice or child safety orders. He said that reengagement with education was a focus of the work of this group. The coresponder model had a focus on establishing supportive relationships with young people. Other initiatives included the Respected Persons Youth Cautioning (Townsville First Nations Trial) which established a collaborative cautioning process involving First Nations Elders.
125. Detective Inspector Shepherd acknowledged that most recidivist young offenders were also victims of abuse and neglect. While detention in custodial settings provided a short-term fix, the engagement of young people in education and meaningful employment is essential. The lack of engagement by the parents of these children was also a significant obstacle.
126. Mr Olsen spoke of the suite of programs and strategies implemented in Townsville by Youth Justice that endeavour to engage with young people after they are known to the youth justice system. Mr Olsen explained the risk of excessive intervention with low risk young people and the adverse impact this can have, rather than a preventative effect.
127. DCYJMA submissions noted that the Department has a longstanding concern with the number of deaths and injuries suffered after young persons, often with one or more passengers aboard, abscond in a stolen car. Those young persons have often already come to the attention of Youth Justice. In this case the driver of the vehicle, Master QTS, had a traumatic childhood and was suffering from long-term behavioural problems as a consequence of this trauma.
128. Youth Justice has developed programs to address the needs of young offenders. Those programs attempt to address the social, emotional, behavioural and other difficulties which emerge from a range of common factors shared by young people who engage in motor vehicle offending. Those factors are largely consistent with the criminogenic needs of young people who are at risk of reoffending generally. No real distinction can be made with respect to motor vehicle offending alone.
129. Consistent the evidence of AC Scanlon and DI Shepherd, Youth Justice data indicates that the following factors are common among many of those who engage in motor vehicle offending, such as Master QTS:
- a. child protection concerns or notifications in early years;
 - b. disadvantaged socio-economic status;
 - c. history of trauma including exposure to family violence;
 - d. exposure to parental substance use;
 - e. neglect;
 - f. abuse;
 - g. parental involvement in the criminal justice system;
 - h. early disengagement from educational settings and/or low educational attainment;
 - i. low level of parental supervision;
 - j. anti-social peers;

k. substance use.

130. None of these factors is more prevalent than the others. Motor vehicle offending is just one of a range of criminal acts which young offenders commit. There is no determining factor for those offenders. Motivation for motor vehicle offending differs, depending on the criminogenic needs of individual young people and the circumstances that arise. These are often impulsive events in opportunistic situations.
131. The Youth Justice strategy adopted to address youth crime generally is set out in *Working Together Changing the Story: Youth Justice Strategy 2019-2023* (the Youth Justice Strategy). Four objectives or “four pillars” have been identified as key to the policy position of Youth Justice when addressing youth crime. They are:
- a. intervene early;
 - b. keep children out of court;
 - c. keep children out of custody;
 - d. reduce reoffending.
132. Those four pillars are supported by two fundamental principles:
- a. Public safety is paramount; and
 - b. Community confidence is essential.
133. Mr Olsen provided a detailed overview of the steps taken to implement the Youth Justice Strategy to reduce reoffending generally among young offenders. In late 2022 there were 77.5 full time youth justice workers employed in the two Youth Justice Service Centres in Townsville providing casework and program delivery to over 200 young people on supervision.⁴⁴ These include:
- Changing Habits and Reaching Targets
 - Emotional Regulation and Impulse Control
 - Black Chicks Talking (for First Nations Girls)
 - Integrated Case Management
 - Transition to Success
134. In addition to the steps taken in the Youth Justice Strategy, as explained in Mr Olsen’s statement, Youth Justice had previously delivered the Motor Vehicle Offending Program (MVOP). MVOP was delivered as a result of an increase in Far North Queensland motor vehicle related offences and was focused on young persons in youth detention centres with a view to providing them with education, awareness and an understanding of why they behaved as they did. It was based on cognitive behavioural therapy models and presented in a group format. It was delivered in Youth Justice Service Centres and adapted to suit those circumstances.
135. That Program was reviewed in 2018-2019. The review team identified a number of factors which would enhance the efficacy of any program designed to reduce youth motor vehicle offending. A new program was developed Called Re-Thinking our Attitude to Driving (ROAD).

⁴⁴ Ex B7

136. ROAD has been trialled in four Youth Justice Service Centres and in Two Youth Detention Centres. The Program's content was then adapted to accommodate the feedback from the various trial locations. ROAD was endorsed for Statewide use by the Youth Justice Governance board in March 2021.
137. The importance of preventing children from entering the Child Safety and Youth Justice systems through investment in early childhood health care, education and housing and strengthening First Nations communities is recognised in the draft *Putting Queensland Kids First: Giving our kids the opportunity of a lifetime strategy*.
138. Since the evidence was heard at this inquest there has been ongoing debate in the community about how to respond effectively to youth crime, including ways to prevent the unlawful use of motor vehicles by young offenders and enhance community safety. This includes the establishment of the Youth Justice Reform Select Committee by the Legislative Assembly in October 2023.
139. In those circumstances, I make no further comments or recommendations under s 46 of the *Coroners Act*.
140. I close the inquest.

Terry Ryan
State Coroner
BRISBANE