CORONER'S COURT

Inquest:	Stacey Lee HUTCHINS
Hearing dates:	14-15 May 2015
Place of Inquest:	Coroner's Court, Glebe NSW 2037
Submissions Received:	29 May 2015 – Counsel Assisting, 25 June 2015 – NSW Police Force, 2 July 2015 – Sargent Paul Goodwin, 16 July 2015 – Counsel Assisting in reply (Senior Constable Jason Chesire advised that he did not wish to make submissions)
Date of findings:	26 August 2016
Place of findings:	Court House, Tweed Heads NSW 2485.
Findings of:	Paul MacMahon Deputy State Coroner

Catchwords:	CORONIAL LAW – Resumption of inquest following suspension, Cause and manner of Death, Involvement of NSWPF in circumstances of death.
File number:	2009/473079
Representation:	Mr W Hunt – Counsel Assisting, Mr M Spartalis – NSW Police Force, Mr M Breeze – Sergeant Paul Goodwin, Mr S Wilkinson – Senior Constable Jason Cheshire

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

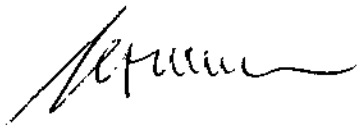
Nil

Findings made in accordance with Section 81(1) Coroners Act 2009:

Stacey Lee Hutchins (born 21 January 1982) died on 6 June 2007 at the Nepean Hospital, Kingsford in the State of New South Wales. The cause of her death was head injury which she sustained when she fell from a moving truck on Adelaide Street, Blayney in the State of New South Wales at about 4.20pm on 5 June 2007.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

Nil



Paul MacMahon

Deputy State Coroner

26 August 2016

Introduction

1. Stacey Lee Hutchins (who I will refer to as 'Stacey' in these reasons) was born on 21 January 1982.

2. On 5 June 2007 Stacey was a passenger in a 'Greenfreight' prime mover vehicle registration number VV66FA. The driver of the vehicle was her former de facto, Mr Dean Willett.

3. At about 4.20pm that day the prime mover was travelling at about 50km/h in Adelaide Street, Blayney in the central western area of New South Wales. The day was a fine dry day and the traffic conditions at the time were light.

4. As the vehicle was travelling along Adelaide Street, Blayney Stacey exited the vehicle from the passenger side. As a result Stacey sustained serious head injuries. Stacey was provided first aid almost immediately. She was then transferred to the Nepean Hospital at Kingswood however the injuries she sustained were not survivable. Stacey was pronounced deceased at 10.40am on 6 June 2007.

5. Her death was subsequently reported to the Office of the NSW State Coroner.

Role and Function of the Coroner

6. At the time of Stacey's death the relevant coronial legislation was the Coroners Act 1980. That legislation was repealed and replaced by the Coroners Act 2009. This Inquest is conducted in accordance with the 2009 Act. In all relevant matters the function and powers of a coroner are identical in each Act.

7. In these reasons all legislative references will be to the Coroners Act 2009 unless otherwise indicated.

8. Section 6 defines a *"reportable death"* as including one where a person died a *"violent or unnatural death."* Section 35 requires that all *reportable deaths* be reported to a coroner.

9. Section 18 gives a Coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or the

person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

10. Section 74(1) (b) provides a Coroner with the discretion to prohibit the publication of any evidence given in the proceedings if he or she is of the opinion that it is in the public interest to do so.

11. The primary function of a coroner at an inquest is set out in Section 81(1). That section requires that at the conclusion of the inquest the Coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of the deceased, the date and place of their death and the cause and manner thereof.

12. The primary function of the coroner as set out in Section 81(1) is to be undertaken having regard to the provisions of Section 78. That section deals with the situation where the circumstance of a death raises the possibility of a known person being charged with an indictable offence.

13. Section 78 provides that if a coroner forms the opinion during the course of an inquest that the admissible evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, that there was a reasonable prospect that a jury would convict the known person and that the indictable offence would raise the issue of whether the known person caused the death with which the inquest is concerned then the coroner has the discretion of taking certain actions.

14. The actions that a coroner may take in such a situation are set out in Section 78(3). They are that the coroner may either, continue the inquest and make findings in accordance with Section 81 (1), or to suspend the inquest.

15. Section 78(3) provides that where an inquest is suspended the coroner is to forward the depositions taken at the inquest to the Director of Public Prosecutions (DPP) together with a statement specifying the name of the known person and the particulars of the indictable offence concerned.

16. Section 79 deals with the finalisation of an inquest that has been suspended in accordance with Section 78. Where following the referral of the depositions and statement to the DPP in accordance with Section 78(3) the DPP advises that no proceedings will be taken against the known person as referred to in Section 78(1) (b) in relation to the indictable offence the

coroner is to determine whether to resume the inquest or to dispense with the resumption of the inquest.

17. Section 79 (2A) provides that a coroner may decide to resume an inquest subject to the coroner giving written notice to the State Coroner of his or her intention to do so and not receiving a direction from the State Coroner not to do so in accordance with Section 79(5A).

18. Section 79(6) provides that where an inquest has been suspended in accordance with Section 78 and the coroner who suspended the inquest is unavailable then the State Coroner, or a coroner authorised by the State Coroner, may resume the inquest or dispense with the resumption of the inquest.

19. Section 82 (1) provides that a Coroner conducting an inquest may make such recommendations as he or she considers necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

History of the proceedings

20. An inquest touching the death of Stacey commenced on 14 February 2011 before His Honour the late Deputy State Coroner Scott Mitchell. On 16 February 2011 His Honour made findings as to Stacey's identity and date and place of her death in accordance with Section 81(1) (a) and (b).

21. His Honour also formed the opinion that the evidence met the requirements of Section 78(1) (b) in respect of a known person. In accordance with Section 78(3) (b) His Honour then suspended the inquest and referred the depositions and statement to the DPP in accordance with Section 78(4).

22. On 14 April 2014 the DPP advised the State Coroner that no proceedings would be taken against the known person for the indictable offence identified by Deputy State Coroner Mitchell. Because His Honour was not available the State Coroner authorised me to determine if an order should be made to resume or dispense with the resumption of the inquest.

23. Having reviewed the material available I considered that an order should be made for the resumption of the inquest. On 12 December 2014 I gave written notice to the State Coroner of my intention to do so in accordance with Section 79(2A). I did not thereafter receive a direction from the State Coroner pursuant Section 79 (5A) not to resume the inquest.

24. The inquest resumed before me on 14 May 2015. At that time I had the benefit of the evidence before His Honour Deputy State Coroner Mitchell together with further oral and documentary evidence.

25. Following the completion of oral evidence a timetable was then set for the parties granted leave to appear at the resumed inquest to make written submissions with respect to the issues for determination at inquest.

26. At the resumption of the inquest leave was granted for the NSW Commissioner of Police, Sergeant Paul Goodwin and Senior Constable Jason Cheshire to appear as parties in the proceedings and they were represented by counsel. Mr Dean Willett, who had been identified as a person of interest in the proceedings conducted by Deputy State Coroner Mitchell was advised of the resumption of the inquest but chose not to participate further in the inquest.

Issues for Inquest

27. The matters to be determined at the Inquest related to the cause and manner of Stacey's death.

28. The direct cause of Stacey's death was not a contentious matter at Inquest.

29. Following Stacey's death an autopsy was conducted by Forensic Pathologist Dr Diane Little. Dr Little's findings at autopsy were described in the following terms:

> *Autopsy revealed the presence of a head injury which directly caused (Stacey's) death. There were multiple skull fractures with an apparent primary impact point on the left occipital (back of the head) where there was a laceration...with underlying stellate skull fracture. There was haemorrhage around and within the brain with secondary swelling and hypoxic and ischaemic encephalopathy (damage due to lack of oxygen / blood flow to the brain).*

30. Dr Little's report noted that there was no evidence of significant pre-existing natural disease that would have caused, or accelerated, Stacey's death. In addition the toxicological report showed that there was no alcohol or drugs in Stacey's system.

31. Dr Little's opinion was that the cause of Stacey's death was *head injury* that was consistent with *a forcible blunt force impact as could occur following a fall from a moving truck.*

32. I accept the Dr Little's evidence and her opinion and I am satisfied that evidence establishes that the cause of Stacey's death was head injury.

Manner of Death

33. The determination of the manner of Stacey's death can be separated into two parts firstly the identification of the incident that resulted in Stacey sustaining the injuries that led to her death and secondly a determination of what factors brought about, or contributed, to that incident occurring.

34. There is little doubt as to how Stacey sustained the injuries that led to her death.

35. The evidence at Inquest was that a little after 4pm on 5 June 2007 the truck driven by Mr Dean Willett, in which Stacey was a passenger, was travelling on a straight stretch of highway between Bathurst and Blayney in the central west of New South Wales when it was observed to driving erratically and sometimes tailgating other vehicles. Shortly after those observations were made the truck was seen to veer to the right and then hard to the left after which something, described variously by witnesses as being a *'body,'* a *'bundle'* or a *'tarpaulin,'* fell or rolled away from the front passenger side of the truck. It was Stacey who fell from the truck.

36. I am satisfied that the evidence establishes Stacey's death resulted from the injuries she received when she fell from a moving truck which was driven at the time by Mr Willett.

37. Determining how Stacey came to fall from the truck on 5 June 2007 requires a close examination of Mr Willett's explanation of what happened that day, Stacey's relationship with Mr Willett at the time, the events that occurred in the days preceding Stacey's fall and Stacey's mental state at the time.

38. Before commencing that examination it is necessary to deal with the possibility that Stacey's fall was due to the door to the truck inadvertently opening due to some mechanical or other fault. Dr Robert Casey, a mechanical engineer, examined the door and provided a report for the assistance of the inquest. Dr Casey found that the door locking mechanism was fully serviceable (notwithstanding a misalignment of the sleeper cabin door because of distortion to its hinges). Dr Casey considered it *highly unlikely* that the door inadvertently opened causing Stacey to fall from the passenger side cabin door. I accept Dr Casey's evidence and am satisfied that Stacey's fall was not due to misadventure arising from mechanical or other fault to the door through which she exited the truck.

39. In the circumstances Stacey's exit from the truck must have been due to either her jumping or being pushed.

40. Following Stacey's fall Mr Willett gave different explanations as to what had happened. Specifically he:

- Explained in an ERISP statement on 6 June 2007 that Stacey suffered postnatal depression and said words to the effect of, *I don't know why your with me Dean, I'm not worth it, I'm not even a decent mother to my child, I don't deserve to live,* before exiting the truck,
- Stated to a number of witnesses at the time that *we had a blue and she jumped out of the* tuck.
- Stated to Senior Constable MacKinnon that he did not know why Stacey jumped or what happened, and
- Told Mr Lee that he and Stacey had been arguing and that she *had fallen out of the bunk* door.

41. Mr Willett in some of these explanations was clearly suggesting that Stacey's fall out of the truck occurred as a result of actions by taken by her that were intended to either end her life or cause her significant personal injury.

42. Mr Willett did not give evidence at the inquest so it was not possible to explore with him this suggestion or the contradictory suggestion made by him that her fall was an accident that occurred whilst he and Stacey were having an argument.

Relationship between Stacey and Mr Willett

43. In about December 2006 Stacey became involved in a relationship with Mr Willett who, like her father, was involved in the trucking industry. She subsequently moved in with him at his home in Corowa. The relationship between them soon began to deteriorate and Stacey spoke to her mother about leaving the relationship. Mr Willett was observed by witnesses to be a very controlling person and this caused Stacey considerable anxiety.

44. On 28 March 2007 Stacey attended the Howlong Police Station and spoke to Senior Constable Smith and advised him that she wished to end her relationship with Mr Willett and was seeking assistance with recovering her property. In April 2007 Stacey left Corowa and moved, with her daughter, to Wangaratta and began living in a caravan in the same caravan park as her mother, Ms Britton, was living.

45. Mr Willett did not accept Stacey's decision to end the relationship and continued to contact her in an attempt to get her to change her mind. As a result Stacey sought the issue of two Apprehended Violence Orders (AVO).

46. The first of these occurred on 30 April 2007 when police applied to the Wangaratta Magistrates Court for a Family Violence Intervention Order (FVIO) against Mr Willett after an incident on 28 April 2007 when he attended the caravan park where Stacey was living.

47. Both Stacey and her mother provided statements to police about the incident. In her statement Stacey described the abuse Mr Willett had directed towards her and the fear that she experienced when he came to the caravan park. She said that she was *terrified* and was afraid that *if he got hold of me I would have been dead.* On 16 May 2007 these proceedings were adjourned to 6 June 2007.

48. On 15 May 2007 Stacey also spoke with police at Corowa Police Station and said that she was concerned that Mr Willett was becoming more violent towards her and that she was scared of him. As a result Senior Constable McCarthy applied for a Provisional AVO with Mr Willett as the defendant and Stacey as the Person in need of Protection. On 23 May 2007 the Corowa Local Court made an interim AVO and adjourned the proceedings to 20 June 2007.

49. On the evening of 1 June 2007 Stacey was informed by a police officer that Mr Willett had not yet been served with the FVIO which was before the Wangaratta Magistrates Court on 6 June 2007. This caused her to become anxious and frustrated. When talking to her mother at the time she said that Mr Willett had threatened her life and said *'she wouldn't make it to Christmas.'*

50. To alleviate her anxiety Ms Britton suggested that Stacey contact a friend in the trucking industry and go on one of his runs for a couple of days. Ms Britton was to care for her granddaughter while she was away. Ms Britton understood that Stacey intended to return to Wangaratta on the evening of 5 June 2007 and attend court on 6 June 2007.

51. Stacey had arranged for a friend, Scott Lee, to pick her up at the Wangaratta by-pass and was to accompany him to Sydney. Mr Lee and Stacey travelled to Marulan where they stopped for a drink and then continued to Chullora where they stayed overnight. In the interim, around 10pm that Sunday evening, Mr Willett had visited Ms Britton at the caravan park wanting to know where Stacey was. Ms Britton told him to leave and threatened to call the police if he did not. After he left Ms Britton sent an SMS to Stacey informing her of his visit.

52. The next day, Monday 4 June 2007, Mr Lee was informed that he had to travel to Brisbane and as Stacey had to return to Victoria arrangements was made for another friend, Cody Purchase, to take her home. Mr Purchase's plans were later changed again and it was agreed that Mr Lee and Mr Purchase would meet at Marulan and Stacey would then return home with Mr Lee. This, however, did not occur and Stacey continued to travel with Mr Purchase after they left Marulan.

53. While Mr Lee was on his way to Marulan he received a message that Mr Willett was trying to get in contact with him. When he returned the call Mr Willett informed him that he was Stacey's boyfriend, that he was looking for her and that *'she was supposed to be travelling with'* Mr Lee. He also said that Wangaratta Police were looking for Stacey.

54. Sometime before 9pm on 4 June 2007 Mr Purchase, Stacey, Mr Lee and another friend, Mr Brian Lawlor, stopped at the 'Volume Plus' Roadhouse on the Hume Highway just outside Holbrook for a meal and coffee.

55. Mr Lawlor had previously met Stacey at Marulan for the first time. At Marulan he had observed Stacey to be happy but she had mentioned to him that she was terrified of her former boyfriend from whom she was trying to get away and start a new life. At Holbrook he thought she appeared more nervous and did not want to stay too long as her former boyfriend often stopped there.

56. Mr Lee's observation was that at Holbrook Stacey seemed *'a little bit different than normal, not like – not usually bubbly'.*

57. As the four were finishing their meals and preparing to leave Mr Willett's Greenfreight truck pulled into the roadhouse. There are a number of accounts of what happened next.

58. Mr Lawlor said that as Stacey walked out through the front door she spotted Mr Willett's Greenfreight truck coming through the entrance towards the bowsers. *'She started screaming that that's his truck and sort of hit the panic button then she ...didn't know which way to run or which way to go.'* He said that she appeared very frightened. Stacey ran in front of the glass door '*...and the next minute the guy's chased her up there and grabbed her by the hair or neck and stopped her.'* Mr Lawlor said he saw this *'clear as day.'* He said that Stacey was screaming loudly, and was struggling. Mr Lawlor heard Mr Purchase tell the consul operator to call the police.

59. Mr Lawlor, Mr Purchase and Mr Lee then walked back through the exit door. They could not see anything because it was dark. At this point the lights of the Greenfreight truck went on. Mr Lawlor said that he could see Stacey. The truck then drove off onto the highway but returned a short time later. The driver then got out of the truck and walked up to Mr Lee and spoke to him. At this point Mr Lawlor could see Stacey in the bunk of the truck. He saw her put her fingers across her throat a couple of times. It was Mr Lawlor's evidence that he took this to mean that Stacey was too frightened or scared to get out of the truck. He said that when the driver went back to the truck Stacey appeared to be very upset and appeared to be crying.

60. Scott Lee's account of the event was that when Mr Willett arrived he noticed that Stacey was '*getting a little bit paranoid'*. She said *'There's Dean, there's Dean.'* As they walked out of the front of the service station Mr Willett came around from Mr Lee's left hand side *'as thought he was in a rage'* At that point Stacey... *ran to the end of the building of the servo, Dean*

actually grabbed her, Stacey was yelling, calling for help and Dean dragged her off at that point of time down beside the service station like out of view'. Mr Lee said that Mr Willett's action was *'pretty physical'.* He said that Stacey called for help twice. Mr Lee said that the truck drove off and then came back. When it did he could see Stacey in the sleeping compartment of the truck. Mr Willett got out and spoke to him. Mr Lee said that he was very confused by the events.

61. Mr Cody Purchase's evidence was that Stacey rode in his truck for about six hours prior to arriving at Holbrook he said that during this time she seemed to be in a good mood. She had mentioned to him incidents of violence by her former boyfriend. They arrived at Holbrook at about 8pm. Later as they were leaving the roadhouse Stacey saw Mr Willett and said in a frightened way *'he's come to get me'* at which time she got up and ran outside.

62. Mr Purchase said that Mr Willett *'came around the front, had a bit of a glance inside then noticed her running off and went and got her...He sort of grabbed her by the arm and around the back of the neck with two hands and then dragged her off around to the right hand side of the service station.'* Mr Purchase said that the force used by Mr Willett *was 'enough to pick her up off the ground and take her around the corner.'*

63. Mr Darren Yates was the manager and console operator on the volume Plus roadhouse at Holbrook at the time. He was on duty on the evening of 4 June 2007. He said that between about 8.30 and 9.00pm he witnessed a woman in the roadhouse having a meal with a couple of truck drivers. He observed the woman to be laughing and happy and chatting to the truck drivers for about half an hour. Shortly after Mr Yates left the roadhouse to tidy up the truck drivers dining area.

64. He then said that he saw the woman he had previously seen run past the roadhouse in a northerly direction. He saw that she was *'grabbed and taken out to a vehicle'* by a man. Mr Yates initially thought the pair were joking as he had seen her laughing however when he was told to do so he phoned the police.

65. Mr Yates then made his way to the rear bay for the trucks. He saw the truck start and travel towards the highway. It then stopped and the driver got out and approached him. The driver asked him if he had contacted the police.

Mr Yates told him he had. The driver said that the woman was his wife/girlfriend. Mr Yates said he then told the driver that he would contact the police and let them know that everything was fine. The driver then got in and drove off before coming back again pulling up alongside Mr Yates. When he did so the driver asked him if he was onto the police and he confirmed that he was and that he was *'telling them everything was okay.'* The truck then departed in a northerly direction towards Sydney.

66. Melita Cronin was the cook and console operator at the Volume Plus roadhouse working in the kitchen on the evening of 4 June 2007. She said that she heard *'a scream from out the front of the roadhouse'* which sounded like a young girl. A young guy then ran in front of the roadhouse and said *'call the cops, someone's grabbed her'.* Mr Yates then phoned the police.

67. Ms Cronin said that Mr Yates later told her that he had *'seen him* [the truck driver] *throw her* [the young girl] *into the truck kicking and screaming.* Ms Cronin was then able to write down some details of the registration and trailer plates when it returned to the roadhouse before finally leaving.

68. Mr Willett when he gave an ERISP statement on 6 June 2007 gave an altogether different account of what happened at the roadhouse. He said: *'Not much, I pulled up and went over I asked to see how she was, she wasn't too good, yeah, pretty well said you know, you wanna come back to Sydney with me you know. She said, yeah, I do cause I don't want to go home cause I don't like my mother to know I'm going to have this AVO lifted in Victoria, she doesn't want it and her mother's going to hound her so she came back to Sydney with me.'* Mr Willett then said *'...no worries I'll go and grab your bags if you want, I went to grab her bags, jumped in the truck, got going.'*

69. Mr Willett's account of the event is completely at odds with that of all the other persons who were present. I do not accept his evidence on this issue. I am satisfied that, on the balance of probabilities, when Stacey left the Volume Plus Roadhouse at Holbrook between 8.30pm and 9.00pm on 4 June 2007 in the truck driven by Mr Willett she did so against her will after he had physically forced her into the truck. She had been abducted.

70. The next day at about 4.00pm Stacey fell from that truck and sustained the injuries that resulted in her death. The police investigation of her death sought to identify what happened to Stacey in the hours between these two events.

71. About 30 minutes after leaving Holbrook Mr Willett met a Mr Pelzman at the Kyeamba Gap Rest Area where the two men consumed *'some drugs'*. While there Mr Willett told Mr Pelzman *'I've been having some dramas with my Mrs. She only told me a couple of days ago how much she loves me and I find out that she is in the truck with another guy'*.

72. The evidence also suggests that at Stacey sustained injuries at about this time.

73. In his ERISP interview Mr Willett sought to explain those injuries saying that she *'...tripped and fell out of the truck and fell on her face...at Yass I seen she had a black eye cause it was swollen up. I don't know what she done if she tripped or slipped but she went to grab the doors and just went down you know...'*

74. Mr Lee later spoke to Stacey and Mr Willett by phone. During the course of that conversation Mr Willett told Mr Lee that Stacy had slipped and hit her head when getting out of the truck at Kyeamba to go to the toilet.

75. At about midnight on 5 June 2007 Mr Pelzman met up again with Mr Willett who at the time was crushing ice which he claimed was for Stacey's black eye. Mr Willett told Mr Pelzman that *'...the Mrs has a black eye to bring the swelling down. We've been arguing. She knows she has done wrong. She's got court tomorrow.'*

76. At about 1.00am on 6 June 2007 at the BP petrol station at Marulan Mr Willett and Stacey went in and asked for the shower key. Ms Catherine Minogue was the attendant. Ms Minogue thought that Stacey's actions were *'odd behaviour'*. She said that Stacey appeared to be standing behind Mr Willett hiding her face. She said that Stacey *'never lifted her head, she just walked with her head down and her hair coming over her face, and appeared, lost or scared'* . She said that the truckie had *'seemed to control the girl she saw – [i]t was like she had to stand there and not to come to the counter.'*

77. At the scene of the accident at Blayney Mr Willett sought to explain Stacey's pre-existing injuries to persons who were trying to assist her. To nurse Bronwyn Halsted he said that the injuries to her eyes *'...were like that already from when she fell from the truck a few days ago.'* To nurse Karen

Watterson he said that Stacey '*already has two black eyes from falling off the truck a week ago'.*

78. In his ERISP interview on 6 June 2007 Mr Willett stated that when he left Bathurst Stacey was asleep in the bunk of the truck. He said that at that time '*I was charging her mobile up for her, took it off the charger when it was full, I turned the phone on to check you know, cause she was asleep to see if she had any messages or unanswered phone calls. There was a heap of messages there from an ex-boyfriend. I woke her up and asked her what was going on'*

79. The examination of Stacey's mobile phone records following her death show that between 1 June 2007 and 5 June 2007 there were 13 communications between Stacey and her ex-boyfriend *'Johnno'* (Matthew Johnson).

80. The distance between Bathurst and Blayney is about 38 kilometres and could be expected to take in the order of 30 minutes.

Discussion and Conclusion

81. We can never know for sure what happened in the hours that Stacey was in the truck with Mr Willett. We do know that she sustained and injury that resulted in black eyes. Mr Willett said that she sustained that injury when she fell. To different people he gave different stories.

82. He admitted to Mr Pelzman (in the context of explaining the need to reduce the swelling to her black eye) that he had been arguing with her and that *'she knows she's done wrong.'* It was shortly after this that, at Marulan, Stacey appeared to the service station attendant to be *'lost or scared'* and that Mr Willett *'seemed to control the girl'.* These are all signs that are regularly associated with significant domestic violence.

83. On Mr Willett's own admission it was shortly before Stacey fell from the truck that he found the messages between Stacey and Mr Johnson and that he *...woke her up and asked her what was going on.*

84. It was at about this time that witnesses also observed the truck driving erratically, sometimes tailgating other vehicles, to veer to the right and then very hard to the left after which Stacey fell from the truck door.

85. There is little doubt that Mr Willett was a very controlling man who was not prepared to accept Stacey's decision to end their relationship. There is also little doubt that their relationship was one in which Mr Willett was violent towards Stacey. On 4 June 2007 he abducted Stacey from the Holbrook roadhouse. Sometime shortly after that she sustained injuries to herself that resulted in her having black eyes. This was after Mr Willett stated that they had been arguing and that he said *'she knows she's done wrong.'* It is hard not to conclude that those injuries resulted from an act of violence towards Stacey by Mr Willett which occurred during the course of that argument.

86. At Marulan she appeared to be intimidated by and under the control of Mr Willett. This description is consistent with the actions of a woman subjected to domestic violence. Stacey subsequently fell from the truck in which she was a passenger shortly after Mr Willett found that she had been communicating with an ex-boyfriend over the preceding days.

87. Taking into account the evidence of Mr Willett's violent and controlling actions towards Stacey, the evidence of the erratic driving of the truck shortly before Stacey fell from it and Mr Willett's admission that at about that time he woke Stacey to find *out what was going on* following this discovery of the SMS's between Stacey and Matthew Johnson I am satisfied, on the balance of probabilities, that having woken Stacey and confronted her about the SMS's, an incident occurred between Mr Willett and Stacey during the course of which Stacey, perhaps trying to protect herself but we will never know for sure, left the moving truck.

88. It seems, in the circumstances, that the likely explanation for the erratic driving of the truck by Mr Willett in the moments before Stacey left the truck was something associated with that incident and at the same time maintain control of the truck.

89. I reject Mr Willett's suggestion that Stacey left the truck with the intention of ending her life. There was absolutely no evidence available to suggest that Stacey was depressed or intended to commit suicide. Prior to Mr Willett attending the roadhouse at Holbrook all the evidence available was to the effect that Stacey was very happy and making plans for the future. What changed this was Mr Willett's abduction of her and the events that followed on 4 and 5 June 2007.

Section 23(c) Coroners Act 2009

90. This section requires that where a reportable death occurs *'as a result of, or in the course of, a police operation'* then it is mandatory that an inquest be conducted to investigate the circumstances of such death and that such inquest be conducted by either the State Coroner or a Deputy State Coroner.

91. In his submissions Counsel Assisting has argued that the circumstances of Stacey's death were such that it came within the ambit of this Section. Counsel for NSWPF and Sgt Goodwin submitted otherwise.

92. It is well understood the purpose of the Section is to ensure that in circumstances where police action is associated with a death it is mandatory that an inquest be conducted. This is so as to provide a positive incentive to police to ensure that actions in the course of the performance of their duties are appropriate in all situations and to satisfy the community that those deaths that occur when police are involved are properly investigated. It is also in the interest of the police that such deaths be properly investigated so as to ensure that officers involved, and police in general, are not the subject of unsubstantiated or malicious allegations.

93. In this case an inquest has been conducted, first by His Honour Magistrate Mitchell and subsequently by me. At the relevant times both His Honour and I held commissions as a Deputy State Coroner. The inquest touching Stacey's death has thus been conducted in accordance with the requirements of Section 23. It is, however, not necessary, in undertaking my function as a coroner in these proceedings, for me to decide whether Stacey's death comes within the ambit of Section 23.

94. It is, however, appropriate for me to examine, as part of determining the cause and manner of Stacey's death, the NSWPF response to the '000' call made by Mr Yates notifying them of Stacey's abduction.

The NSWPF Response

95. At 9.06pm on 4 June 2007, following Stacey's abduction, Darren Yates made a '000'call. Ms Fiona Wilson, communications operator for NSWPF,

took the call. Mr Yates reported *'we have just had a truck driver abduct a woman ... we need a police car here pretty quickly.'* Ms Wilson, as a result, created a CIDS (Computerised Incident Dispatch System) message. That message was: 'M POI HAS JUST GRABBED A FM FROM OUT SIDE THE ROADHOUSE AND DR'M POI HAS JUST DAGGED HER BACK TO HIS PRIME MOVER WITH TRAILER – INFT THINKS POI IS STILL IN THE TRUCK WITH THE FM AT LOC – ONLY DESC OF POIN IS WRING GREEN FREIGHT JUMPER – INFT WILLPH BACK IF POIN TRIES TOLEAVE OR ANY FURTHER DETAILS.'

96. The CIDS message was classified as a *'check bona fides,'* and allocated a 'PRIORITY 2' status which required an urgent response.

97. Following the creation of the CIDS message Mr Neil Faust (police radio operator, Wagga Wagga) broadcast a job as follows: *'...standing by for possibly a highway car or a car in the area of the Roadhouse, one kilometre north of Holbrook, on the Hume Highway, northbound lanes. The informant who works at the Roadhouse has seen a male grab a female at the side of the Roadhouse and dragged her into the back of his prime mover. The prime mover is not described other than that is has a trailer. The informant thinks that the POI is still in the truck with the female at the location. The only description of the POI is that he is wearing a green freight jumper. The informant will phone back if POI tries to leave or he gets any further information. A possible highway car or car in the area.'*

98. At about 9.20pm Senior Constable Jason Chesire was at his residence at Holbrook when he received a call from police radio and was recalled to duty. S/C Chesire put on his uniform, attended the police station to obtain his appointments and the police vehicle (Holbrook 20). At 9.24pm police radio broadcast an update for Holbrook 20 containing further information as follows:

'Radio: Holbrook 20, just an update on the job that you're heading to. The informant called us back. Said POI has driven off northbound from the ...on the Hume Highway. He said the vehicle was a green freight truck with a tort liner, just left northbound. He's taken the female with him. The POIN apparently told the informant that the female was his wife, although the informant was very concerned for the welfare of the female. The truck, he's given us a partial registration number of a YANKEE-VICTOR-6-6. We've got nothing further.'

99. That radio broadcast was replied to by S/C Chesire as follows:

'HOL20- Holbrook 20 copy that. I/ll take a run north. See if I can catch up to it Radio: Terrific.'

100. S/C Chesire stated that he then drove some 45km north on the Hume Highway to the northern most boundary of the Local Area Command (LAC) at Aeroplane Hill, but was unable to locate the truck. In his statement he estimated that he would have arrived at the border of the LAC at about 9.45pm.

101. S/C Chesire stated that as he travelled along the relevant stretch of highway looking for the truck he say that there were a number of vehicle rest areas. He said that he checked each of the rest areas and believed that the truck was not in any one of them. He believed that because the Greenfreight truck was distinctive he would have seen it had it been there. Having done so he said that he thought that the best thing he could do was to return to the service station *'to obtain such information as would help the investigation'.*

102. At 9.41pm S/C Chesire had the following exchange with police radio:

> HOL20: Yeah mate…just out of my area, I still havn't located the truck. Could you pass the job onto the Wagga area?
>
> Radio: Yeah, Ive got a copy. I can keep a lookout, and I'll let them know that you couldn't find it.
>
> HOL20: Yeah, copy that. There was a couple of trucks on the other side. I couldn't quite see…on the way up. When I double back I'll have a look at those as well.
>
> Radio: Copy.

103. Following this exchange police radio CIDS messages were duplicated to the Wagga Wagga channel and at 9.43pm Wagga VKG radio operator broadcast a message containing the information available and asking them to keep a lookout for the truck. Unfortunately, for reasons that are unknown, that message was not repeated.

104. S/C Chesire then returned to the Roadhouse at Holbrook to speak to the informant however when he got there he found that Mr Yates had gone home and that other persons then at the roadhouse *'knew very little of the incident.'*

105. S/C Chesire's involvement in the matter appears to have concluded at about 10.13pm when he called police radio to advise:

> *'Yeah radio, back on. There's no real further information than what we've got. Its only the, it's a single trailer and not a B-Double, so...'*

106. S/C Chesire returned to duty early the next morning however did not undertake any further action associated with the events of the previous night.

107. There was no further police involvement arising from the abduction of Stacey until they were called to the scene following her falling from the truck at Blayney the next afternoon.

108. Superintendent Luke Moore was the Commander of the Robbery & Serious Crime Squad (RSC Squad). He provided a statement for the assistance of the inquest. In his statement he said:

'...it is my opinion that notification to State Crime Command (SCC) would have been expected and indeed required at some time in the first hour or two after Ms Hutchins was last seen in the truck leaving the road house just north of Holbrook on 4 June 2007...the circumstances outlined in the transcript of '000' calls and Computerised Incident Despatch System data, at face value, clearly constitute the necessary elements of a kidnapping offence contrary to S.86 of the NSW Crimes Act...'

109. In addition, Supt. Moore said that as it became apparent that the truck containing Ms Hutchins could not be located ...that notification [to SCC] should have been made in order to commence a coordinated investigative and search response.

110. In Supt. Moors view, there would have been an escalation of the response within 2-3 hours of the victim not being recovered, including the establishment of a command post, and the use of covert physical and

electronic resources together with the activation of a full team of investigative and intelligence staff.

111. Supt. Moore was unavailable to give evidence at the inquest however the acting Superintendent of the RSC Squad A/Supt Michael Sheehy did give evidence to a similar effect to that of Supt' Moore and stated that in the circumstances the RSC Squad would *'without question'* have become involved in ensuring the safe return of the victim and would have assumed control of this aspect of the investigation if the victim had not been located by the next day.

112. Superintendent Elizabeth Stirton, Commander of the Albury Local Area Command, gave evidence at inquest. She expressed the opinion that based on the reference to the victim being *'grabbed'* and *'dragged back to the prime mover'* there was adequate information for a *'prudent and reasonable'* person to conclude that an abduction had occurred.

113. Supt. Stirton agreed with Supt. Moore that *'the incident clearly fitted within the offence category of abduction requiring immediate notification to the SCC in accordance with the 'Major Crime Guidelines.'*

114. Supt. Stirton was critical of S/C Chesire's failure to follow up Mr Yates and the other truck drivers who had tried to prevent the truck leaving and stated that she would have expected that S/C Chesire would have contacted Mr Yates during the recall to duty.

115. Supt. Stirton was also very critical of S/C Chesire's failure to prepare a COPS event. Supt. Stirton explained that the COPS event was important as had it been created it would go in for quality review and the supervisor on duty would review the event to see if the investigation had been finalised or whether further steps ought be taken. She stated *'If [the supervisor] saw further investigations were required at the time, they could task other officers on duty at the time to perform further inquiries.'* The supervisor was also able to escalate the matter to a crime co-ordinator.

116. Supt. Stirton was also critical of Sgt Goodwin's supervision of the matter stating that she would have expected him to *'monitor the incident as it unfolded.'*

117. Detective Inspector Luke Rankin also provided a comprehensive review of the police response to the circumstances of Stacey's abduction. Det Insp Rankin was critical of S/C Chesire's response saying that it should have been *'more comprehensive.'* He said that the major inadequacy was S/C Chesire's failure to prepare a COPS event saying that *'preparation of a COPS event would have alerted supervisors to the matter and would have had the effect of ensuring further assessment by supervisors as to the adequacy of [the] police response'.*

118. Senior Sergeant Greg Robinson also gave evidence. Sen. Sgt Robinson had previously been the State Co-ordinator of the Radio Operators Group. He provided assistance concerning aspects of the applicable communications protocols and procedures at the time and since.

119. Sen. Sgt Robinson's evidence was that in 2007 there was an obligation on both the telephonist and the dispatcher to notify the DOI (Duty Operations Inspector) of SUN (Serious, Unusual or Newsworthy) events. His evidence was that the reported abduction of Stacey Hutchins was within the SUN category because of its seriousness.

Submissions

120. In his submissions Counsel Assisting has argued that: *'considered in totality...the response (of police) to the report of Stacey Hutchins' abduction on the evening of 4 June 2007 was seriously deficient in a number of respects including in terms of internal communications, investigation, documentation and supervision.'* Counsel Assisting sets out the deficiencies identified in detail in his submissions.

121. A summary of the communication failures identified by Counsel Assisting are as follows:

- Ms Wilson's failure to identify and report the abduction as a 'SUN' event and, as a consequence, failing to notify the DOI as was required in such situations,

- Ms Wilson's failure to include the words *'abduct'* or *'abduction'* in the initial CIDS message the inclusion of which might have prompted others to the seriousness of the event,

- Ms Wilson's categorisation of the incident as *'check bona fide'* rather than *'concern for welfare'* or *'assault occurring now'* the latter categorisation being more appropriate to the circumstances,

- Senior Constable Brown (the shift coordinator) also failing to identify the abduction as SUN event and also failing to notify the DOI of it,

- Senior Constable Brown (unintentionally) downgrading the priority of the event from category 2 (urgent) to category 3 (non-urgent),

- The VKG dispatcher failed to identify the event as a SUN event and as a consequence similarly failing to notify the DOI of the event,

- Sgt Goodwin (whose decision it was to return S/C Chesire to duty) failing to escalate investigation of the incident to the DOI, or to contact the on-call detectives, so that appropriate consideration could be given to investigative methods that should be applied in the circumstances,

- Sgt Goodwin's failure to appropriately brief the incoming team leader or duty officer as to the incident that S/C Chesire had been recalled to duty to attend so that appropriate further investigation could occur, and

- The *'keep a look out for'* broadcasts by the Wagga dispatcher not being broadcast across the channel a number of times as was required nor was the request passed to other channels which would have been appropriate having regard to the mobility of the truck.

122. Counsel Assisting also submitted that the police response to Stacey's abduction was deficient due to S/C Chesire's failure to properly investigate the reported abduction.

123. Det Insp Rankin and Superintendent Stirton (who had each reviewed the event) were of the opinion that S/C Chesire's response was

not *'proportionate'* to the information in the CIDS message and that the matter required a more 'comprehensive response.'

124. Counsel Assisting summarised the inadequacy of S/C Chesire's response and suggested that, as a matter of urgency but no later than when he returned to duty the following day, at the very least, he should have:

- Obtained the contact details of the original informant (Darren Yates) and immediately contacted him notwithstanding that he had finished his shift,
- Made contact with Greenfreight so as to identify the subject vehicle, driver and scheduled route (noting that police radio had a partial vehicle registration and a partial trailer plate number which would have assisted the company to provide such information),
- Canvassed customers in the roadhouse in more detail to identify potential witnesses and recording their particulars,
- Appropriately reported and recorded the circumstances of the incident, as required by the relevant SOPS (standard operating procedures), at the time, which required an investigation to be undertaken into whether a domestic violence offence had been committed. (The Investigation and Management of Domestic and Family Violence –Standard Operating Procedure 2007). In evidence Supt Stirton stated that on the information available, at the very least, an assault had occurred and it was S/C Chesire's responsibility to investigate whether an offence had occurred, and finally
- Det. Inspector Rankin's opinion (which was supported by Supt Stirton) was that the *'major inadequacy'* of the initial police response was the failure to complete a COPS event. The evidence was that had a COPS event been prepared it would have alerted supervisors to the matter and *'had the effect of ensuring further assessments as to the adequacy of ...police response'*. Supt. Stirton empathised that the domestic violence SOPS required S/C Chesire to create a COPS event if a domestic violence incident

was believed to have occurred. There was no explanation given for the failure to complete the COPS event.

125. S/C Chesire returned to duty at 6am the following day (7.5 hours after he had signed off from his recall to duty). He took no steps to follow up the status of the incident at the Roadhouse the night before. There was no explanation given as to why he did not do so.

126. Counsel Assisting also submitted that there was a failure of supervision that negatively affected the police response to the reported abduction of Stacey.

127. It was submitted that it was Sgt Goodwin's responsibility, as S/C Chesire's supervisor, to ensure that *'All domestic and family violence events [were] ...completed and placed on the COPS system as early as practicable and in every case before the conclusion of a shift.'* (The Investigation and Management of Domestic and Family Violence SOP 2007).

128. In addition the evidence was unable to determine whether or not S/C Chesire was debriefed following the events at the Holbrook Roadhouse by Sgt Goodwin or his delegate. It was, submitted that it was a mutual obligation, on the part of both S/C Chesire and Sgt Goodwin, for this to occur. Had it occurred, as required, it would have allowed a superior officer to *'escalate the investigation of the incident to the DOI at the NSW Police Radio.* It would have also required (in accordance with the Southern Region SOPS for the Preparation of SITREPS), the preparation of a SITREP by Sgt Goodwin, or his delegate, which would have alerted more senior officers of the reported abduction.

129. Counsel Assisting, in conclusion, submitted that:

- There was some 17.5 hours between Stacey's abduction, as reported to police, and her exiting the truck and suffering the injuries that led to her death,
- It was the clear and unequivocal evidence of senior officers of the NSWPF that had the policies and procedures in place at the time been complied with the DOI, a detective and the RSC Squad

would all have become involved in investigating what had happened to Stacey,

- That the RSC Squad's involvement in particular, as A/Supt Sheehy explained, would have been important for this purpose it had the specialist resources and capacity to provide a *'rapid'* response and to utilise covert investigation techniques in searching for victims,

- The tracking of the vehicle was unlikely to have proven difficult given the size of the vehicle, its distinctive nature and the fact that the driver maintained his distribution route on major highways and that information concerning the registration of the vehicle, the trailer and the identity of the driver could have been obtained from Greenfreight Management.

130. It was Counsel Assisting's submission that, on the balance of probabilities, had the applicable policies and procedures been followed Greenfreight truck 671 would have been intercepted at some time in the 17.5 hours after Stacey's abduction was reported to police and her life would have been saved.

131. The NSWPF substantially agreed with the submissions of Counsel Assisting and adopted the evidence that Supt Stirton, A/Supt Sheehy, Supt Moore, Det Insp Rankin and Sen Sgt Robinson gave at inquest. In particular the failure to describe the matter as serious prevented the DOI considering whether to contact a local detective or to involve the State Crime Command (SCC).

132. In response to the submission that S/C Chesire failed to properly investigate the abduction of Stacey the NSWPF submissions were that there was no failure on the part of the officer to investigate. They pointed out that he was recalled to duty, he drove past the Roadhouse looking for the subject truck, he drove to the extent of the command's territory, he checked the locations on the side of the highway where the truck might be located and when this proved fruitless he returned to the roadhouse and made inquiries discovering that the informant had left for the evening.

133. The NSWPF submissions emphasised that at the time the relevant SOPS were appropriate to deal with the events as reported. The NSWPF accepted that there was an obligation to create a COPS event and that this was not done. It was submitted that the creation of a COPS event may not have altered the outcome however it was accepted that doing so would have changed the scope of the investigation.

134. The NSWPF also accepted that there was a failure of supervision of S/C Cheshire on the part of Sgt Goodwin saying that *'it is unfortunate that Sergeant Goodwin did not follow up Senior Constable Cheshire in circumstances where Senior Constable Cheshire was recalled to duty and was operating as an alpha unit. At the very least a COPS event should have been prepared. Officer safety reasons mandated a follow up from Sergeant Goodwin'.*

135. The NSWPF finally submitted that I should reject the submissions of Counsel Assisting that, had the police response been different, Stacey's death may not have occurred.

136. It was submitted in support that Counsel Assisting was not a prosecutor and that an Inquest was not a court sitting to determine liability. It was put that an inquest is non-adversarial and it was inappropriate for Counsel Assisting to draw the conclusions he did in his submissions.

137. In support of this submission Counsel for the NSWPF referred to the statement of His Honour State Coroner Barnes in *The Inquest into the Deaths rising from the Lindt Café Siege* where, on 5 June 2015 at paragraph 10, His Honour said:

> *'An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-*
>
> *'[A) n inquest is a fact finding exercise and not a method for apportioning guilt...it is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends...*
>
> *The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.'*

138. It was submitted by counsel for the NSWPF that the particular submissions referred to by Counsel Assisting were *'akin to closing submissions in either a criminal or civil trial seeking to apportion liability, guilt or blame, rather than an inquiry as to the manner and cause of death'* and as such the conclusions proffered by Counsel Assisting ought not be adopted by me.

139. Sgt Paul Goodwin was rostered as supervisor for the night shift on 4 June 2007. He commenced duties at 6pm on that evening and concluded his shift at 6am on 5 June 2007. It was he who recalled S/C Chesire to duty at about 9.20pm on 4 June 2007. By recalling S/C Chesire Sgt Goodwin acknowledged that *'the information was possibly credible and that the matter had the potential to be of a serious nature and warranted immediate police response'*.

140. Sgt Goodwin, in response to submissions by Counsel Assisting to the effect that he failed to adequately supervise S/C Chesire, submitted:

- It was the responsibility of S/C Chesire, having been recalled to duty, to provide a briefing to his supervisor on conclusion of his recall to duty. He referred to the evidence of Det Insp Rankin to this effect,

- Even if such a briefing had occurred the evidence did not show that there was anything additional known by S/C Chesire at the conclusion of his recall to duty so any briefing would have been *'fruitless'* because Sgt Goodwin *'knew precisely the same information as S/C Chesire did and that information was contained in the VKG broadcasts,'*

- There was no requirement on the part of Sgt Goodwin to escalate the investigation of the incident to the DOI as such a requirement would only arise if S/C Chesire had briefed him with information that made that necessary and that did not happen,

- In any event the DOI at Police Radio should have been alerted if the internal policies of Police Radio Communications had been followed. It was submitted that objectively viewed the 'OOO' calls by Mr Yates should have led to the VKG operators who answered the calls to treat them as SUN events and send the CIDS

messages to the DOI and others. This would have resulted in the DOI notifying the SCC pursuant to the *'Major Crime Guidelines'*,

- On the information he had available there was no obligation on the part of Sgt Goodwin to consult the Crime Manager and involve a detective in the investigation, and
- Sgt Goodwin conceded that he failed to ensure that a COPS event was submitted.

141. In summary it was submitted on his behalf *'that the only oversight by Sgt Goodwin was his failure to ensure that S/C Chesire completed a COPS event prior to the completion of his shift.*

Discussion and Conclusions:

142. The evidence available is abundantly clear that when Stacey's abduction was reported to police what was reported was, on any interpretation, a serious event. Either a male had kidnapped an unrelated female and had driven off with her in his truck or, if Mr Willett's assertion to Mr Yates is to be accepted, there was a significant act of domestic violence involving an assault and abduction. On any basis it required, and the community would both expect and demand, a rapid and effective response by police so as to determine what had happened and ensure that the female, whoever she was, was safe.

143. On the evidence available it is also abundantly clear that the corporate response of the NSWPF was inadequate and failed to meet what the community would be entitled to expect in such circumstances.

144. Sgt Goodwin's decision to recall S/C Chesire to duty because he considered that *'the information was possibly credible and that the matter had the potential to be of a serious nature and warranted immediate police response'* was correct and, indeed, the only appropriate response at the time.

145. S/C Chesire's decision to immediately look for the truck by travelling at speed along the Hume Highway to the boundary of his command's jurisdiction was, as the only officer available, an appropriate

decision on his part. I accept his evidence that he looked in the various parking areas along the highway and did not find the subject truck.

146. I accept the evidence of the senior officers, who reviewed S/C Chesire's action, and gave evidence at the inquest, that having been recalled to duty it was his duty to investigate what had happened to the female and that, although his initial action was appropriate, his subsequent action in:

- Failing to contact Mr Yates and obtain such further information as he may have been able to provide,
- Failing to identify and contact such other witnesses to the events as may have been available so as to obtain such further information as may have been available,
- Failing to contact Greenfreight management so as to identify the registration details of the prime mover and the trailer, the identity of the driver and the anticipated route of the subject vehicle and to provide that information to police radio to assist in locating the vehicle,
- Failing to brief his supervisor, or delegate, as to his actions following his recall to duty, and his
- Failing to complete a COPS event prior to concluding his return to duty,

were manifestly inadequate having regard to the seriousness of the events that had been reported.

147. No explanation was given for S/C Chesire's failure to take the action that would have been expected of him on the night or for his failure to take any further action to investigate what had happened to Stacey on his return to duty at 6am the next day. It would be hard to infer that, in the circumstances, he did not think it important or that he forgot about it when he returned to work the next day. Whatever the reason I am satisfied that his failure to reasonably investigate and comply with the relevant policies and procedures contributed the inadequate NSWPF response to Stacey's abduction.

148. I am also satisfied that the failure of the officers at VKG to identify that the information provided to them by Mr Yates constituted a SUN event. Manifestly it did. It was either a kidnapping or a serious domestic violence event. Either way it should have been identified for what it was and brought to the attention of the DOI for a considered response at that level. The failure to do so also contributed to the inadequate NSWPF response to Stacey's abduction.

149. As I said above Sgt Goodwin's decision to recall S/C Chesire to duty was an appropriate one. It is clear that Sgt Goodwin immediately recognised the potentially serious nature of what had been reported to police.

150. I accept that the primary responsibility for investigating what had occurred fell to S/C Chesire following him being recalled to duty. I accept that, on the evidence, it does not appear that S/C Chesire briefed Sgt Goodwin prior to him concluding his return to duty.

151. I also accept that it was S/C Chesire's obligation to complete a COPS event prior to him completing his shift. I also note Sgt Goodwin's acknowledgment that he failed to ensure that the COPS event was completed in accordance with NSWPF policy.

152. I do not, however, accept Sgt Goodwin's assertion that *'the only oversight was his failure to ensure that S/C Chesire completed the COPS event prior to him completing his shift'.*

153. The suggestion that Sgt Goodwin had no obligation to find out what S/C Chesire had done during his return to duty ignores the very concept of the supervisory function. It is not sufficient to say *'my subordinate did not tell me anything so I had no responsibility to ensure that appropriate action was taken.'*

154. It would never be acceptable for a supervising doctor to say that his/her intern did not tell him/her what treatment was being provided to a patient so he/she did not have the obligation to find out what the treatment was or to ensure that the treatment given was appropriate.

155. The very nature of the supervisory role is to find out what has been done by the subordinate, review what has been done and where other or

additional action is considered necessary to ensure that such other or additional action occurs.

156. Although S/C Chesire had a responsibility to inform Sgt Goodwin what had occurred following his return to duty when he did not do so it was Sgt Goodwin's responsibility as supervisor to find out. Had he done so, knowing that the truck had not been located and that it was not known what had happened to the girl who had been dragged into the truck by her hair, he would have undoubtedly, as an experienced police officer, ensured that the investigation did not, as unfortunately it did, stop at that point.

157. One might have reasonably expected that, in such circumstances, he would have directed S/C Chesire to continue his investigations and / or made inquiries of either the crime manager or the DOI as to what further action was considered necessary.

158. It would be hard to believe that had the abduction of a female by the hair by a truck driver been brought to the attention of the DOI at the time the police efforts to locate that female would not have concluded when they did that evening but would have continued until she was found.

159. There were numerous opportunities for the police response to have been different:

- The police radio operators identifying the circumstances as being a SUN event and reporting it to the DOI in accordance with their procedures,
- S/C Chesire undertaking a more thorough investigation and identifying the truck, trailer, driver and route and reporting such information to VKG prior to finishing his shift,
- S/C Chesire briefing Sgt Goodwin prior to completing his shift which would have allowed Sgt Goodwin to ensure that the investigation did not conclude at that time,
- S/C Chesire completing a COPS event prior to completing his shift which would have brought the event to the attention of the DOI,

and other senior officers, giving them the opportunity to continue and expand the investigation,

- Sgt Goodwin realising that S/C Chesire had not briefed him and had not prepared a COPS event prior to him concluding his shift and, having done so, taken appropriate action to ensure that the investigation was continued.

160. I am satisfied that the evidence establishes that at the time of Stacey's abduction the NSWPF policies and procedures then in effect were sufficient and appropriate for the NSWPF to adequately respond to the circumstances of the '000' call made by Mr Yates.

161. The NSWPF response to the '000' call by Mr Yates was however manifestly inadequate and this was due to the multiple failures on the part of NSWPF personnel to comply with the applicable policies and procedures. Had any one or more of these failures not occurred I am satisfied that, on the balance of probabilities, the necessary resources would have been brought to bear in order to locate Stacey and apprehend her abductor.

162. I am also satisfied, on the balance of probabilities, that had appropriate police resources been brought to bear in order to find Stacey given the size of the truck, its distinctive features and the fact that the driver travelled his allocated delivery route, she would have been located prior to the events that resulted in her sustaining the injuries that brought about her death occurring.

163. This brings me to the considering the submission made by Counsel Assisting that *'On the balance of probabilities, it seems difficult to escape the conclusion that had the applicable police policies and procedures been followed, Greenfreight truck 671 would have been intercepted at some time in the 17.5 hours after Stacey Hutchins abduction was reported to police, and her life ultimately saved.'*

164. As mentioned before Counsel for the NSWPF submitted that this submission by Counsel Assisting should be rejected as, by implication, it does not go to determining the manner and cause of Stacey's death.

165. There is no doubt that an inquest is not a trial between parties as is the case in criminal or civil proceedings. I agree that an inquest is a fact finding exercise that is undertaken for the purpose of identifying, if the evidence is available, the manner and cause of a person's death. An inquest does not thereby seek to apportion liability, guilt or blame for that death.

166. I do not, however, agree with the suggestion that Counsel Assisting's submission seeks to do this. In my view Counsel Assisting's submission does no more than continues his analysis of the factors that contributed to the circumstances that resulted in Stacey's death.

167. Having accepted the evidence of the senior officers of the NSWPF that had reviewed the NSWPF response to Stacey's abduction, having found for the reasons given that the response was manifestly inadequate and having found that had the response been in accordance with NSWPF policies and procedures it is likely Stacey would have been found prior to the events that resulted in her death I am also satisfied that had those policies and procedures been followed her death, on the balance of probabilities, would have been prevented.

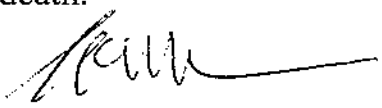
168. Making such a finding of fact is the function of an inquest and does no more than what His Honour State Coroner Barnes stated as being to *'seek out and record as many of the facts concerning the death as the public interest requires.'*

Section 82 Recommendations

169. It is now more than nine years since the events that resulted in Stacey's death occurred. I have found that the policies and procedures of the NSWPF applicable at the time were appropriate to deal with the events that occurred on 4 June 2007. The difficulty was that they were not complied with.

170. The evidence available at the time of the resumption of the inquest was that there had also been significant changes in such policies and procedures that, hopefully, will ensure that the situation that occurred in response to the abduction of Stacey will not occur again. It is not necessary for me to set out in detail the changes that have occurred other than to acknowledge that this has happened.

171. In the circumstances, given the time that has elapsed, the changes in circumstances that have occurred and having had regard to the submissions made by Counsel Assisting and Counsel appearing for the parties I do not consider that it is necessary or desirable for me to make recommendations pursuant to Section 82 in respect of any matter connected with the Stacey's death.



Paul MacMahon

Deputy State Coroner

26 August 2016