



Western

Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 37/17

*I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of **Anthony John BILICK** with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 12-13 October 2017 find the identity of the deceased was **Anthony John BILICK** and that death occurred on 6 February 2016 at Sir Charles Gairdner Hospital as the result of Chest Injury in the following circumstances:-*

Counsel Appearing:

Ms F Allen assisted the Deputy State Coroner

Mr K Seneviratne appeared on behalf of the Commissioner for Police and police officers.

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SUPPRESSION ORDER

No publication of the detail of the discussion about the police emergency driving policies and guidelines and procedures.

INTRODUCTION

At about 10.44 pm on Saturday 6 February 2016, Anthony John Bilick (the deceased) was riding at Ducati motorcycle (the Ducati), at speed, south, in the southbound lanes of West Coast Highway (WCH), Scarborough. At the intersection of WCH and Ventnor Street the deceased's motorcycle collided with a Toyota Tarago (the Toyota) which had driven west across WCH intending to turn right into the northbound lanes of WCH at the median access. The deceased was thrown from the Ducati onto the road and suffered serious injuries. He died a short time later in hospital.

The deceased was 34 years of age.

Shortly before the crash the deceased had attracted the attention of police while travelling at speed, east, along Scarborough Beach Road, Scarborough. Before the police, in a fully marked class 2 police vehicle, could attempt to stop the deceased he disappeared.

The deceased reappeared, travelling west, at an appropriate speed. When the police activated their lights in an attempt to stop the deceased and speak with him, he rode into a car

park as though to stop and then, as the police were stopping, the deceased accelerated away at speed. The police then activated their lights and sirens and followed him out of the car park and onto Brighton Road. The police were then instructed to cease any attempt to stop the motorcycle and in response turned off all of their emergency lights and sirens. They continued to drive in the same direction as the deceased at the posted speed limit. They lost sight of the deceased before they reached WCH.

Under the provisions of the *Coroners Act 1996* (WA) there is no doubt the death of the deceased was a reportable death.

In addition, by the provisions of section 22 (1) (b) where it appears the death was caused or contributed to by any action of a member of the police force, there must be an inquest into the circumstances of the death to enable independent review of the actions of the police officers involved.

BACKGROUND

The Deceased

The deceased was born on 13 November 1981 in East Fremantle. He had completed year 10 in high school before starting a cabinet making apprenticeship in his father's business, which he did not complete. He had a difficult relationship with his family of origin and was largely estranged from them, other than a sister.

The deceased had never married, but had four children, aged 7, 10, 11 and 12 at the time of his death. He was considered to be fit and healthy, but had used illicit drugs from a young age.

The deceased enjoyed anything to do with motorcycles, which included all forms of riding both on and off road. Unfortunately, he had never held any type of motor vehicle driver's licence having always received suspensions of any learner's permits he had obtained.¹

Information from the deceased's partner indicated he may have been suffering from injuries for which he had not sought treatment at the time of his death. It is possible he was having difficulties with a foot and shoulder which could have affected his riding performance.

The Motorcycle

The Ducati was a 2013 black, Panigale vee twin cylinder 1199 cc, with a liquid cooled, fuel injected petrol engine and a left foot operated six speed manual transmission with a chain drive to the rear wheel. It was high performance and capable of speeds in excess of any Western Australian permissible speed limits.

¹ Ex 1, tab 8

It had been reported stolen from an address in Armadale in October 2015 and at the time of the crash had a false, hand fabricated number plate.² It had been sprayed with green florescent paint over the back surfaces.

An examination of the Ducati by qualified police mechanics after the crash could find no defects with the Ducati which would have contributed to the crash, although it was extremely damaged. It had front impact damage as well as all over damage. The transmission was located in 6th gear.³

The Police Vehicle

The police vehicle involved in the earlier attempt to stop the deceased on the Ducati was a class 2 fully marked police vehicle, call name NS106, fitted with all appropriate emergency beacons in the form of lights and sirens and was fitted with an automotive vehicle locator (AVL) used to identify the approximate position of police vehicles. It can also provide a rough estimate of speeds travelled between two points. The AVL allows the Police Operations Centre (POC) to visualise the relevant position and speed of police vehicles fitted with the device.⁴

The Toyota Tarago (Toyota)

The other motor vehicle damaged in the crash was a Toyota Tarago four door wagon with seating capacity for eight

² t 13.10.17, p89

³ Ex 1, tab 9

⁴ t 12.10.17, p60

people. The Toyota was examined by police qualified mechanics and no defects were located with respect to the Toyota which would have caused or contributed to the crash. It had suffered impact damage to the right side.⁵

The Police

Police, under the direction of the Commissioner for Police, are expected to provide the law enforcement arm of Government on behalf of the community.

To enable them to fulfil their role police are provided with powers over and above those ordinarily residing in members of the public. To ensure police officers are competent to carry out the various duties required by their law enforcement function on behalf of the community they are trained, both in theory and practice, in different aspects of law enforcement. With the powers they achieve by being qualified police officers, there are also responsibilities to carry out those powers as safely as possible to protect both themselves as police officers and members of the community.

One of the areas in which all police officers are expected to obtain a degree of proficiencies is that of driving. Many law enforcement activities require competent and skilful driving. There are many aspects to the need for competent driving which range from enabling police officers to respond in a

⁵ Ex 1, tab 9

timely manner to incidents which require their attention, convey people or items in a competent and timely fashion from one location to another, and active law enforcement activities such as apprehending perpetrators or offenders and protecting life and property.

To achieve this the Commissioner for Police has developed an Emergency Driving Policy and Guidelines (EDPG) which identifies different aspects of emergency driving and outlines policies, procedures and protocols to be followed depending on the driving in question. Aside from policies with respect to driving itself, there are other safety aspects considered with the types of vehicles which may be used in different types of driving. Implementation of the EDPG seeks to ensure the safety of police officers, members of the community and, where relevant, the perpetrators and offenders. It has been updated frequently in an attempt to clarify relevant considerations when police officers are involved in emergency driving.

The EDPG, applicable in February 2016, was a detailed document many pages long and all police officers were, and still are, expected to understand the relevant EDPG from the academy stage. This is regardless of their competence in driving because any police officer may find themselves in the position of a passenger in a police vehicle, involved in law enforcement activities, and certain obligations attached to police passengers in police vehicles during emergency

driving in addition to those attached to the drivers of police vehicles.

Additionally, in remote areas not controlled by the metropolitan POC, the most senior police officer on duty assumes the role of the Police Operations Central Command Centre (POCCC). All police officers need to understand the requirements of any current EDPG.

There has been confusion over the interpretation of some aspects of the relevant EDPGs, and over the last few years the most practicable way for the EDPG to be written and interpreted has been an ongoing discussion. A new policy was released on 1 December 2016 which it is hoped will clarify some of the difficulties experienced to date and discussed in inquest findings over the last few years.

The EDPG current in February 2016 divided emergency driving into four categories. Vehicle intercept, priority 2, priority 1 and priority pursuit. Different criteria and expectations related to each category of driving, as did the qualifications of the police drivers, and the conformity of police vehicles. The responsibilities of police passengers and directions arising from POC were consistent, with the exception of priority pursuits, where supervision by POC was constant once engaged. It emphasised the requirement for adequate risk assessment on behalf of drivers, passengers, and with appropriate interrogation, POCCC.

In the current case the police driver involved in the earlier attempt to intercept the deceased was a priority 1 driver who had gained that qualification in 2015. His police passenger was a priority 2 driver and NS106, a class 2 police vehicle. That particular combination of driver, passenger and vehicle were competent to drive in a vehicle intercept, but not a pursuit unless specifically authorised by POC.

Late Evening 6 February 2016

On 6 February 2016 police constables Sutherland and Weir were on night shift conducting patrols as directed in the vicinity of Scarborough. They were in uniform, driving a fully marked class 2 police vehicle, NS106. The vehicle was being driven by Dayne Sutherland (Sutherland) with Daniel Weir as his passenger (Weir). They had started their shift at approximately 9.00 pm.

At approximately 10.35 pm Sutherland and Weir were travelling east on Scarborough Beach Road intending to attend a disturbance in Tuart Hill. When approximately at the intersection of Flamborough Street with Scarborough Beach Road, Weir noticed a dark coloured sports style motorcycle in the right hand lane. To both constables the motorcycle appeared to be travelling at a higher speed than the vehicles around it.

The motorcycle was in the right hand, eastbound, lane while the police vehicle was in the left hand, eastbound, lane. There were three vehicles between NS106 and the motorcycle and Sutherland changed lanes in an attempt to move closer to the motorcycle and read the number plate so they could perform a vehicle check which might inform them of a reason why the motorcycle appeared to be travelling at speed.⁶

Before Sutherland was able to move close enough for Weir to obtain the registration number, the motorcycle rider conducted a U-turn, Weir believed at the intersection of Sydenham Road and Scarborough Beach Road. At that stage the motorcycle was approximately 40 metres in front of the police vehicle and Weir was still not able to read the registration number.⁷ This was unusual and Sutherland also conducted a U-turn in order to intercept the motorcycle. The motorcycle then accelerated past NS106 in a westerly direction on Scarborough Beach Road. There is no doubt the motorcycle rider would have realised there was a marked police vehicle behind him once he executed the U-turn and it is likely he observed the police vehicle U-turn in his rear vision mirror. The motorcycle accelerated away from NS106 and was lost from sight as it rounded the bend on Scarborough Beach Road near Hancock Street. There were no lights or sirens activated on NS106 at that point. There was no intercept in operation.

⁶ Ex 1, tabs 17 & 18, t 12.10.17, p6-7

⁷ t 12.10.17, p34

Once NS106 had completed the sweeping left hand bend neither Sutherland or Weir were able to see the rear tail light of the motorcycle and concluded it must have turned down a side street.⁸

Sutherland turned off Scarborough Beach Road to the right and the two police officers drove along the streets in the area to see if they could observe the motorcycle. Neither police officer is sure of the street they were on when they drove in a southerly direction back towards Scarborough Beach Road and discussed they would continue with their task towards Tuart Hill. Before they reached the intersection a motorcycle rode in a westerly direction on Scarborough Beach Road to their south.

The motorcycle passed from their left to right and appeared to be travelling at the speed limit (60 km/h).⁹ Weir believed the motorcycle matched the appearance of the rider and motorcycle they had observed earlier and they made a decision to again follow the motorcycle, rather than return to Tuart Hill, in an effort to obtain the registration number. Sutherland turned right instead of left onto Scarborough Beach Road and travelled in a westerly direction while accelerating towards the rear light belonging to the motorcycle. Sutherland then saw the motorcycle's left

⁸ Ex 1, tab 17

⁹ t 12.10.17, p23

indicator flashing. Weir was puzzled he still could not see the registration number of the motorcycle clearly.¹⁰

The rider of the motorcycle completed the left hand turn into Westview Street and was then travelling in a southerly direction. The police believe they were only 20-30 metres behind the motorcycle. As the police vehicle rounded the corner Sutherland initiated the police lights to indicate to the motorcycle rider the police wished him to stop.

The motorcycle rider pulled to the left and entered the Scarborough Library car park on the left on Westview Street on Brodie Lane. The motorcycle was travelling at low speed and both police officers believed the rider was intending to comply with their request to stop and pull over. In evidence Weir stated it may have been possible for him to see the registration number at that point because they were very close, however, his focus was on the rider and not the registration at the time he believed the rider was intending to stop. Weir had started to disengage his safety belt with the expectation the motorcycle would stop and he would need to get out of NS106.¹¹

Instead of stopping in the car park the motorcycle rider continued through the car park and then exited back onto Westview Street and accelerated away south, towards Brighton Road.

¹⁰ Ex 1, tab 18

¹¹ † 12.10.17, p24

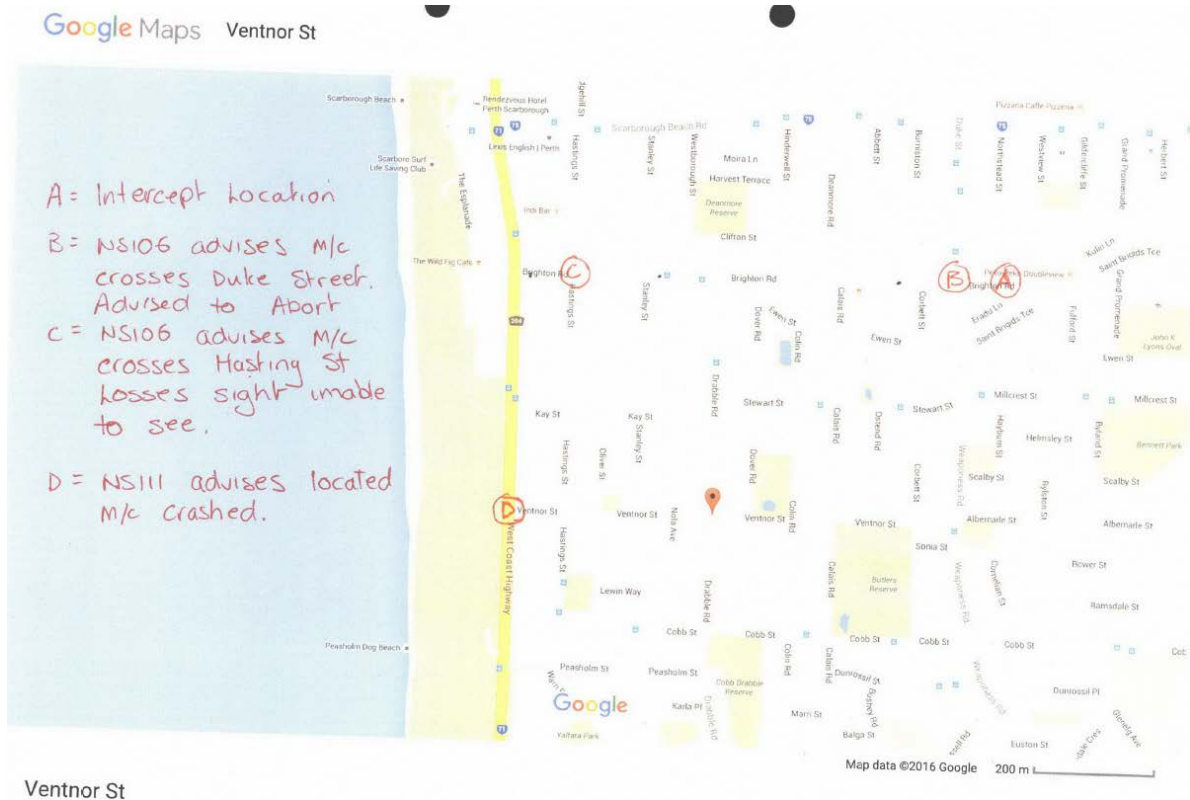


Exhibit 1, tab 14 – Google Map Intercept

Sutherland accelerated after the motorcycle with the emergency lights still active and added the sirens, while Weir used the police radio to alert POC to the fact they had attempted to stop a motorcycle which was now attempting to evade them.¹²

The recording of the radio exchange between NS106 and POC clearly covers Weir’s attempt to attract the attention of POC and, in the background of the recording the siren can be heard.¹³ By the time the protocols were completed for the appropriate supervision of a POCCC to oversee the failed

¹² t 12.10.17, p8
¹³ t 12.10.17, p30

intercept the motorcycle had already turned right and would have been headed in a westerly direction on Brighton Road.

Weir advised POC of their position, classification and driver qualification. NS106 was advised to keep calling while the input of the POCCC was obtained. In order to keep calling it was necessary NS106 maintain visual sight of the motorcycle and to do so involved acceleration beyond the speed limit for Brighton Road, permitted for a priority 1 driver. There was general input over the radio concerning information related to the failed intercept of the motorcycle and the availability of other resources to conclude the matter.

It is then apparent POCCC approached the call operator in contact with NS106 and advised NS106 to “*abort*”.¹⁴

Weir estimated this was in the vicinity of Weaponess Road intersection with Brighton Road and he confirmed with POC they had downgraded and aborted, shortly before the intersection with Calais Road. At this point the motorcycle had been drawing away from NS106 and was about 300 metres ahead of them on Brighton Road. The lights and sirens for NS106 had been turned off and Sutherland had returned to the posted speed limit.

¹⁴ Ex 1, tab 39, Ex 2

NS106 continued down Brighton Road, but did not have the motorcycle in sight although they knew it had last been travelling towards the intersection of WCH. At the roundabout of Brighton Road and Hastings Street, Sutherland stopped NS106 and asked pedestrians if they had observed the motorcycle. They were told the pedestrians had not seen it.¹⁵ Sutherland returned to NS106 and continued in the direction of WCH.

West Coast Highway

Slightly earlier in the evening Senior Constable John Cream (Cream) and First Class Constable Adrian Ng (Ng) had been conducting patrols and enquiry duties in NS111. It was a police Toyota Hilux utility and was classified as a class 2 vehicle. Cream was driving and they had been patrolling the Scarborough central business district adjacent to the beach. As Cream pulled up to the intersection of Manning Street with the WCH to turn right onto WCH they overheard the radio transmission of NS106 with POC indicating a black motorcycle had failed to stop and was last seen travelling on Brighton Road.¹⁶

Cream continued to drive NS111 at the speed limit south on WCH towards the intersection with Brighton Road. As they passed the White Sands Tavern both police officers observed a black motorcycle turn, at high speed, through the traffic

¹⁵ † 12.10.17, p16

¹⁶ † 12.10.17, p37

control lights from Brighton Road onto WCH. They noted the motorcycle accelerated hard in a southerly direction and had disappeared out of sight as they passed the Brighton Road intersection themselves.¹⁷ Cream is an experienced motorcycle rider and he recognised the motorcycle as a high performance Ducati and heard three gear changes before the motorcycle passed out of sound. Cream advised it was in at least 4th gear when he had last seen it riding south on the WCH.¹⁸ Cream stated he had researched the Ducati model and its credentials included the ability to exceed 200 km/h under full acceleration in 4th gear in less than 400 metres.

NS111 was travelling at the posted speed limit of 60 km/h. As NS111 drove through the Brighton Road/WCH intersection Cream looked left down Brighton Road, but could not see any evidence of police emergency lights or hear police emergency sirens.¹⁹ Cream continued south along WCH at 60 km/h.

The Intersection of Ventnor Street and WCH

At roughly 10.42 pm Mr Ross Oliver was driving a Toyota Tarago Wagon west on Ventnor Street. The Ventnor Street intersection with WCH has a stop sign facing Ventnor Street. It was Mr Oliver's intention to drive across the southbound lanes of WCH and turn right at the median

¹⁷ t 12.10.17, p49

¹⁸ t 12.10.17, p42, Ex 1, tab 19

¹⁹ t 12.10.17, p39,49

access into the northbound lanes to travel towards Joondalup.²⁰ Other motorists who observed the Toyota described it as moving slowly towards the intersection before moving across the southbound lanes towards the median access.

Mr Oliver no longer has any recollection of events at the intersection other than his intention had been to turn right onto WCH. His first recollection after the event was of a civilian passer-by patting his hand in an attempt to rouse him.²¹

However, immediately after the incident while he was in hospital, he spoke to Senior Constable Rita Cobanov (Cobanov). Cobanov had approached Mr Oliver while he was in the trauma unit at Royal Perth Hospital on 8 February 2016. Mr Oliver was with his wife and son and she asked him whether he had any memory of the crash. Mr Oliver indicated he did and when he was asked about seeing the motorcycle his response was *“yes I do, it had its lights on and it was way away when I pulled out”*. He also confirmed that he had not seen any lights or heard any sirens on the road at the time of the incident.²²

In evidence Mr Oliver stated he could no longer recall that detail, however, he was confident he would only have said

²⁰ t 12.10.17, p56

²¹ t 12.10.17, p54

²² Ex 1, tab 28, t 12.10.17, p56

that if it were true. He further advised he had been driving for in excess of 40 years and it was not his habit to make a right hand turn across traffic if he believed it posed a threat, as a well experienced driver.²³

Mr and Mrs Gilchrist were also driving south on WCH in a Hyundai Trophy. Mr Gilchrist is a retired paramedic and had worked with St John Ambulance (SJA) for 18 years.

Mrs Gilchrist was driving and her husband was in the front passenger seat. They were driving in the left hand southbound lane slightly under the speed limit, following a silver Holden Commodore.

As their vehicle approached Ventnor Street Mr and Mrs Gilchrist saw the Toyota travel slowly across the intersection towards the median access. Mr Gilchrist did not believe the Toyota was travelling under acceleration and was concerned there may have been a problem with the driver.²⁴ He had not observed the motorcycle at that stage. The Toyota had travelled across the northbound lanes and had come to rest on the kerb on the west side of the northbound carriageway.²⁵

Mr Gilchrist walked across to the Toyota to examine the driver and realised there had been a crash because the

²³ † 12.10.17, p55

²⁴ Ex 1, tab 30

²⁵ Ex 1, tab 33

Toyota was extensively damaged at the driver's door. He established the driver of the Toyota was able to recall his name.

Due to the damage Mr Gilchrist looked around and saw a cloud of smoke in the vicinity of the median strip with a very badly damaged motorcycle. He then saw the deceased lying on the road on his back and went to assist.

Meanwhile Benjamin Arthur and his mother, Jennifer Doogan, had been travelling north on WCH in the northbound lanes. They observed the Toyota in the intersection and described the Toyota as appearing "*to bounce across the road*". Mr Arthur's immediate view was the Toyota must have hit the median kerb and bounced off the kerb. Mrs Doogan, who was driving, immediately stopped their vehicle and Mr Arthur went to check on Mr Oliver while his mother called for an ambulance. Mrs Doogan's phone records this call as having been made at 10.44 pm.²⁶

Mr Arthur was the first person to approach Mr Oliver and noted he appeared to be conscious, but dazed. It was at that point Mr Arthur noticed the motorcycle in the road in the slip lane and the deceased lying on the road. Mr Arthur confirmed another gentlemen, presumably Mr Gilchrist,

²⁶ Ex 1, tab 34

came over to assess the Toyota driver and then went and attended to the motorcycle rider.²⁷

Mr Arthur and Ms Doogan were adamant that at the time of the incident there were no police vehicles in the vicinity of the crash, nor did they see or hear any emergency lights or sirens.²⁸

It was Mr Gilchrist's recall he assisted police officers, however, the evidence of the other civilians and the police indicated Mr Gilchrist arrived at the deceased before the police arrived and was attempting to assist the deceased when the police officers in NS111, travelling south, came across the crash scene.²⁹

Cream and Ng confirm that at the intersection of Ventnor Street they came across the crash soon after it had occurred. Cream observed the Toyota parked across the northbound lanes at an angle to the pine logs on the western most side. At the time the police arrived there were several civilians in attendance. Cream looked in the median access strip and saw the black motorcycle he had observed shortly before on its side with smoke coming from the motor. After he had seen the motorcycle Cream noticed the deceased lying on his back still wearing a helmet with an elderly male, presumably Mr Gilchrist talking to the

²⁷ Ex 1, tab 33

²⁸ t 12.10.17, p73, 76

²⁹ t 12.10.17, p50, 74, 76

deceased and attempting to reassure him. Cream noted the Toyota driver door had extensive damage.

As Cream stopped the police vehicle Ng advised POC on the radio channel that the motorcycle that had been mentioned beforehand appeared to have crashed at the intersection of Ventnor Street and requested an ambulance urgently. This is recorded as happening at approximately 10.45 pm.³⁰ Once he had requested an ambulance Ng attended to the deceased with Mr Gilchrist. He was still wearing his helmet and he was clearly very badly injured. Mr Gilchrist advised Ng he was a retired paramedic and removed the driver's helmet.

NS106 had heard NS111 advise POC there had been a crash between a motorcycle and a car at the intersection with Ventnor Street and they drove to the incident to assist. They could see the lights of NS111 blocking off traffic as they approached the intersection of Ventnor Street. Sutherland in NS106 parked about 20 metres before the crashed motorcycle and left NS106 with its emergency lights operating as a warning to approaching vehicles. Weir walked to the deceased and noticed there was both the damaged motorcycle and a damaged vehicle further across the intersection. Mr Gilchrist advised Weir he was a retired ambulance officer and instructed Weir to undo the deceased's helmet. Weir supported the deceased's head

³⁰ Ex 1, tab 20

while Mr Gilchrist completed removing the helmet and assessed the condition of the deceased.

At this stage other police officers had attended to assist and control the area. Mr Gilchrist wanted an airway and Weir asked one of the other police to locate an airway from one of their vehicles. Weir tilted the deceased's head while Mr Gilchrist accessed his airway and kept hold of his head for full support. Very shortly thereafter the deceased stopped breathing and Mr Gilchrist commenced compressions while Weir maintained the stability of the deceased's head. Ng assisted Mr Gilchrist with CPR while Weir continued to support the deceased's head.

The ambulance patient care record records receiving the call with respect to the deceased as occurring at 10.46 pm with their arriving at the intersection at 10.57 pm.³¹ When they arrived Mr Gilchrist was still conducting CPR with Ng and Weir assisting and Weir could see Mr Gilchrist was getting tired so he continued with compressions while Mr Gilchrist supported the deceased's head. Ng and Weir stopped assisting once the paramedics had stabilised the deceased and transferred him to the ambulance ready for him to be taken to the hospital.

The most senior police officer to have arrived at the scene, post the crash, advised the police officers that due to their

³¹ Ex 1, tab 10

possible involvement with the deceased earlier in the evening they were to be separated and not to speak to one another until they had spoken to investigators. At that time Sutherland, Weir, Ng and Cream moved away from the immediate scene and isolated themselves until they were advised they could leave the area.³²

Royal Perth Hospital

The deceased was taken by ambulance to Royal Perth Hospital (RPH) where he was assessed as being in traumatic cardiac arrest from which he could not be revived. He was declared dead shortly before midnight on 6 February 2016.³³

Post Mortem Report

The post mortem examination of the deceased was undertaken on 9 February 2016 by Dr Clive Cooke, Chief Forensic Pathologist at the PathWest Laboratory of Medicine WA.

The examination showed a severe chest injury with fractures to the ribs and the breast bone with internal bleeding associated with laceration of a number of the thoracic internal organs including the heart and lungs. There were no further significant internal injuries and little

³² Ex 1, tab 18

³³ Ex 1, tab 11

evidence of natural disease.³⁴ There were some healing abrasions and older bruising on the left foot and ankle.

Toxicology revealed a level of amphetamine and methylamphetamine in the deceased's system consistent with intoxication with amphetamines. While the level was not excessive in an experienced user it was in the range where the empirical evidence indicates a rider would not be in full control and their judgement would be impaired at that level of intoxication.³⁵

POLICE ACTIONS

Review of the available information with respect to the events in the vicinity of Westview Street, Doubleview, confirm the police officers in NS106 complied with all procedures expected of them with respect to a vehicle intercept and the EDPG. It was a routine law enforcement role.

There is still a lack of clarity surrounding the issue of when a failed intercept becomes a pursuit and the elapse of time, and distance, between the ability for POC to appropriately supervise events. Both Inspector Bordin (POCCC for the event) and Weir and Sutherland confirmed their understanding of a "pursuit" was that it commenced at the moment an intercepted target vehicle failed to stop, and the

³⁴ Ex 1, tab 4

³⁵ Dr Joyce: General advice on driving impairment due to drugs – 22.06.2000

police officers conducting the intercept made the decision to continue in an attempt to intercept the vehicle while seeking instructions from POCCC.³⁶ Sutherland and Weir were also quite clear that, regardless of instructions from POCCC, either one of them retained the ability to abort the pursuit at any time.³⁷

This leaves a time lag as to appropriate driving, but not risk assessment between the target vehicle failing to stop and the relevant police vehicle providing POCCC with appropriate information for the event. To be able to provide POC with relevant information it is necessary the police maintain sight of the offending vehicle to enable them to provide information which may assist POC make a determination as to the best resolution of the incident.³⁸ Certainly, it remains the responsibility of the police driver and passenger to risk assess and abort the pursuit pending any decision by POCCC, in the event they consider the circumstances warrant it.

Reconciliation of the available data for relevant events in this case provided the following time line. The first request by NS106 for POC supervision occurred at 10.42.47 pm on 6 February 2016. NS106 was able to provide basic information at 10.43.06 pm as they turned right onto

³⁶ t 12.10.17, p18, 32, 58, 65

³⁷ t 12.10.17, p31

³⁸ t 12.10.17, p18, 61

Brighton Road.³⁹ That information warranted the call taker activating input from POCCC while NS106 continued to provide relevant information.

At 10.43.29 pm NS106 was advised to keep providing information while a general call was made for the location of other available resources. POCCC at that point advised NS106 to abort their pursuit, that is return to the posted speed limit and turn off all warning lights and sirens at 10.43.46pm. NS106 was asked to provide POCCC with their latest information. NS106's siren can be heard on the transmission at 10.42.47 pm. It cannot be heard on their acknowledgement they have already downgraded at 10.43.56 pm where they advise they cannot provide a registration number and that the rider is wearing a helmet and about to go out of sight.

The time lag involved is one minute and the AVL data indicates NS106 reached speeds of approximately⁴⁰ 105 km/h while on Brighton Road and the motorcycle rider drew away from NS106. That was the extent of the pursuit before it was aborted.

The deceased was travelling at speed and certainly it was his intention to evade police. There was no active pursuit at the time he turned left at WCH but he continued at speed as

³⁹ Ex 1, tab 39; Information provided by IAU post inquest on request.

⁴⁰ Correspondence to OSC on 31 March 2017 from WAPol Communications Division Support as to accuracy of AVL speed data (+2.5 km/h) and location where speed is an average over given distances. † 12.10.17, p61

evidenced by the observations of the police officers in NS111, who did not activate lights and sirens or pursue.⁴¹

At 10.44.56 pm NS111 called the crash in with a request for urgent SJA attendance. At 10.44.41 pm the AVL data indicated NS106 was still on Brighton Road before the intersection with WCH and did not arrive at the crash location to assist until 10.46.13 pm. So while the crash occurred in less than one minute from the conclusion of the pursuit, it occurred at some distance from the point the pursuit was aborted and out of sight of NS106. The police officers in NS106 were at all times acting in the course of their proper law enforcement duties and during the time lag between intercept and conclusion of the pursuit were making appropriate risk assessments, also part of their duties.

The problem is whether the period covered by the time lag can reasonably be termed part of the intercept and the speeds permissible under the EDPG for an intercept, when it is clearly already a pursuit on the wording of the EDPG as acknowledged by Sutherland, Weir and POCCC for the incident, and different speed considerations, but not risk assessments, apply.

Police officers Sutherland and Weir both advised the court they were seriously distressed by the events of 6 February

⁴¹ † 12.10.17, p38, 41

2016, and since that time have not attempted to follow a motorcycle specifically, once it had not stopped when requested to stop by police.⁴² Inspector Bordin advised the court as far as he was concerned it was “*quite obvious, I shut it down*” in view of the risks of attempting to continue with an intercept of a motorcycle rider who had clearly demonstrated a determination to evade police without any other information.⁴³

The actions of the deceased in this case in appearing to stop, and then accelerating away hard on a motorcycle, reflect a determination to evade police and consequently a high likelihood he would risk take. This was likely to be in the form of speed and evasive actions.

I note the police officers in NS106 are unlikely to attempt to follow a motorcycle in suburban conditions again without good indication of known reasons to continue with a pursuit.

The evidence of Cream as to the deceased’s exit from Brighton Road onto WCH, when it was evident there was no longer a pursuit in operation, would indicate the deceased was a determined risk taker and probably supports the proposition he was prepared to take serious risks to avoid apprehension by police.⁴⁴

⁴² t 12.10.17, p18, 28

⁴³ t 12.10.17, p64

⁴⁴ t 12.10.17, p41

This is supported by the later discovery, unknown to any police officers at the time, that the Ducati was stolen and the registration plate was false.⁴⁵ The material out of which the false plate was constructed was one of the reasons Weir was unable to observe a registration number. Added to this the deceased's level of amphetamine intoxication would support the proposition the deceased was a risk taker and had good reason to wish to evade the police.

The same considerations also apply to the law enforcement perspective, the deceased was a potential danger to himself and others on the road, regardless of the observations of police in NS106 on Westview Street. It is one of the tensions always present for police in balancing law enforcement with community welfare.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 34 year old male with a partner, who was responsible for a number of children, two of which lived with the deceased and his partner.

The deceased's partner advised counsel assisting the deceased would choose to evade police and would not stop when required to do so, regardless of the situation.⁴⁶

⁴⁵ Ex 1, tab 7, tab 9

⁴⁶ Discussion post evidence 12.10.17

I am satisfied that on the night of 6 February 2016 the deceased had consumed amphetamines, probably in the form of methylamphetamine, and was intoxicated. I do not believe the deceased was a naive amphetamine user which means he had some tolerance to amphetamine intoxication, however, I am satisfied he would have been intoxicated to the extent his judgement was impaired, although I do not doubt he was generally a competent rider.⁴⁷ That intoxication would also have promoted a sense of invulnerability and confidence he could risk take with impunity.

The deceased was riding a high performance motorcycle which, aside from the speed it was able to achieve in a short distance, was stolen, displaying a fabricated number plate and being ridden at a speed which attracted attention. The police in NS106 were unaware of the fact the motorcycle was stolen, the number plate was fabricated and the deceased was intoxicated with methylamphetamine, but the speed and riding of the motorcycle certainly attracted their attention. The deceased had a number of reasons to try and evade police and so was motivated to risk take when required to stop.

Unfortunately, while he successfully outran the police on Brighton Road following their attempt to stop him and question him about his earlier speeding, he did not desist

⁴⁷ t 12.10.17, p42

from traveling at speed once he had evaded the police. It is clear he accelerated out of Brighton Road and turned left onto WCH, at speed, as the lights changed. He continued down WCH at an excessive speed.

The motorcycle he was riding was observed by Mr Oliver to be in the distance, but Mr Oliver did not believe the motorcycle would pose a problem to him in the Toyota when moving into the median strip of WCH, to turn right.

The deceased was mistaken as to his ability to control all factors while traveling at that speed. He was obviously unable to avoid impact with the Toyota as it approached the median access to turn onto the northbound lanes of Scarborough Beach Road. The impact sent the Toyota across the northbound lanes into the logs at the boundary on the west side of WCH and the impact damage to the Ducati and the Toyota indicated the deceased's motorcycle impacted with the Toyota at speed in the vicinity of the driver's door. Both Mr Oliver and the deceased received serious injuries.

Unfortunately, despite prompt intervention with CPR at the time he arrested, the deceased could not be saved and died shortly thereafter at hospital.

Mr Oliver was also taken to hospital and received treatment. He has recovered, although he has a permanent disability as a result of the crash.⁴⁸

MANNER AND CAUSE OF DEATH

I am satisfied the deceased died as the result of the injuries he received when the Ducati he was riding impacted with the driver's side of the Toyota, at speed, as he rode south on WCH at the same time Mr Oliver in the Toyota attempted to travel west across the southbound lanes into the northbound lanes.

I find death occurred by way of Accident.

COMMENTS ON THE ACTIONS OF THE POLICE

As previously stated the deceased had good reasons for wishing to evade the police and similarly the police were appropriately involved in law enforcement, when they attempted to intercept the rider of the motorcycle and determine the reasons for the deceased's speeding, and the registration number of the motorcycle. The facts of this case emphasise the tension for police officers between appropriate law enforcement and appropriate risk assessment. This is particularly of concern where there will inevitably be a time lag between the failure of a vehicle to

⁴⁸ † 12.10.17, p55

stop and the appropriate authorisation of a pursuit in compliance with the Commissioner's EDGP.

In this case WAPol Internal Affairs Unit (IAU) were satisfied the Police Commissioner's EDGP had been appropriately followed and that the police involved aborted the attempt to stop the motorcycle as soon as they were instructed to do so by POCCC. The policy surrounding appropriate risk assessment requires individual police officers to appropriately risk assess during all aspects of emergency driving and it is unlikely the police officers in NS106 will contemplate following a motorcycle in the given circumstances again, despite the fact there were no issues with their risk assessment. It was clear the deceased was highly motivated to evade police and so would involve himself in risk taking behaviour regardless of the police presence. This is supported by the fact the deceased, once on WCH, continued at speed when there was no reason for him to do so other than his intoxication and knowledge the motorcycle was stolen with fabricated plates.

Motorcycles at speed are vulnerable and the AVL data, as imprecise as it may be, clearly supports the proposition the deceased was speeding from the speeds NS106 reached, while the motorcycle was still able to evade NS106 and disappear from sight.

The decision from POC was also, to quote Inspector Bordin, “*obvious*” in view of the fact it was a motorcycle and it was traveling at speed in all the relevant circumstances. It was unknown to everybody there was a reason for the police officers in NS106 not to be able to read the registration number.

Appropriate risk assessment was paramount and supported the non-continuation of any form of pursuit, regardless of the fact the motorcycle rider was clearly breaching the law and a danger to himself and others on the road. This case, for police, emphasises the tension between law enforcement and appropriate risk assessment, taking into account the fact that not only the deceased died, but a completely uninvolved bystander was permanently injured as a direct result of the deceased’s breach of the posted speed limits.

The only other issue which may have been useful for the purposes of the inquest and an understanding of all the circumstances surrounding the death was the desirability for more understanding of the speed at which the Ducati was actually travelling at the time of impact with the Toyota. The crash investigators were unable to determine the speed of the Ducati or the Toyota from the physical evidence at the scene.⁴⁹ I am unable to determine whether crumple analysis would have assisted police investigators to calculate the relative speeds at impact, and have

⁴⁹ † 13.10.17, p84

commented in previous inquests there may be some benefit to WAPol in having some of its crash investigators trained in crash impact analysis, although I understand there is some concern it is too imprecise a measure of actual speed to provide relevant input where there are already speed limits in place.

In this case some of the deceased's family were concerned the police were specifically targeting the deceased. They did not appreciate the speed at which the motorcycle was ridden as the factor attracting police attention initially, nor the concern with community welfare as part of law enforcement. Insensitive social media comment did nothing to help the deceased's partner understand the facts and circumstances surrounding the deceased's death. She had been left with unanswered concerns while attempting to care for a number of children without the support of the deceased. It is hoped some participation in the inquest process has assisted her in understanding the course of events.

E F Vicker
Deputy State Coroner
22 January 2018