Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 29/16

I, Barry Paul King, Coroner, having investigated the death of ***Jason Barry Winchester*** *with an inquest held on* ***1 and 2 September 2016*** *at the* ***Perth Coroner's Court*** *find that the identity of the deceased person was* ***Jason Barry Winchester*** *and that death occurred on* ***29 January 2014*** *at* ***Sir Charles Gairdner Hospital*** *from* ***complications of head injury*** in *the following circumstances:*

Counsel Appearing:

Ms K E Ellson assisting the Coroner
Mr G J Huggins (WA Police Service) appearing on behalf of the Commissioner of Police, Senior Constable J Mora and Senior Constable W B Elston

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INTRODUCTION

1. Jason Barry Winchester (**the deceased**) died in Sir Charles Gairdner Hospital 29 January 2014 from injuries he sustained on 11 November 2013 when he crashed a motorcycle into the front of a stationary car.

2. Just prior to the crash, a police officer carrying out a traffic speed check on foot had directed the deceased to pull over to the side of the roadway in which he was travelling. Instead of complying with the police officer's direction, the deceased accelerated the motorcycle and swerved off the roadway. He returned to the roadway a short time later but lost control of the motorcycle and crashed into the car. He was thrown over the car and hit the road surface, sustaining a severe head injury from which he did not recover.

3. Under s 3 of the *Coroners Act 1996* (**the Act**) the term '*reportable death*' is defined to include a Western Australian death that appears to have been unexpected, unnatural or violent or have resulted, directly or indirectly, from injury. The deceased's death was therefore a 'reportable death' under the Act.

4. Under s 19 of the Act, a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death.

5. Section 22(1)(b) of the Act requires a coroner who has jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death and it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

6. As it appeared possible that the actions of the police officer could have contributed to the deceased's

death, an inquest into the death of the deceased was considered mandatory under the Act.

7. I held an inquest into the deceased's death on 1 and 2 September 2016 at the Perth Coroner's Court.

8. One of the primary purposes of the inquest was to conduct an independent review of the actions of the relevant police officer.

9. The documentary evidence adduced at the inquest comprised reports and statements compiled by officers of the Internal Affairs Unit and the Major Crash Investigation Section of the Western Australia Police.[1] A report by clinical pharmacologist and toxicologist, Professor David Joyce, was included in that exhibit.[2] A copy of a St John Ambulance of Western Australia patient care record in relation to the deceased was also adduced.[3]

10. Inspector Eric Smith, who was the inspector in charge of critical incidents in the Internal Affairs Unit in the Western Australia Police at the material time, provided oral evidence of a report produced by that unit in relation to the actions of the police officers present at the crash.[4]

11. Eye-witnesses to the crash provided oral evidence of what they had seen.[5]

12. The two police officers present at the crash, including the officer who directed the deceased to pull over, also provided oral evidence.[6]

13. Due to the effects of the passage of time on witnesses' memories, there were often minor inconsistencies between witnesses' oral testimony and the contents of

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[1] Exhibit 1, Volumes 1 and 2
[2] Exhibit 1,Volume 2, Tab 30
[3] Exhibit 2
[4] ts 7-16 per Smith, E
[5] ts 16- 59
[6] ts 72-95 per Elston, W B; ts 96-104 per Mora, J

their statements provided closer to the date of death. Where such inconsistencies existed, I relied on the earlier statements.

THE DECEASED

14. The deceased was born in Perth on 9 May 1979, making him 34 years old at the time of his death. He was the younger of two sons. His mother and father were still alive but had separated several years previously. The deceased maintained contact with his mother but was estranged from his father. He was the father to a 10 year old daughter but was not married.[7]

15. The deceased completed year 10 at school and was self-employed as the manager of a furniture upholstery business. He was in good health and enjoyed going to a gym to engage in weight training.[8]

16. The deceased was a member of what police call an outlaw motorcycle gang, or OMCG, the Rebels Motorcycle Club. He never spoke to his mother about his activities with that club and he kept his involvement with it separate from his family lifestyle.[9]

THE POLICE SPEED CHECK

17. The evidence of the police officers and that of the independent witnesses was sufficiently consistent for there to be no need for me to provide an analysis of the evidence in order to determine the facts. The following is my distillation of that evidence.

18. At about 4.50 pm on 11 November 2013, two police officers attached to the Traffic Enforcement Group of the Western Australia Police, Senior Constable Jason

[7] Exhibit 1, Volume 1, Tab 3
[8] Exhibit 1, Volume 1, Tab 3
[9] Exhibit 1, Volume 1, Tab 3

Mora and First Class Constable Wesley Bryan Elston, (**the officers**) set up a speed check on Duffy Street in Carine, about 80 metres south of Monyash Road. The location was chosen because Duffy Street was a link road between Beach Road and Reid Highway, on which vehicles were known to regularly exceed the speed limit.

19. In the relevant location, Duffy Street is a north-south oriented suburban street with one lane in each direction. The speed limit there was 50 kilometres an hour.

20. The officers arrived at the speed check location on their motorcycles, which they parked on a paved area to the west side of Duffy Street. The police motorcycles were in plain view to motorists on Duffy Street.

21. The officers were each equipped with a laser speed measuring device. Senior Constable Mora was wearing a high-visibility police-issue polo shirt with reflective banding and police markings. Constable Elston was wearing a police-issue motorcycle jacket with reflective banding and police markings, over which he was wearing a police-issue high-visibility vest with similar markings.

22. The weather was fine and the visibility was good. The traffic conditions on Duffy Street were light to medium. There were no objects that could have prevented a clear and uninterrupted line of sight between the officers and approaching vehicles.

EVENTS LEADING UP TO THE CRASH

23. As the officers were setting up the speed check, the deceased was riding a Harley Davidson motorcycle south on what I infer to have been Tresise Street in Carine, which runs roughly parallel to Duffy Street to the east of it. The deceased was wearing a black

leather vest with Rebels Motorcycle Club insignia, known as colours, on it. He was wearing an open-face helmet and a face-mask.

24. The deceased did not have a driver's licence for the relevant class of motorcycle. The motorcycle had a stolen registration plate attached to it and had no Australian compliance plate fitted as required, indicating that it was a private import from the USA and had probably never been registered in Australia.[10]

25. From where they were located, the officers could hear the sound of the motorcycle's exhaust, which they thought may have been excessively loud. Constable Elston told Senior Constable Mora that, if the motorcycle should travel in their direction, he would stop it to check the exhaust.

26. It seems that the deceased turned right from Tresise Street onto, probably, Camelot Street and then turned right again onto Duffy Street to the south of the officers. He travelled north and overtook several cars by moving into the southbound lane.

27. Constable Elston could see and hear the deceased approaching from the south, so he stepped out into northbound lane of Duffy Street in front of other vehicles travelling north and then into the southbound lane. As he did so, the vehicles in the northbound lane slowed down and, by doing so, the distances between them reduced.

28. As the vehicles which the deceased was overtaking slowed down, the deceased was prevented from returning to the northbound lane. As he approached Constable Elston within 20 to 30 metres, Constable Elston yelled at him and directed him with his arm to pull over to the west side of Duffy Street in front of the northbound vehicles, which by this time were

[10] Exhibit 1, Volume 2, Tab 5; ts 16 per Smith, E

coming to a stop. Vehicles travelling south in the southbound lane were also coming to a stop due to Constable Elston's presence in the lane.

29. Rather than pulling over as directed, the deceased accelerated the motorcycle towards Constable Elston and, at the last moment, swerved to his right and passed Constable Elston's position. Just before he did so, Constable Elston jumped back to the northbound lane, almost colliding with Senior Constable Mora who had moved towards him to pull him out of the motorcycle's path.

30. By swerving to his right on the southbound lane, the deceased was forced to travel between southbound traffic and the eastern kerb of Duffy Street. He managed to avoid the first southbound vehicle, but the rear tyre of the motorcycle mounted the kerb. The deceased travelled for a short distance at about 60 kilometres an hour with the rear tyre on the kerb before the motorcycle's front wheel struck something, perhaps the kerb of a driveway, and rose up.

31. The deceased managed to return the motorcycle to the roadway, but as the rear tyre came off the kerb, he accelerated, lost control and crashed head-on into a small car that had stopped when the driver had seen the motorcycle coming towards him. The force of the crash broke both of the motorcycle's forks. The deceased was thrown over the car and landed on the roadway behind it, sustaining serious injuries. The occupants of the car were unhurt.

AFTER THE CRASH

32. When he saw the crash, Constable Elston put on his helmet, got onto his motorcycle and rode to where the deceased was lying in the road. As he was doing so, a fourth-year medical student, who had been driving the northbound vehicle closest to Constable Elston when the deceased drove past him, rushed up

and assisted him to look after the deceased until ambulance paramedics arrived.[11] She removed the deceased's helmet and Constable Elston removed the deceased's face mask. Constable Elston took a jacket out of his motorcycle pannier to use as a pillow for the deceased's head.[12]

33. When the paramedics attended, the deceased was aggressive and uncooperative, so the paramedics requested that police officers search him before they placed him in the ambulance.[13]

34. The police constable who searched the deceased removed the deceased's bum bag and found in it two clip-seal bags containing a white crystalline substance suspected to be methylamphetamine and two driver's licences that did not belong to the deceased.[14]

35. The paramedics took the deceased to the emergency department at Sir Charles Gairdner Hospital where a blood sample was taken from the deceased for toxicological analysis.[15] The analysis showed methylamphetamine at 0.4 mg/L and amphetamine at 0.02 mg/L.[16]

36. The deceased underwent emergency surgery for severe traumatic brain injury and was admitted into the intensive care unit in an induced coma, but he died from his injury on 29 January 2014.

37. The crystalline substance found in the deceased's bum bag was not analysed because no criminal charge could be laid.[17]

[11] Exhibit 1, Volume 1, Tab 8, p.38; Exhibit 1, Volume 1, Tab 12
[12] Exhibit 1, Volume 1, Tab 8, p.12
[13] Exhibit 1, Tab 2.4, p.2
[14] Exhibit 1, Volume 2, Tabs 24 and 19
[15] Exhibit 1, Volume 2, Tab 28
[16] Exhibit 1, Volume 1, Tab 25
[17] Exhibit 1, Volume 1, Tab 2.1

CAUSE OF DEATH

38. Forensic pathologists Dr J White and Dr D M Moss conducted post mortem examinations of the deceased on 30 January 2014 and found evidence of a recent head injury with severe brain swelling, a linear posterior skull fracture and neurosurgical intervention. The lungs were heavy and fluid-laden, and microscopic examination showed widespread bronchopneumonia. Microbiology showed methicillin resistant *Staphylococcus aureus* in both lungs.[18]

39. Dr White formed the opinion that the cause of death was complications of head injury.[19]

40. I am satisfied that the deceased crashed his motorcycle into a car and sustained a head injury, which led to complications, including bronchopneumonia, which caused his death.

ACTIONS OF THE POLICE OFFICERS

41. The evidence established that the officers acted appropriately in all aspects of their involvement with the deceased. They set up a standard speed check on a suburban road and attempted to carry it out in accordance with departmental policy.

42. The evidence of independent witnesses established that the deceased must have been aware that the person standing in the southbound lane and directing him to pull over was a police officer.

43. I am satisfied that the actions of the officers did not contribute to the deceased's death.

44. Constable Elston deserves particular commendation for his actions in rendering the deceased assistance following the crash, especially considering that he

[18] Exhibit 1, Volume 1, Tab 24
[19] Exhibit 1, Volume 1, Tab 24

believed at the time that the deceased had deliberately driven the motorcycle at him.

HOW DEATH OCCURRED

45. I find that death occurred by way of misadventure.

THE RELEVANCE OF THE METHYLAMPHETAMINE

46. Recently there has been a great deal of publicity in relation to the multifaceted social problems caused or increased by the use and abuse of methylamphetamine. The deceased's case is yet another example.

47. In his report dated 16 June 2016, Professor Joyce provided the following:

> Mr Winchester had blood concentrations of methylamphetamine and amphetamine that indicated a state of intoxication at the time of driving and predicted driving impairment. Mr Winchester's apparent aggression towards the police office(r), his decision to flee, his impetuosity, his continuing to accelerate even after narrowly missing the first oncoming car and his preparedness to continue in the face of such danger are highly characteristic of intoxication with methylamphetamine.
>
> Risk-taking behaviours, such as deciding to drive without a licence, and background illegal activity (as implied by the stolen registration plates and the white powder on his person) may, themselves, be partly due to methylamphetamine effects on personality and decision-making.[20]

48. It seems likely that a combination of methylamphetamine-induced foolhardiness and a

[20] Exhibit 1, Volume 2, Tab 30.1

desire to avoid detection of criminal activity stoked the deceased's decision to take the significant risks that led to his death.

49. It must be noted that in doing so, the deceased also risked injuring or killing other members of the community. A complete indifference to the outcome of a serious crash is, as Professor Joyce points out, a surprising characteristic of the methylamphetamine-intoxicated driver.[21]

50. A frightening statistic provided by Professor Joyce is that, in Australia, North America and Western Europe, amphetamine-type drugs are among the most prevalent drug classes found in impaired drivers.[22]

CONCLUSION

51. The evidence made clear that the deceased died as a result of his own deliberate actions.

52. While it might be argued that he would not have done so but for the fact that police officers had tried to stop him, there is no doubt that they were carrying out their duties diligently and appropriately. There is no basis for concluding that they were in any way responsible for the deceased's actions.

B P King
Coroner
2 December 2016

[21] Exhibit 1, Volume 2, Tab 30.1
[22] Exhibit 1, Volume 2, Tab 30.1