



Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 32/19

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of **Daniel Paul HILDER** with an inquest held at the **Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth** on **15 August 2019** find that the identity of the deceased person was **Daniel Paul HILDER** and that death occurred on **8 July 2016** at **Royal Perth Hospital** as a result of **multiple injuries** in the following circumstances:*

Counsel Appearing:

Ms F Allen assisted the Coroner.

Ms P Aloï (State Solicitor's Office) appeared on behalf of the Western Australia Police Force.

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SUPPRESSION ORDER

On the basis it would be contrary to the public interest, I make an order under s49(1)(b) Coroners Act 1996 that there be no reporting or publication of the details of any of the versions of the WA Police Emergency Driving Policy and Guidelines, including, but not limited to, any cap on the speed at which police officers are authorised to drive.

INTRODUCTION

1. Daniel Paul Hilder (the deceased) died at Royal Perth Hospital on 8 July 2016 from multiple injuries after he lost control of the car he was driving and collided with a brick wall. He was 36 years of age.¹
2. At the time of his death, the deceased was attempting to evade police and pursuant to the *Coroners Act 1996* (WA) (Coroners Act) his death was a “reportable death”.²
3. Further, because the deceased’s death may have been caused or contributed to by a member of the Western Australia Police Force (WA Police), a coronial inquest is mandatory.³
4. I held an inquest into the deceased’s death on 15 August 2019. The documentary evidence adduced included reports by WA Police’s Internal Affairs Unit (IAU)⁴ and Major Crash Investigation Section (MCIS)⁵ concerning the circumstances of the deceased’s death. The Brief of evidence comprised one volume.
5. The inquest focussed on the conduct of police officers prior to the crash, and whether the police officers complied with relevant policies and procedures.
6. The following witnesses gave oral evidence at the inquest:
 - i. Constable Logan Wichman (Officer Wichman);
 - ii. Sergeant Neil Worland (Officer Worland);
 - iii. Detective First Class Constable Cameron Outred (Officer Outred); and
 - iv. Mr Trevor Douglas, formerly Detective Sergeant (Mr Douglas)⁶.
7. At the conclusion of the inquest hearing, I observed that there was nothing in the evidence before me to suggest that police officers contributed to, or caused the deceased’s death.

¹ Exhibit 1, Vol.1, Tab 6, Post Mortem Report

² Section 3, *Coroners Act 1996* (WA)

³ Section 22(1)(b), *Coroners Act 1996* (WA)

⁴ Exhibit 1, Vol. 1, Tab 9, Report - IAU

⁵ Exhibit 1, Vol. 1, Tab 3, Report - MCIS

⁶ At the relevant time, Mr Douglas was a Detective Sergeant attached to IAU. He has now retired from WA Police.

THE GUIDELINES

8. Emergency driving by officers of the WA Police is regulated by a policy referred to as: TR-07.04 Emergency Driving Policy and Guidelines (the Guidelines).⁷
9. At the relevant time, the Guidelines identified four categories of emergency driving, namely: vehicle interception; priority 2 driving; priority 1 driving and pursuit driving. According to the definitions in the Guidelines, an attempt to stop a motor vehicle for the purpose of law enforcement (vehicle intercept) can become a pursuit when, for whatever reason, the driver of the vehicle being intercepted does not stop when called upon to do so.⁸
10. Clearly, pursuit emergency driving carries risks, as the Guidelines note:

*All instances of 'Pursuit Emergency Driving' places an onerous duty on police that weighs heavily in favour of the need for prudence, restraint and the absolute commitment to the protection of life.*⁹

11. The Guidelines set out requirements with respect to the qualifications of the pursuit driver, the class of police vehicle which may be used for a pursuit, and the obligations of a police pursuit driver, before, during and after the pursuit.¹⁰ A critical aspect of the pursuit is the risk assessment process. Risk assessment means:

*The process, either mental or written, of obtaining and processing information to determine the degree of risk posed to all involved in the response and management (includes police, road users, the community and the occupants of the target vehicle).*¹¹

12. Factors that impact on the risk assessment process include: an assessment of threats to the safety of any person, threats to property, the seriousness of the incident, the manner in which the target vehicle is being driven, the competencies of the police driver, road, weather, traffic conditions and the location of the pursuit, including risks to vehicular and/or pedestrian traffic.^{12,13}

⁷ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines

⁸ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.01

⁹ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.1

¹⁰ Officer Wichman was a qualified priority one driver at the relevant time, see: ts 15.08.2019 (Wichman), p5

¹¹ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.3

¹² Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.3

¹³ See for example: ts 15.08.2019 (Worland), pp23-24

- 13.** It is incumbent upon all officers involved in pursuit emergency driving, either directly (driver) or indirectly (passenger) to make proper assessments of all associated risk before, during and after a pursuit.¹⁴
- 14.** Pursuant to the Guidelines, the commencement of a pursuit must immediately be communicated to the Police Operations Centre (POC) and an accurate risks and situation report (SITREP) provided for consideration by the Police Operations Centre Communications Controller (POCCC).^{15,16} Regular SITREPs are required during the pursuit, and if they are not sent, POC may order the pursuit to be terminated.^{17,18}
- 15.** A pursuit may be terminated in various circumstances, predominantly relating to the risk of continuing with the pursuit as opposed to the need to obtain the objective of the pursuit.¹⁹
- 16.** A pursuit may be terminated by POC, the pursuit vehicle driver, a pursuit vehicle passenger, or one of a range of authorised police officers carrying out roles connected with the pursuit. When a pursuit is terminated, the driver of the pursuit vehicle must immediately reduce speed and comply with applicable speed limits.²⁰
- 17.** Following a pursuit which results in serious injury or death, an investigation must be carried out by the Superintendent of the IAU. The investigation of the crash includes an assessment of whether the Guidelines and any relevant legislation has been complied with and the appropriateness of the actions of the pursuit driver.²¹
- 18.** At the inquest, Officer Wichman confirmed that he was required to complete compulsory online training to maintain the currency of his priority one driver authorisation. He felt he would benefit from additional training relating to the limits that apply to a priority one driver conducting vehicle intercepts and pursuits.²² Nevertheless, at the relevant time, Officer Wichman felt he had a working knowledge of the Guidelines.²³

¹⁴ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.3

¹⁵ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4

¹⁶ See for example: ts 15.08.2019 (Worland), pp20-21

¹⁷ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.9.1

¹⁸ See for example: ts 15.08.2019 (Wichman), p16

¹⁹ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4.9.1

²⁰ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4.9.1

²¹ Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.8.1 & TR-07.04.8.4

²² ts 15.08.2019 (Wichman), pp13-14

²³ ts 15.08.2019 (Wichman), p15

THE DECEASED

Background²⁴

19. The deceased was born on 2 May 1980 and grew up in Karratha. He had two older sisters and was described as a bright, athletic child.
20. When the deceased was about 17-years of age, he began using methylamphetamine. His addiction to this drug is said to have dominated his adult life.
21. The deceased never married and had no children. He had been in a 10-year relationship during which he helped his partner care for her three children.
22. At the time of his death, the deceased was said to be attempting to address his methylamphetamine use and was only using the drug once a week.
23. The deceased's family said he had "*a heart of gold*" and noted that during his admissions to prison, the deceased mentored and helped younger prisoners, several of whom came to his funeral.

Criminal and traffic record

24. The deceased's criminal and traffic record is extensive and records over 90 convictions for criminal and traffic offences. The offences include: burglary, stealing, possession of drugs, grievous bodily harm, and driving with a blood alcohol level in excess of 0.08%.^{25,26}
25. At the time of his death, the deceased was disqualified from holding or obtaining a driver's licence.²⁷

²⁴ Exhibit 1, Vol. 1, Tab 3, Report - MCIS (victimology report), p1

²⁵ Criminal Record - Daniel Paul Hilder

²⁶ Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p8

²⁷ Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p8

THE ATTEMPT TO STOP THE DECEASED

Events leading up to the pursuit

- 26.** Shortly before 11.00 pm on 8 July 2016, Officer Wichman and Officer Worland (the Officers) were conducting routine patrols in Carlisle in a 'class one police vehicle' (JN185). At that time, the Officers were attached to the Cannington Police Station. Officer Wichman, who was a qualified 'priority one' driver, was driving, and Officer Worland was in the front passenger seat. It had rained earlier in the night, and road surfaces were wet.^{28,29}
- 27.** As the Officers were driving in a northerly direction on Mars Street, near Mercury Street, they saw the deceased in a green hatchback parked adjacent to Parnham Reserve. Officer Worland used TADIS, (the police computer system) to check the vehicle's registration, but it appears that the registration was entered incorrectly. In any event, TADIS did not identify the deceased's vehicle.^{30,31}
- 28.** The Officers continued their patrol through the streets of Carlisle and a short while later, they saw the deceased's car on Mars Street. They saw the deceased drive north on Star Street and pull up on the verge next to Parnham Reserve. Officer Worland used TADIS to identify the deceased's car and this time, it showed that the vehicle's registered owner, (whose first name was "Dean") did not have a current driver's licence.^{32,33}
- 29.** Following the crash, it was determined that the car the deceased was driving was registered to the defacto partner of the deceased's sister. The deceased had the permission of the registered owner to use the vehicle, although the registered owner was apparently unaware that at the relevant time, the deceased did not have a valid driver's licence.³⁴
- 30.** JN185 pulled up alongside the deceased's vehicle so that Officer Worland could speak to the deceased. Officer Worland asked the deceased if he was Dean, and the deceased said he was. Officer Worland then told the deceased (who he assumed was the registered owner of the vehicle) that his licence was not current.^{35,36}

²⁸ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p1 and ts 15.08.2019 (Wichman), p6

²⁹ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, p1 and ts 15.08.2019 (Worland), p18

³⁰ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p1 and ts 15.08.2019 (Wichman), pp6-7

³¹ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, p1 and ts 15.08.2019 (Worland), p18

³² Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p2 and ts 15.08.2019 (Wichman), p7

³³ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, pp1-2 and ts 15.08.2019 (Worland), p19

³⁴ ts 15.08.2019 (Outred), pp44-45

³⁵ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p2 and ts 15.08.2019 (Wichman), p7

³⁶ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, p2 and ts 15.08.2019 (Worland), p19

- 31.** When he spoke to the deceased, Officer Worland did not suspect that the deceased was intoxicated or affected by drugs.³⁷ However, Officer Worland did notice that there was heavy condensation on the windows of the deceased's car, perhaps indicating that the deceased had been in the vehicle for some time. This, linked to the fact that the deceased had been seen by the Officers in the area earlier that night, led Officer Worland to be suspicious as to what the deceased was doing in the area.^{38,39}
- 32.** As noted, the Guidelines require police officers to conduct a risk assessment prior to engaging in intercepts and pursuits. In this case, the Officers considered the fact it was late evening, it had been raining, traffic was minimal and the deceased's manner of driving in the context of an interaction with police about an expired driver's licence.^{40,41}

The decision to pursue the deceased

- 33.** Whilst Officer Worland was making further checks using TADIS, the deceased suddenly reversed his car. Despite being ordered to stop, the deceased sped off on the wrong side of the road, in a southerly direction on Star Street. Officer Wichman activated JN185's emergency lights and sirens, did a U-turn and set off after the deceased while Officer Worland advised Police Operations Centre (POC) about the situation.^{42,43}
- 34.** Officer Worland recalls making an earlier transmission about the deceased having driven off that does not appear on the POC transcript of radio transmissions to and from JN185.^{44,45} This can sometimes occur if the attempted transmission occurs at the same time as a transmission from POC, but in any event, is not material in this case.⁴⁶
- 35.** Meanwhile, the deceased drove the wrong way through a roundabout at the intersection of Star and Oats Streets. As he did so, he almost collided with another vehicle.^{47,48}

³⁷ ts 15.08.2019 (Worland), p33

³⁸ ts 15.08.2019 (Worland), p18 & p28

³⁹ ts 15.08.2019 (Wichman), pp9-10

⁴⁰ ts 15.08.2019 (Worland), p24 & pp32-33

⁴¹ ts 15.08.2019 (Wichman), pp10-11

⁴² Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p2 and ts 15.08.2019 (Wichman), p7

⁴³ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, p2 and ts 15.08.2019 (Worland), pp19-20

⁴⁴ ts 15.08.2019 (Worland), pp20-22

⁴⁵ Exhibit 1, Vol. 1, Tab 18, Police communications audio timeline

⁴⁶ ts 15.08.2019 (Worland), pp20-21

⁴⁷ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p2 and ts 15.08.2019 (Wichman), p8 & p11

⁴⁸ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, pp2-3 and ts 15.08.2019 (Worland), p29

- 36.** The deceased continued to drive on the wrong side of Oats Street at high speed with his car lights off. Officer Worland heard the wheels on the deceased's car lose traction and saw what appeared to be a small amount of mist or smoke spraying up from the road. At this stage, JN185 was about 100 metres behind the deceased's vehicle.^{49,50}
- 37.** Officer Worland determined that in all of the circumstances, it was too risky to pursue the deceased and told Officer Wichman to abort the pursuit.⁵¹ Officer Wichman complied and turned JN185's lights and sirens off and reduced speed. The pursuit had lasted for a matter of a few seconds.^{52,53}
- 38.** Police vehicles are fitted with an 'automatic vehicle locator' system (AVL) which records the location and speed of the vehicle. AVL data established that JN185's maximum speed during the pursuit was only 39 kilometres per hour.^{54,55}

The crash

- 39.** JN185 was about 300 metres behind the deceased as he continued along Oats Street and drove the wrong way round the roundabout at Bishopsgate Street. Officer Wichman estimated the deceased's speed to be in excess of 100 kilometres per hour at this stage. The deceased's car then turned right onto Raleigh Street and crashed into a brick wall at 145a Raleigh Street.^{56,57}
- 40.** The deceased's car sustained significant impact damage and the left front passenger door was pushed into the vehicle's cabin area. Investigators from MCIS noted that the vehicle's driver seatbelt was in the retracted position and free from abrasions and stretching, indicating it was not being worn at the time of the crash.⁵⁸
- 41.** Officer Wichman activated JN185's emergency lights and parked in front of the deceased's vehicle. As he ran to assist the deceased, Officer Wichman says he saw him sitting in the front passenger seat slumped towards the driver's seat, apparently unconscious.⁵⁹

⁴⁹ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p2 and ts 15.08.2019 (Wichman), p8 & p11

⁵⁰ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, pp2-3 and ts 15.08.2019 (Worland), p29

⁵¹ ts 15.08.2019 (Worland), pp25-26

⁵² Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, p2 and ts 15.08.2019 (Wichman), p8

⁵³ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, pp2-3 and ts 15.08.2019 (Worland), p20

⁵⁴ Exhibit 1, Vol. 1, Tab 19, JN185's AVL Data; ts 15.08.2019 (Wichman), p14 and ts 15.08.2019 (Outred), p41

⁵⁵ See also: ts 15.08.2019 (Wichman), p14; ts 15.08.2019 (Worland), p32 and ts 15.08.2019 (Outred), p40

⁵⁶ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, pp2-3 and ts 15.08.2019 (Wichman), p8

⁵⁷ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, p3 and ts 15.08.2019 (Worland), pp28-29

⁵⁸ Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p4 and ts 15.08.2019 (Outred), pp38-39

⁵⁹ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, pp 3-4 and ts 15.08.2019 (Wichman), p8

- 42.** I note that Officer Worland says that after updating POC and requesting the urgent attendance of an ambulance, he ran to the deceased's car and saw the deceased slumped into the front passenger footwell with his feet jammed under the dash on the driver's side.⁶⁰
- 43.** In my view, Officer Worland's evidence about the deceased's position after the crash makes more sense and is therefore more likely to be correct. In any event, after unsuccessfully trying to remove the deceased from his car, the Officers started CPR through the car's window.^{61,62}
- 44.** A short time later, the Officers were assisted by other police, who had by then arrived on the scene.^{63,64} Ambulance officers subsequently arrived and removed the deceased from his car using spinal boards. They took over resuscitation efforts and transported the deceased to Royal Perth Hospital (RPH).⁶⁵ Despite the efforts of hospital staff, the deceased could not be revived and was declared dead at 11.42 pm on 8 July 2016.^{66,67}

The cause of the crash

- 45.** A report completed by Officer Outred (who was attached to MCIS at the time), found the street lights in the area were illuminated and road surfaces were wet. The deceased's car had sustained significant damage as a result of the crash and the indications were that the deceased was not wearing a seatbelt. Officer Outred concluded that speed, illicit drugs and vehicle defects (unserviceable front tyres with insufficient tread), all contributed to the deceased losing control of his car and crashing.⁶⁸
- 46.** As I have already observed, the MCIS initial collision report noted that the driver's seatbelt was in the retracted position, indicating that it was not being worn at the time of the crash. The seatbelt was also found to have no abrasions or stretching, and this is consistent with it not having been worn by the deceased at the relevant time.^{69,70}

⁶⁰ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, p3 and ts 15.08.2019 (Worland), p29-30

⁶¹ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, pp1-2 and ts 15.08.2019 (Wichman), pp8-9

⁶² Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, p3 and ts 15.08.2019 (Worland), p30

⁶³ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, pp3-4

⁶⁴ Exhibit 1, Vol. 1, Tab 11, Memo - Officer Worland, pp3-4

⁶⁵ Exhibit 1, Vol. 1, Tab 16.2, St John Ambulance Patient Care Record

⁶⁶ Exhibit 1, Vol. 1, Tab 17, RPH Emergency Department Notes (08.07.16)

⁶⁷ Exhibit 1, Vol. 1, Tab 4, RPH Death in Hospital Form

⁶⁸ Exhibit 1, Vol. 1, Tab 3, Report - MCIS, pp9-10 and ts 15.08.2019 (Outred), pp43-44

⁶⁹ Exhibit 1, Vol. 1, Tab 15, Report Initial collision report (MCIS), p1

⁷⁰ ts 15.08.2019 (Outred), pp39-40

- 47.** It is impossible to know exactly how fast the deceased was travelling at the relevant time. Officer Wichman estimated the deceased's speed to be in excess of 100 kilometres per hour shortly before the crash.⁷¹ As a result of colliding with a brick wall, the deceased's vehicle sustained significant damage and the front passenger side door was forced into the cabin area.⁷² On the basis of the available evidence, I conclude that the deceased was travelling at excessive speed prior to the crash.
- 48.** Toxicological analysis of post mortem samples taken from the deceased, showed methylamphetamine (i.e.: 1.1 mg/l) and tetrahydrocannabinol (cannabis) (i.e.: 2.8 ug/l) in his system.⁷³
- 49.** The Brief contained a table prepared by Professor Joyce, (an eminent clinical toxicologist), which sets out the levels of various common drugs, below which impairment would not be expected. According to that table, the deceased's level of cannabis would have resulted in impairment. The table also notes that any measurable amount of methylamphetamine causes impairment.^{74,75} I therefore accept that at the time of the crash, the deceased's ability to drive safely and responsibly was impaired.
- 50.** Following the crash, the deceased's car was inspected by an investigator attached to the Vehicle Investigation Unit. The investigator found that the vehicle's handbrake was inoperative and both its front tyres had unserviceable tread depth, before noting:
- A tyre with unserviceable tread depth would not readily dissipate water on a wet road surface. This may in turn lessen the grip of the tyre to the wet road surface.*⁷⁶
- 51.** The evidence of the deceased's car losing traction coupled with the state of the vehicle's front tyres and the fact that water spray was noted coming from the tyres led Officer Outred to state that the conclusion that the deceased's car did in fact lose traction was "fair".⁷⁷
- 52.** On the basis of the evidence before me, I am satisfied that the crash occurred because the deceased's car was defective (i.e.: front tyres had insufficient tread) and he was driving at excessive speed on wet roads at a time when he was impaired as a result of taking illicit drugs.

⁷¹ Exhibit 1, Vol. 1, Tab 10, Memo - Officer Wichman, pp1-2 and ts 15.08.2019 (Wichman), p8

⁷² Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p3

⁷³ Exhibit 1, Vol. 1, Tab 7, ChemCentre Toxicology Report

⁷⁴ Exhibit 1, Vol. 1, Tab 8, Table showing levels of common drugs causing impairment - Professor David Joyce

⁷⁵ ts 15.08.2019 (Outred), pp43-44

⁷⁶ Exhibit 1, Vol. 1, Tab 13.2, Vehicle Examination Report, p1

⁷⁷ ts 15.08.2019 (Outred), p44

CAUSE OF DEATH

- 53.** The deceased was visually identified by his father in the presence of First Class Constable Healy at Royal Perth Hospital at 11.40 am on 9 July 2016.⁷⁸
- 54.** On 13 July 2016, a forensic pathologist (Dr McCreath), conducted a post mortem examination of the deceased's body. Dr McCreath found extensive injuries, including: fractures to his spine and ribs, transection of his brainstem, laceration of his liver and blood in his abdominal cavity.⁷⁹
- 55.** The deceased was also found to have marked coronary artery atheroma (a degeneration of the vessel's walls). This degree of coronary vessel damage was said to be "*severe for someone of such a young age*".⁸⁰
- 56.** Toxicological analysis found methylamphetamine along with its metabolite amphetamine and tetrahydrocannabinol in the deceased's system. Alcohol was not detected.⁸¹
- 57.** At the conclusion of the examination, Dr McCreath expressed the opinion that the cause of death was multiple injuries.
- 58.** I accept and adopt the opinion of Dr McCreath as to the cause of death.
- 59.** I find that death occurred by way of accident.

⁷⁸ Exhibit 1, Vol. 1, Tab 2, Identification of Deceased Person Form

⁷⁹ Exhibit 1, Vol. 1, Tab 6, Post Mortem Report, p1 & p6

⁸⁰ Exhibit 1, Vol. 1, Tab 6, Post Mortem Report, p1

⁸¹ Exhibit 1, Vol. 1, Tab 7, ChemCentre Toxicology Report

INTERNAL AFFAIRS UNIT INVESTIGATION

- 60.** After receiving a phone call about the incident, Mr Douglas and Acting Superintendent Vidovich (Officer Vidovich) from IAU, attended the scene and subjected the Officers to drug and alcohol testing. The tests were negative in each case.⁸²
- 61.** Mr Douglas recalled being told by Officer Vidovich to make a note of the fact that JN185 was undamaged.⁸³ Officer Vidovich spoke to the Officers at the scene in order to enable a brief account of the incident to be prepared and forwarded to the relevant Assistant Commissioner. Mr Douglas did not identify any issues of concern at the scene.^{84,85}
- 62.** Subsequently, Mr Douglas conducted an investigation into the crash and the conduct of the Officers to identify any breaches of legislation or policy in relation to police actions.⁸⁶ Although it was his usual practice to interview police officers directly involved in 'critical incidents', he did not do so on this occasion.⁸⁷
- 63.** Mr Douglas said that on the basis of AVL data indicating the maximum speed achieved by JN185 during the short pursuit was less than 40 kilometres per hour, it was decided not to interview either of the Officers.⁸⁸
- 64.** Mr Douglas felt it was unnecessary to interview the Officers, although the decision not to do so was not his. Mr Douglas explained that the status of current investigations was regularly discussed during meetings at IAU attended by investigating officers and senior IAU staff. The decision not to interview the Officers would have been taken at one of these 'status meetings' by officers more senior than Mr Douglas.⁸⁹
- 65.** Mr Douglas said he was posted to the IAU in January 2016 and remained there for 3 years. He said that during that time, this was the only occasion on which he had not interviewed the police officers most directly involved in an investigation he was conducting.⁹⁰

⁸² ts 15.08.19 (Douglas), p46 and ts 15.08.19 (Wichman), p15

⁸³ ts 15.08.19 (Douglas), p52 and see also: ts 15.08.19 (Wichman), p16

⁸⁴ Exhibit 1, Vol. 1, Tab 9, IAU report, p3

⁸⁵ ts 15.08.19 (Douglas), p47

⁸⁶ ts 15.08.19 (Douglas), pp46-47

⁸⁷ ts 15.08.19 (Douglas), p48

⁸⁸ ts 15.08.19 (Douglas), p51

⁸⁹ ts 15.08.19 (Douglas), p48 & p52

⁹⁰ ts 15.08.19 (Douglas), p48

- 66.** It is unfortunate that the Officers were not interviewed after the crash. Although each of the Officers provided a memorandum setting out the circumstances that led to the crash, had they been interviewed, further valuable information could have been gleaned.
- 67.** For example, the discrepancy between the Officers as to the deceased's location in his vehicle immediately following the crash could have been explored. Further, the rationale for the Officers seeking to intercept, and then pursue the deceased could have been teased out.
- 68.** Furthermore, additional subtle detail about the incident, which emerged at the inquest, could have been captured at a time closer to the events. For instance, at the inquest Officer Worland recalled that there was heavy condensation on the windows of the deceased's car, perhaps indicating that the deceased had been in the vehicle for some time. As mentioned earlier, when linked to the fact that the deceased had been seen by the Officers in the area earlier that night, led to understandable suspicion on the part of the Officers as to what the deceased was doing in the area.
- 69.** Whilst these matters were ventilated at the inquest, they should have been the subject of investigation at the time. That would only have been possible had the apparently normal (and very sensible) practice of interviewing police officers directly involved in an incident been followed.
- 70.** Mr Douglas referred to the IAU report he co-authored as being a "short-form" report and said that subsequently, reports he prepared were more detailed.⁹¹
- 71.** I accept that in situations like the present, the report that records the relevant investigation is unlikely to be voluminous. However, it seems to me that a basic requirement of any investigation into the conduct of police officers (which is essentially what IAU reports are) should involve interviewing those officers who are most directly involved in the relevant incident.
- 72.** It is unclear whether the MCIS report (which is undated) was available to Mr Douglas at the time his report was finalised. Mr Douglas said he had spoken to MCIS officers about the direction their investigation was taking⁹² but it would clearly have been preferable for the formal findings in the MCIS report to have been considered during the IAU investigation.

⁹¹ ts 15.08.19 (Douglas), p52

⁹² ts 15.08.19 (Douglas), p50

73. In any event, after reviewing the memoranda prepared by the Officers, and obtaining AVL data and records of police communications, Mr Douglas prepared a brief report and concluded that: *“There is no evidence to support a breach of the EDD and no further managerial (is) action required.”*^{93,94}

COMMENTS ON THE ACTIONS OF POLICE

74. The evidence in this case establishes that the deceased was untruthful when he was initially spoken to by Officer Worland. He agreed his first name was Dean, when in fact it is Daniel. Although the Officers had not identified the deceased at that time and were therefore unaware that he had lied, they had reasonable basis to be suspicious about what the deceased was doing in the area.

75. Understandably, the deceased’s actions in reversing his car and speeding off on the wrong side of the road with his lights off after an innocuous interaction with police, further aroused the suspicions of the Officers and underpinned their decision to intercept the deceased.

76. The deceased’s conduct clearly indicated that he did not intend to stop for police. He may have been motivated to evade police because he was disqualified from holding or obtaining a licence at that time. He would also have been aware that he had consumed methylamphetamine and cannabis and may have been concerned that this would be detected.

77. In any event, after careful consideration of the evidence before me, I am satisfied that the actions of the Officers did not contribute to, or cause the death of the deceased.

78. On the contrary, when arrived at the scene of the crash, the Officers rendered first aid to the deceased and arranged for his urgent evacuation to hospital. In all of the circumstances, I consider that the actions of the Officers were reasonable.

⁹³ Exhibit 1, Vol. 1, Tab 9, IAU report, p5

⁹⁴ ts 15.08.19 (Douglas), p50

CONCLUSION

- 79.** The tragic outcome in this case resulted from the deceased's decision to drive away from police in a defective vehicle at excessive speed on wet roads whilst he was affected by methylamphetamine and cannabis.
- 80.** As he attempted to evade police, the deceased narrowly avoided colliding with another road user. At that time, the deceased was driving on the wrong side of the road with his car lights off.
- 81.** There is no doubt that the deceased's tragic death has had an incalculable effect on his family and friends. The scale of this tragedy would have been even greater had other road users been injured or killed as a result of the deceased's actions.

MAG Jenkin
Coroner
20 August 2019