

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Barry Paul King, Deputy State Coroner, having investigated the death of **Joshua David Polo** with an inquest held at Kalgoorlie Courthouse on 26 and 28 November 2019, find that the identity of the deceased person was **Joshua David Polo** and that death occurred on 23 March 2017 at Kalgoorlie Hospital from chest and abdominal injuries in the following circumstances*

Counsel Appearing:

Ms M F Allen assisted the Deputy State Coroner
Mr J D Berson (State Solicitor’s Office) appeared for the Western Australia
Police Force

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ORDER UNDER S 49(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. On 23 March 2017, Mr Polo was a passenger in a Holden Commodore sedan (the Holden) that was being driven by Brandon Rhys Peterson. Mr Peterson failed to stop at a stop sign at an intersection and the Holden crashed into another vehicle. Mr Polo sustained injuries from which he died soon thereafter. He was 27 years old.
2. A few minutes before the crash, two WA Police Force (WAPF) officers, First Class Constable B Moore and Acting-Sergeant J Greenlees (the officers) were conducting patrols in a marked police vehicle when the Holden came to their attention as a vehicle of interest.
3. While the Holden was parked, the officers stopped their vehicle in front of it, but Mr Peterson drove off at speed. The officers began to pursue the Holden, but they terminated the pursuit when Mr Peterson drove through an intersection without stopping at the stop sign. Seconds later, the crash occurred at the next intersection.
4. Section 22(1)(b) of the *Coroners Act 1996* (the Act) requires that an inquest be held where it appears that the actions of a police officer caused or contributed to a death. As Mr Peterson was attempting to evade the officers at the time of the crash as they followed him, it was arguable that the officers contributed to his death, so an inquest was deemed mandatory.
5. I held an inquest at the Kalgoorlie Courthouse on 26 November 2019 and 27 November 2019.

6. The documentary evidence adduced at the inquest comprised a brief of evidence¹ which contained a report by Sergeant P May of the Major Crash Investigation Section, together with relevant attachments including pathology and medical reports, witness statements and a memorandum from Superintendent D Wood, Superintendent State Traffic Operations.²
7. Oral evidence was provided by (in order of appearance):
 - a. First Class Constable Moore;³
 - b. Acting-Sergeant Greenlees;⁴
 - c. Ms J Worthington, the driver of the other vehicle in the crash;⁵
 - d. Sergeant May;⁶
 - e. Mr J Whitehead, a civilian witness who had seen the Holden prior to and at the time of the crash;⁷
 - f. Detective Sergeant T D Newington, an Internal Affairs Unit (IAU) officer who investigated the officers' actions leading up to the crash;⁸ and
 - g. Superintendent Wood.⁹

JOSHUA DAVID POLO

8. Mr Polo lived in Boulder with his partner, Ms A Wilkinson, and their 11-month-old daughter. They had moved from Kalgoorlie about a week before his death.¹⁰
9. Mr Polo was born in Western Australia on 14 December 1989. He was the eldest of two children. His father died when Mr Polo was eight years old

¹ Exhibit 1

² Exhibit 2

³ ts 26/11/19 4 – 18

⁴ ts 26/11/19 18 – 25

⁵ ts 26/11/19 25 – 27

⁶ ts 26/11/19 28 – 34

⁷ ts 26/11/19 34 – 37

⁸ ts 27/11/19 2 – 14

⁹ ts 27/11/19 14 – 31

¹⁰ Exhibit 1.15 1

and his mother remarried but remained close to Mr Polo. Mr Polo grew up in Victoria and was also close to his sister, who still lived in Victoria.¹¹

10. Mr Polo loved cricket and AFL. He also enjoyed spending time with his family and friends, playing music and playing computer games.¹²
11. After completing a light-vehicle mechanical apprenticeship in Victoria, Mr Polo moved to Western Australia. In December 2016, he lost his job when his employer went into liquidation, and after that he struggled to make ends meet.¹³ He was recovering from a methylamphetamine addiction and had arranged to move back to Victoria to undertake a drug rehabilitation program with the support of his mother.¹⁴

EVENTS LEADING UP TO THE DEATH

12. At the time of Mr Polo's death, Mr Peterson and his partner, Ms C Porter, were staying with him and Ms Wilkinson. Mr Polo and Mr Peterson had previously worked with each other for a while.¹⁵
13. Mr Peterson and Ms Porter had arranged to move into their own rental house in Shaw Street in West Lamington, a suburb of Kalgoorlie. On 23 March 2017, they borrowed the Holden from a friend, who dropped it off at Mr Polo and Ms Wilkinson's home.¹⁶
14. At about 2.00 pm that afternoon, Mr Polo told Ms Wilkinson that he was going with Mr Peterson and Ms Porter to look at their house in Shaw Street. The three of them got into the Holden and drove off.¹⁷ Ms Porter said in a statement that she was driving, while Mr Peterson was in the front passenger seat and Mr Polo was in the left rear passenger seat.¹⁸

¹¹ Exhibit 1.3

¹² Exhibit 1.3

¹³ Exhibit 1.3

¹⁴ Exhibit 1.3

¹⁵ Exhibit 1.15 1 - 2

¹⁶ Exhibit 1.14 2

¹⁷ Exhibit 1.15.A 4 - 7

¹⁸ Exhibit 1.14 3

15. Ms Porter said that, when they drove into the West Lamington area, she got lost. Shortly before 2.20 pm, she pulled over on Collins Street in West Lamington, and she and Mr Peterson swapped seats to allow him to drive.¹⁹ Mr Polo remained in the back seat.
16. At about the same time, the officers were travelling northwest on Maritana Street in West Lamington in a police vehicle with the call-sign KG105. First Class Constable Moore was driving. They turned southwest from Maritana Street onto Collins Street and noticed the Holden parked in a driveway on the southeast side of the road. They thought that it may have been a car that they had seen earlier in suspicious circumstances.²⁰
17. As the officers drove past the Holden, they noted that it had a different number plate from the one that they had originally suspected. As they continued driving past it, First Class Constable Moore observed it in the rear-view mirrors. He saw it reverse out of the driveway and park on the southeast side of Collins Street, facing northeast against the traffic.
18. Acting Sergeant Greenlees checked the police database on the on-board computer and saw alerts that the Holden was a vehicle of interest for a fail-to-stop incident and that the owner held no valid driver's licence in Western Australia. The vehicle licence was also expired.²¹
19. First Class Constable Moore made a U-turn, activated the emergency lights, and stopped directly in front of the Holden at a 45 degree angle in order to stop it from moving forward to drive away. He was concerned on the basis of the alert that the driver may attempt to evade police.²²
20. The officers opened the doors of KG105 to get out, but Mr Peterson started the Holden, reversed at speed, and swung around to face southwest.²³ He then accelerated quickly, with the rear tyres of the Holden spinning as he

¹⁹ Exhibit 1.14 3

²⁰ Exhibit 1.20 2

²¹ Exhibit 1.19A 2

²² Exhibit 1.19A 2

²³ Exhibit 1.19A 2

took off down Collins Street at speed.²⁴ The posted speed limit on Collins Street was 50 km per hour.²⁵

21. First Class Constable Moore also reversed KG105 and swung around to head southwest. Acting Sergeant Greenlees notified the Kalgoorlie Police Station Operations Desk (KPSOD) of the Holden failing to stop, and he provided the Holden's number plate details.²⁶ The emergency lights on KG105 were still on.²⁷
22. First Class Constable Moore was authorised as a Priority 2 driver to attempt a vehicle intercept but not to undertake evade police intercept driving (also called a pursuit). KG105 was appropriate for vehicle intercepts and pursuits.²⁸
23. After notifying KPSOD about the Holden, Acting Sergeant Greenlees advised First Class Constable Moore to keep the Holden in sight but not 'to engage'. He said that it was his intention to provide the Holden's details and direction of travel to other WAPF vehicles in the area.²⁹
24. Mr Peterson continued to accelerate southwest on Collins Street, and the Holden pulled away from KG105, reaching speeds of 80 km per hour or more.³⁰ He drove through the intersection at Woodman Street, which was controlled by a give way sign in favour of the traffic travelling on Collins Street.³¹ Mr Peterson then failed to stop at the stop sign at the next intersection at Hawkins Street, and he continued to accelerate towards the intersection at Shaw Street.³²
25. First Class Constable Moore had accelerated KG105 to 64 km per hour³³ and at some stage activated the siren,³⁴ but after seeing the Holden go through the Hawkins Street intersection without stopping, he considered

²⁴ Exhibit 1.16 2

²⁵ Exhibit 4 12

²⁶ Exhibit 1.54

²⁷ Exhibit 1.19A 2 - 3

²⁸ ts 27/11/19 5-6

²⁹ Exhibit 1.20 3

³⁰ Exhibit 1.17 3

³¹ Exhibit 1.17 3

³² Exhibit 1.16 3 - 4

³³ ts 27/11/19 3

³⁴ Exhibit 1.54 (audio at 2.20.51)

that it was too risky to continue,³⁵ so he turned off the emergency lights and siren and slowed KG105.³⁶

26. At the same time, Acting Sergeant Greenlees reached the same conclusion and advised First Class Constable Moore ‘to let it go, it’s not worth it, to terminate the lights and sirens, and to turn around.’ He said that to First Class Constable Moore because it was local practice when a vehicle failed to stop for a vehicle intercept to immediately terminate the intercept, conduct a U-turn and find the closest CCTV to be captured on.³⁷
27. By that stage, the Holden was approaching the Shaw Street intersection approximately 200 meters away from the officers. Acting Sergeant Greenlees estimated that the speed of the Holden was between 80 km per hour and 100 km per hour,³⁸ and First Class Constable Moore estimated that it was at least 100 km per hour.³⁹ About 15 seconds had elapsed since Acting Sergeant Greenlees had notified the KPSOD of the Holden failing to stop.⁴⁰
28. Five seconds later, the Holden travelled through the stop sign at the Shaw Street intersection without slowing and crashed into the side of a Toyota Prado (the Toyota) being driven by Ms Worthington northwest on Shaw Street.⁴¹ Ms Worthington had no time to brake to avoid the Holden.⁴² Acting Sergeant Greenlees immediately contacted KPSOD to advise of the collision and to request backup and an ambulance.⁴³
29. The force of the collision caused the Holden to jump off the ground as numerous pieces of debris flew off the front; it then spun and came to rest in the intersection facing towards the northeast. The impact crushed the front of the car, including the driver’s door, which left Mr Peterson unable to open the driver’s door.⁴⁴

³⁵ ts 26/11/19 16

³⁶ Exhibit 1.19 8

³⁷ Exhibit 20 3

³⁸ ts 26/11/19 23

³⁹ ts 26/11/19 11

⁴⁰ Exhibit 1.54

⁴¹ Exhibit 1.20 4

⁴² Exhibit 1.13 1

⁴³ Exhibit 1.54

⁴⁴ Exhibit 1.20 4; Exhibit 1.23 1

30. The Toyota was pushed sideways into the stop sign on the opposite side of the intersection. It then travelled a short distance and came to a rest on the north-western verge of Collins Street to the southwest of the intersection.⁴⁵
31. Following the crash, Ms Porter and Mr Polo remained in the Holden. Both of them were injured. Mr Peterson climbed into the back seat and attempted to get out of the Holden by the left rear passenger door. Acting Sergeant Greenlees apprehended him⁴⁶ and, with First Class Constable Moore's assistance, secured him with handcuffs on the ground near the Holden.⁴⁷
32. Acting Sergeant Greenlees then went to Mr Polo in the left rear seat and placed handcuffs on his hands in front of his body.⁴⁸
33. First Class Constable Moore remained with Mr Peterson and Mr Polo⁴⁹ while Acting Sergeant Greenlees went to assist Ms Worthington, who appeared to be in shock and had minor bruising. A woman who lived on a corner of the intersection attended and took Ms Worthington to her house to be checked later by paramedics.⁵⁰
34. Meanwhile, Mr Polo complained of chest pain and loss of vision, so First Class Constable Moore removed the handcuffs, held Mr Polo's head upright to maintain a clear airway for easier breathing, and reassured him that an ambulance was on the way. Mr Polo was wearing a seatbelt, but it was fastened around his waist only, with the sash part of the seatbelt hanging loose under his arm.⁵¹
35. A number of other police officers arrived shortly after the crash and assisted at the scene,⁵² as did ambulance officers and Department of Fire and Emergency Service personnel.⁵³

⁴⁵ Exhibit 1.20 4

⁴⁶ Exhibit 1.20 4

⁴⁷ Exhibit 1.23 2-3

⁴⁸ Exhibit 1.20 4

⁴⁹ Exhibit 1.20 4-5

⁵⁰ Exhibit 1.20 5

⁵¹ Exhibit 1.19B 11- 14

⁵² Exhibit 1.20 4

⁵³ Exhibit 1.19B 13; Exhibit 20 4-5

36. The first crew of ambulance paramedics arrived at the scene at about 2.30 pm and attended to Mr Polo. He was pale and unresponsive and he was having difficulty breathing. His pulse was initially weak, and it then stopped. The paramedics moved him into the ambulance and administered CPR. His pulse and breathing returned. The paramedics then took him to the emergency department at Kalgoorlie Hospital and arrived at 2.50 pm with CPR again in progress.⁵⁴
37. Doctors at the hospital continued to administer CPR to Mr Polo, but they were unable to revive him.⁵⁵ At 3.14 pm, a doctor certified Mr Polo's life extinct.⁵⁶
38. Ambulance paramedics also took Mr Peterson and Ms Porter to Kalgoorlie Hospital.⁵⁷ They received medical attention in the emergency department and were then admitted to the hospital.⁵⁸
39. Police later discovered that Ms Porter's hand bag contained drug-related equipment, including methamphetamine and amphetamine,⁵⁹ and that Mr Peterson's back pack contained a loaded sawn-off .22 rifle, 22 rifle ammunition and a 30 cm hunting knife.⁶⁰ Both bags were in the Holden at the time of the crash.

CAUSE OF THE CRASH

40. An investigation by officers in the Major Crash Investigation Section established that the Toyota was traveling northwest on Shaw Street at 48 km per hour, and the Holden was travelling south-west on Collins Street. Both roads had a speed limit of 50 km per hour, and the entry from Collins Street into the intersection with Shaw Street was controlled by stop signs and associated painted lines. The crash occurred within the

⁵⁴ Exhibit 1.46A

⁵⁵ Exhibit 1.47

⁵⁶ Exhibit 1.6

⁵⁷ Exhibit 1.46B; Exhibit 1.46C

⁵⁸ Exhibit 1.2 3

⁵⁹ Exhibit 1.27 8-12

⁶⁰ Exhibit 1.32 6-7

intersection when Mr Peterson drove the Holden into the driver's side of the Toyota at an unascertained speed.⁶¹

41. Police vehicle examiners found no pre-existing contributory defects to either vehicle. They found that the Holden's right front tyre was worn but there were no apparent defects within its braking system, and there were no lockup/skid or flat tyre run-on marks visible on any tyre.⁶² They noted that the road conditions were wet due to previous rainfall but were otherwise clear.⁶³
42. Safety investigators from the Mains Road Department assessed the intersection of Collins Street and Shaw Street and concluded that there were no road environment factors that contributed to the crash.⁶⁴
43. First Class Constable Moore and Acting Sergeant Greenlees were both tested for drugs and alcohol, and their blood analyses were negative.⁶⁵
44. At the hospital, toxicological analysis of Mr Peterson's blood showed no alcohol, but there were intoxicating levels of methylamphetamine and amphetamine.⁶⁶
45. The available information establishes that the cause of the crash was Mr Peterson's driving while affected by methylamphetamine. While attempting to evade police, he drove the Holden at excessive speeds, failed to comply with a stop sign at an intersection and collided with the Toyota.

CAUSE OF MR POLO'S DEATH

46. On 30 March 2017, forensic pathologist Dr J White performed a post mortem examination of Mr Polo's body and found extensive injuries, including rib fractures with a flail segment involving the left lower lateral chest wall and blood in the chest cavity, torn liver with blood in the abdominal cavity, and extensive bruising of the right hepatic flexure,

⁶¹ Exhibit 1.52B 8

⁶² Exhibit 1.52B 5

⁶³ Exhibit 1.52B 6

⁶⁴ Exhibit 1.50 1

⁶⁵ Exhibit 1.4 11

⁶⁶ Exhibit 1.12 2-3

pancreas and duodenum and associated retroperitoneal tissues. A neuropathology analysis concluded that there was no recent brain injury. Toxicological analysis detected cannabis, methylamphetamine and amphetamine.⁶⁷

47. Dr White formed the opinion, which I adopt as my finding, that the cause of death was chest and abdominal injuries.

HOW DEATH OCCURRED

48. Mr Peterson pleaded guilty and was convicted in the Supreme Court of Western Australia of manslaughter and dangerous driving occasioning death in circumstances of aggravation. The circumstances of aggravation were that he was driving to escape police.
49. In sentencing Mr Peterson on 20 September 2018, Justice McGrath noted that Mr Peterson decided to drive while severely intoxicated by methylamphetamine and incapable of driving, that there was no need for him to drive, and that he was driving while disqualified from holding a drivers licence and while on bail for other offences. His Honour further noted that, while evading police, Mr Peterson was speeding in a residential area, had contravened two stop signs and had ignored the hazardous conditions of wet roads and limited-visibility intersections. As a result, there was a collision where the driver of the other vehicle was unable to take any evasive action. His Honour found that Mr Polo lost his life as a consequence of Mr Peterson's driving.⁶⁸
50. I find that Mr Polo's death occurred by way of unlawful homicide.

⁶⁷ Exhibit 1.9 1

⁶⁸ transcript, *The State of Western Australia v Brandon Rhys Peterson*, Supreme Court of Western Australia, 20 September 2018 6-7

INVESTIGATION OF THE OFFICERS

51. Detective Sergeant T D Newington investigated the actions of the officers in order to determine whether they had complied with the WAPF Emergency Driving Policy and Guidelines (the Policy). He concluded, and his IAU management team agreed, that the officers had complied with the Policy and that there was no managerial action required in relation to them.⁶⁹

52. [REDACTED]

53. [REDACTED]

54. [REDACTED]

⁶⁹ Exhibit 1.4 16

⁷⁰ ts 27/11/19 5-7

⁷¹ In Kalgoorlie, the equivalent was the KPSOD

⁷² ts 27/11/19 6, 7, 11, 12, 13 Newington

⁷³ ts 27/11/19 11

⁷⁴ ts 27/11/19 12, 13

⁷⁵ ts 27/11/19 13

⁷⁶ ts 27/11/19 11

DISCUSSION OF THE OFFICERS' ACTIONS

55.

However, rather than establish that the officers' actions were improper, the evidence highlighted the problematic nature of the Policy and the difficulty officers face when attempting to comply with it.

56.

57.

58. First Class Constable Moore said that 'looking back ... once we initially stopped, and he started the vehicle, revved and made that deliberate action at speed to try and get away, you could say that would be deemed that he wasn't going to make any attempt to stop'.⁷⁹ He said that, 'looking at it now you're going to have a different perspective on things once you take all available, things into account, but yes, at the time it was a lot different'.⁸⁰

59.

⁷⁷ Exhibit 2 2, 18

⁷⁸ Exhibit 1.16 3; Exhibit 2 39, TR-07.04.2.3

⁷⁹ ts 26/11/19 14

⁸⁰ ts 26/11/19 17

[REDACTED]

60. [REDACTED]

61. It is clear that the emergency lights were activated on KG105 when the officers were following the Holden, and both officers stated that the sirens were also activated after Acting Sergeant Greenlees contacted the KPSOD.⁸⁴ However, the audio recording of the radio calls suggests that the sirens may not have been activated until later in the incident.⁸⁵

62. [REDACTED] it is clear that Mr Peterson was actively evading the officers from the time he took off. It is hard to imagine that Mr Peterson would not have seen KG105 behind him as a confirmation that the officers were pursuing him. [REDACTED]

63. Acting Sergeant Greenlees said, regarding intercepting vehicles that do not initially stop when instructed to do so, that it was hard to explain because sometimes people start to evade police but then change their minds and pull over. 'It's a bit of a fluid situation'.⁸⁶

64. [REDACTED]

⁸¹ Exhibit 2 40, 41
⁸² ts 26/11/19 21
⁸³ ts 27/11/19 18
⁸⁴ Exhibit 1.19A 3; Exhibit 1.20 3
⁸⁵ Exhibit 1.54 (audio at 2.20.51)
⁸⁶ ts 26/11/19 22

[REDACTED]

65. As Acting Sergeant Greenlees said, they were stopping the Holden because of the alerts and did not know who was on board, so they were putting their lives and other people's lives at risk for 'something that could have been nothing'.⁸⁹

66. Superintendent Wood said that, seeing that the officers were heading in the same direction as the Holden and wanted to ensure the safety of the wider community, they were doing all the right things by keeping their lights and sirens on and radioing immediately to notify potentially pursuit-qualified drivers. He said that they had only exceeded the speed limit for a very short time. Knowing how difficult and dynamic it is and how things happen so quickly, he had a lot of praise for the officers in that they were trying to do the right thing.⁹⁰

67. [REDACTED]

68. [REDACTED]

69. [REDACTED] it is apparent that the officers were acting responsibly and entirely in good faith. [REDACTED]

⁸⁷ ts 27/11/19 24 – 25

⁸⁸ ts 27/11/19 30

⁸⁹ ts 26/11/19 24

⁹⁰ ts 27/11/19 25

⁹¹ ts 27/11/19 26 – 27

[REDACTED]

CONSIDERATION OF THE POLICY

70. So, what guidance does the Policy provide to officers who are faced with the dilemma that confronted the officers in this case? I have previously been critical of the Policy for a lack of clear, simple prescriptive instructions, and the grounds for those criticisms are yet again confirmed.
71. The proposition that reliance by WAPF on the Policy is problematic was supported in this case by evidence indicating that the IAU investigated the actions of the officers against the standards of a policy which even the IAU investigators did not fully comprehend [REDACTED]
[REDACTED]
[REDACTED]
72. In my view, it is expecting too much of anyone, let alone front-line officers tasked with making split-second, high-risk decisions, to apply complex, unclear guidelines as a requirement of an active decision-making process. If that process were not difficult enough, when a decision made in those circumstances leads to tragedy, the officers face inevitable scrutiny from the IAU and this court, and potential criticism from the public.
73. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

⁹² Email chain Mr Berson to Ms Allen, 2/12/19

74.

[REDACTED]

75. The specific principles underlying the instructions could vary depending on policy considerations, but clear, simple prescriptive instructions in relation to the most crucial decision-making processes that normally occur in police pursuits would be far easier for officers to abide.

76. In addition, I reiterate my suggestion in a previous inquest⁹³ that WAPF institute post-incident analyses of the decision-making processes of the officers involved in incidents in order to inform the practical driver-training provided to officers. As First Class Constable Moore said, ‘looking at it now, you’re going to have a different perspective on things’.⁹⁴

77. Superintendent Wood said that, prior to this incident, a number of changes were made to the Policy, [REDACTED]

[REDACTED]

78. Given Superintendent Wood’s evidence that WAPF appears to have at least taken into account my previous suggestions to amend the Policy and to enhance its driver-training,⁹⁷ I make no formal recommendations. However, I urge WAPF to reconsider those suggestions.

⁹³ *Inquest into the death of AL Armstrong, KT Eades and AS De Agrela* [2020] WACOR 24

⁹⁴ ts 26/11/19 17

⁹⁵ ts 27/11/19 15

⁹⁶ ts 27/11/19 19

⁹⁷ ts 27/11/19 28

DID THE OFFICERS CAUSE OR CONTRIBUTE TO THE DEATH

79. Despite finding that the officers engaged briefly in a pursuit when not qualified to do so, I have no hesitation in finding that they did not cause or contribute to the crash. It follows that the officers did not cause or contribute to the death.
80. Rather, the evidence makes clear that Mr Peterson intended to flee from the officers' lawful attempt to intercept the Holden when it was parked and that his subsequent reckless disregard for the lives and safety of his passengers and other road users was the sole cause of the crash and of Mr Polo's death.
81. It is disturbing that, as with so many other violent deaths seen by this court, Mr Peterson was affected by methylamphetamine at the relevant time. The widespread use of that drug is an unmitigated curse on our community, but it provides no excuse for his actions.

CONCLUSION

82. Mr Polo was a young man who left behind his mother, his partner and his young daughter at a time when he was about to embark on potentially life changing rehabilitation.
83. Despite the fact that they were not to blame, First Class Constable Moore and Acting Sergeant Greenlees no doubt also bear the effects of their involvement in this brief pursuit and its tragic end.
84. The circumstances of this case suggest that, despite continuing reviews and piecemeal changes, there are still fundamental problems with the Policy which need to be addressed.

B P King
Deputy State Coroner
8 October 2020