Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 30/16

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Sharon Ann D'ERCOLE*** *with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 6, 7 & 13 September 2016 find the identity of the deceased was* ***Sharon Ann D'ERCOLE*** *and that death occurred on 12 April 2012 at Royal Perth Hospital as the result of Multiple Injuries in the following circumstances:-*

Counsel Appearing:

Ms A Sukoski assisted the Deputy State Coroner

Ms R Hartley and with her Mr J Bennett (State Solicitors Office) appeared on behalf of the Commissioner of Police
Ms K Vernon and with her Mr S Joyce (Tindall Gask Bentley) appeared on behalf of Mr G Hopley

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SUPPRESSION ORDER

A Suppression Order is in operation with respect to the evidence heard during the course of this inquest that;

1) **There be no recording or publication of any information or image which may identify or tend to identify the police passenger and;**
2) **There be no reporting or publication of the details of discussion surrounding operational aspects of police urgent duty/emergency driving policies and procedures.**

INTRODUCTION

Sharon Ann D'Ercole (the deceased) was the driver of a Toyota Corolla sedan registration number 1ANT 745 (the Toyota) on Alexander Drive, Dianella, on Thursday 12 April 2012. She had as a passenger her 16 year old daughter. As the deceased drove south on Alexander Drive she entered the intersection with Morley Drive, on its eastern set of traffic control lights (TCL), which were displaying green for through traffic.

In the intersection the Toyota was struck heavily to the driver's door by a marked police Ford Territory all-wheel drive station wagon, call sign CA502, (CA502), travelling east through a red TCL with its lights and sirens activated while seeking to apprehend a stolen Audi motor vehicle (the Audi).

The deceased was critically injured and died later that day in hospital of injuries she received in the crash. Her daughter also suffered serious injuries from which she has now recovered, but she retains no memory of events immediately prior to the crash.

The deceased was 50 years of age.

The Police Internal Affairs Unit (IAU) supervised the investigation surrounding the crash and concluded the police driver (police driver) of CA502 and his police passenger (police passenger) had failed to comply with the WA Police Emergency Driving Policy and Guidelines (TR.04).[1]

The circumstances of the case resulted in the police driver being charged with dangerous driving occasioning death under section 59 (1) (b) of the *Road Traffic Act 1974* (WA) with respect to the death of the deceased.

On 4 November 2013 the police driver was acquitted by a judge and jury of that charge. Shortly thereafter he resigned from the WA Police force.

Pursuant to section 3 of the *Coroners Act 1996* (WA), the death of the deceased was a reportable death (g) and must

[1] Ex 2, Tab 18

be reported to a coroner (section 17). Further, under the provisions of section 22 (1) (b) where it appears the death was caused, or contributed to, by an action of a member of the police force, a coroner must hold an inquest into the death to enable an independent review of police actions with respect to that death.

Section 25 (5) directs that a coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence.

Section 53 (1) prevents a coroner from holding or concluding an inquest where charges have been laid and section 53 (2) directs that the finding of the coroner on an inquest must not be inconsistent with the result of any earlier proceedings where a person has been charged on indictment or dealt with summarily for an indictable offence in which the question whether the accused person caused the death is in issue.

In summary, an inquest into the death of the deceased is mandated under the *Coroners Act 1996* (WA), but the inquest is restricted to issues not already determined by another court.

BACKGROUND

The Deceased

The deceased was born in Melbourne, Victoria, on 16 February 1962, but came to Perth as a baby. She grew up in Western Australia and had lived in the Dianella area for most of her life.

The deceased was married and prior to having her children was a librarian teachers aid (mainly relief work), but gave up her career for her children. She was a stay at home mother and was very devoted to her three children, Lashay (20), Bradley (28) and Trent (25). She was married to Ron D'Ercole for 28 years. She was a loving and caring person, much loved by many people including her brothers.

The Police

Police, under the direction of the Commissioner of Police, are expected to provide the law enforcement arm of Government on behalf of the community. To enable them to do that 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 aspects 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 proficiency 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 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 of 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 upon the driving in question. Aside from policies with respect to driving itself, there are other safety aspects considered with respect to the types of vehicles which may be used in different types of driving. The Commissioner of Police's implementation of the EDPG seeks to ensure the safety of police officers, members of the community and, where relevant, 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 April 2012, was a detailed document, over 60 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 attach to 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 Police Operations Centre (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 EDPG and, over the last few years, the most practical 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 April 2012 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, POCCCs.

In the current case the police driver was a priority pursuit driver who had gained that qualification in 2010. His police passenger was a priority 2 driver, and CA502, a class 1 police vehicle. That particular combination of driver, passenger and vehicle were competent to drive in all categories of driving required under the relevant EDPG, to the appropriate capabilities of each classification.

The Vehicles

CA502 was a Ford Territory all-wheel drive four door station wagon with all the appropriate driving alerts, including lights and sirens, and was fitted with an appropriate bullbar.

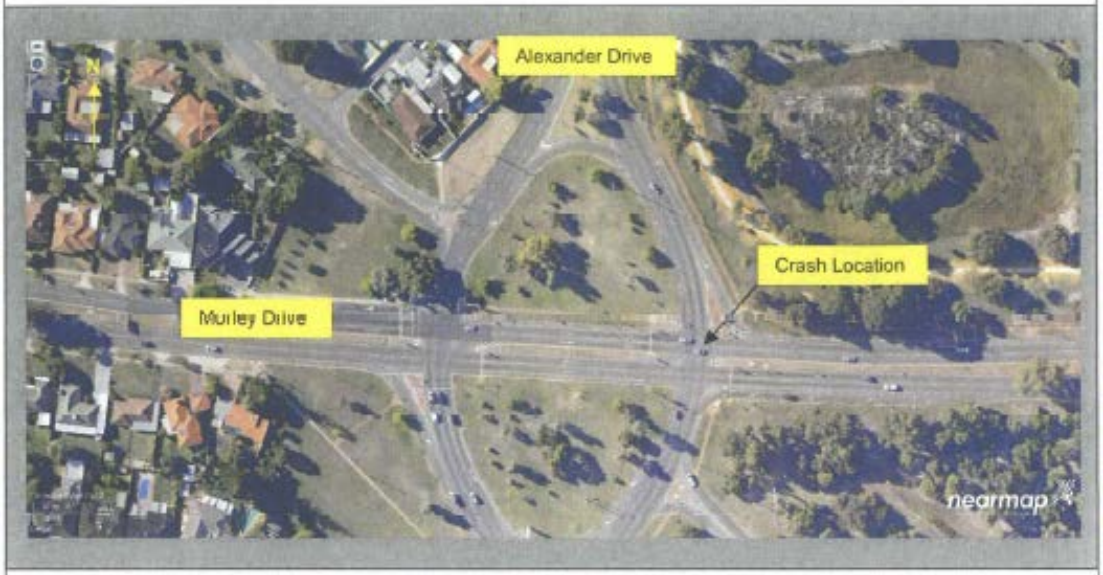
The vehicle driven by the deceased was a 1.8L Toyota Corolla 4 door liftback.

Neither vehicle was assessed as having any defects which would have contributed to the crash.

The Intersection

The crash happened just before 11:06am on 12 April 2012 at the intersection of Alexander Drive and Morley Drive, Dianella.

14.0 APPENDIX 1



Nearmap Aerial Photograph of the intersection of Morley Drive and Alexander Drive, Dianella taken on 6 April 2012.

Exhibit 1, Tab 16, Page 25

The intersection is in the shape of a large oval roundabout with Alexander Drive running north/south and Morley Drive running east/west with two sets of TCLs controlling the movement of vehicles in each direction.

Morley Drive travels through the middle of the roundabout and is a dual carriageway with the east and west bound carriageways separated by a median strip. Each carriageway consists of two lanes in each direction with a posted speed limit of 70km/h.

Alexander Drive travels around the circumference of the roundabout and is a dual carriageway, also consisting of two lanes in each direction and separated by a median strip. As Alexander Drive approaches Morley Drive from either direction it opens up to three lanes to provide an additional dedicated left turn filter lane. The lanes closest to the roundabout are marked for traffic to travel straight ahead or turn right onto Morley Drive. Alexander Drive has a posted speed limit of 60km/h.

The roads and the intersection were at the time both sealed asphalt surfaces in good repair and free from any defects or contaminants. All signage and road markings for the intersections were present, clearly visible and in good repair.[2]

CA502 was being driven east on Morley Drive towards the intersection. The Toyota was travelling south on Alexander Drive towards the intersection. The Toyota's intended direction of travel was to continue south on Alexander Drive, through the intersection. CA502 was following the

[2] Ex 1, tab 16

Audi which continued to travel east on Morley Drive, straight through the intersection.

The Event

On the morning of 12 April 2012 the deceased and her daughter, Lashay (Lashay), were at home and it was Lashay's 16th birthday. It was the school holidays and Lashay intended to meet her brother's girlfriend in the city. She was to go to the hairdresser and this was a birthday present from her brother and his girlfriend.[3] The deceased was driving her daughter to the bus stop near Dianella Plaza so she could catch a bus into town to meet her brother's girlfriend. The deceased drove the family's Toyota with her daughter in the front passenger seat, both were wearing seatbelts. They were driving from their home towards Dianella Plaza and it was a route with which the deceased was very familiar.

The deceased was driving south on Alexander Drive. As she approached the eastern set of TCLs (those facing the southbound traffic lanes) the through lanes had a green TCL facing them. Shortly behind the Toyota, which was in the left lane, was a post woman on a motor scooter and in the far left hand filter lane was a car waiting to turn left into Morley Drive.

[3] Ex 2, tab 2

The post scooter was approximately 20-30 metres behind the Toyota. They were both travelling at about 65km/h on the approach to the intersection.[4]

The two police officers in CA502 were attached to the crime gang squad and were carrying out duties associated with their squad during the course of the morning. They had both come on duty at 7am. The police passenger was accessing the police computer system via the laptop on his lap. This enabled him to receive information with respect to particular tasks and perform duties which on that morning included running checks on vehicles to determine their status. This is a normal part of general police law enforcement duties. The two police officers had earlier that morning received an instruction to assist in the city with a security detail and, having completed their intended task, they were returning to the city on Morley Drive.

At the intersection before that of Morley Drive and Alexander Drive, the police passenger conducted a vehicle check on an Audi in the right hand lane. CA502 was in the left hand lane. The Audi was being driven in a normal manner and the police driver of CA502 was surprised when his police passenger indicated the Audi was reported as stolen. He asked his police passenger to verify that information and the two police officers understood the vehicle had been stolen that morning. This indicated there

[4] Ex 3, t 5.11.13, p201

was a good chance the offender was at the wheel. The police driver moved into the right hand lane behind the Audi and activated CA502's emergency lights to conduct a vehicle stop on the Audi.

Initially, the police officers believed both they and the Audi had been travelling at about the same speed, but once the emergency lights were activated they noted the Audi accelerated slowly, but firmly, away and began to gain distance on CA502. The police siren was activated in addition to the emergency lights and the police driver increased the speed of CA502 to maintain his distance from the Audi, and then attempt to draw closer to the Audi and so affect a vehicle stop. His police passenger, as communicator, firstly used the squad channel to advise his controller they were unlikely to assist with duties in the city, and then switched to the general radio channel to gain the attention of POC by providing their call sign and the word 'urgent'.

That initial call to POC, in an attempt to signify CA502 needed an urgent response, was recorded as occurring at 11:05:12 am. This is a standard transmission intended to cut across all other radio traffic on the main operational channel to indicate a police vehicle requires the attention of a duty inspector at POC to act as POCCC.

This occurred as CA502 approached the western TCLs (east bound) of the Morley/Alexander Drive intersection. The TCLs at that intersection were red and the motorist travelling in a vehicle behind CA502 confirmed he observed both the brake lights of the Audi, and those of CA502 flash red, as if to brake, before the Audi accelerated heavily through the intersection, which was clear towards the eastern intersection. CA502 followed.[5]

The motorist had been driving in the right hand lane, east bound, on Morley Drive and CA502 passed him on the left at a normal speed. The motorist then saw CA502 pull into the right hand lane, in front of him and start flashing its lights. The motorist stated that caused him to take careful note of what was happening on the road.[6]

The motorist was by then approximately 200 metres behind the Audi and CA502 and continued towards the intersection. He stopped at the red TCL. The motorist noted there was not a lot of traffic in the intersection and both vehicles negotiated the first set of TCLs safely. Any traffic in the intersection would have been travelling north on Alexander Drive (right to left). The motorist kept watching the events ahead and observed the lead car weave to the right hand side at the far (eastern) set of TCL. The lead car (Audi) went through that red TCL.

[5] Ex 3, t 5.11.13, p283
[6] Ex 3 t 5.11.13, p283

From the motorist's observations, once CA502 had gone through the western set of TCLs, he observed CA502's brake lights come on again as CA502 approached the eastern set of TCLs. He could not estimate how far ahead of CA502 the lead car was, nor was he particularly watching that car, but he was sure the brake lights came on CA502 as it approached the eastern intersection. He did not consider the speed to be excessive.[7]

To the motorist on Morley Drive it appeared there was a vehicle (a little white car) in the eastbound left-hand lane of Morley Drive, watching the vehicles as they approached. He described the brake lights come on at the back of the *"cop car"*. They went off, then all of a sudden they came back on again, and he saw the little white car do a *"couple of circles"* from his position sitting at the western intersection TCLs on Alexander Drive.[8]

The motorist estimated there were between three and four car lengths between the lead car and CA502, with other drivers, stationary at different parts of the intersection, giving similar information from their different perspectives. None of the other drivers gave evidence as to brake lights but they were situated in positions from which the rear of CA502 could not be seen.

[7] Ex 3, t 5.1.13, p285
[8] Ex 3, t 5.1.13, p286

The police passenger in CA502 does not recall any event following his attempting to attract the attention of POC at 11:05:12 am. He did not register any response at that time.[9] He advised the inquest the main radio channel had been fairly busy and that is why he had notified his squad they may not be able to attend duties in the city, before he called POC.[10]

The police driver had slightly more memory of the events and recalled, in his interview with IAU, that the Audi had braked at the western intersection before accelerating through those red TCLs. He had performed a risk assessment by looking in both directions, because he was not familiar with the intersection and did not realise he only needed to be concerned with traffic from his right at that intersection. He looked both ways and noticed no traffic which would impede his passage through the intersection and accelerated after the Audi.[11]

The police driver then approached the eastern intersection TCLs which he also observed as red, and noted the Audi went straight through those TCLs. He slowed by braking as he approached that intersection. His evidence has been consistent in the fact he observed a vehicle to his left. Again he did not know the intersection and that he only needed to be concerned with vehicles approaching from his left at that

[9] t 6.9.16, p30
[10] t 6.9.16, p36
[11] t 13.9.16, p175

intersection. He looked in both directions (or scanned) and observed a vehicle travelling towards him, on his left, at the eastern set of lights. He observed that vehicle to be apparently slowing and believed the driver of that vehicle was acknowledging his presence at the intersection and intended to stop. Having made that assessment the police driver again turned his attention to the Audi and accelerated after it.[12]

The next thing either police officer remembered was the police driver realising something had occurred, looking across at his police passenger and their checking with one another, before leaving the police vehicle, understanding there had been a crash, and attempting to assist the deceased and her daughter.[13]

It is apparent the police driver had been mistaken in his risk assessment, and the deceased had not acknowledged the police emergency vehicle presence in the intersection. She had continued to drive south as CA502 stopped braking and accelerated after the Audi. CA502 drove directly into the driver's side of the Toyota causing the Toyota to spin before it came to a stop, severely damaged. Both the deceased and her daughter were seriously injured.

Following the police passenger radioing POC at 11:05:12 am, the recordings of the main channel indicate the POC

[12] t 13.9.16, p177
[13] t 6.9.16, p30 & t 13.9.16, p179

operator responded to that urgent call at 11:05:17, 11:05:28 and 11:05:42, with no response from the police passenger.

This implies it was while the crash was happening, because the next recording was from CA502 and was the police passenger radioing POC at 11:05:46, urgently requesting the St Johns Ambulance Service be provided to their location. The call indicates he was extremely distressed and concentrating on seeking help as quickly as possible. From 11:05:12 am to 11:05:46 was a period of 34 seconds. In that time CA502 had attempted to attract POC's attention for proper supervision of a pursuit which required certain input from POC. One has to assume the reason the police passenger did not acknowledge POCs return calls at 11:05:17, 28 & 42, was because that was as the crash was occurring. It had clearly occurred and the two police officers assessed the situation by 11:05:46.

The ambulances arrived at the scene very quickly, as did a number of other police vehicles. As soon as assistance had arrived the police driver and police passenger were removed from the scene into a police vehicle, and as soon as supervisors arrived from IAU the two police officers were separated. They were later interviewed separately as to their recollection of events. The police passenger has consistently been unable to recall events prior to the crash while the police driver has consistently indicated he has no recall of the crash itself. The last thing he remembered was

the risk assessment he made that a vehicle to his left was giving way to him before he accelerated after the Audi through a red TCL.

The Major Crash Investigation Section (MCI) Forensic Collision Report analysis of the impact evidence indicates CA502 was braking at the point of impact and suggests the police driver was responding to external stimuli, likely to be the Toyota at the time the impact occurred.[14] The police driver has no memory of this.

The deceased's daughter also has no recall as to events surrounding the crash, or whether either she or her mother had registered the Audi or the presence of CA502 with lights and sirens activated in the intersection.

The deceased and her daughter were taken to Royal Perth Hospital. Tragically the deceased was critically injured and did not survive the day.

Ms D'Ercole has since recovered from her serious physical injuries but has not recovered her recall of the events.

POST MORTEM REPORT

The post mortem examination of the deceased was carried out on 17 April 2012 by Dr G A Cadden, Forensic

[14] Ex 1, tab 16, p12/14

Pathologist of the PathWest Laboratory of Medicine at Sir Charles Gairdner Hospital.

Dr Cadden indicated the deceased had suffered a severe head injury, confirmed by neuropathology, severe chest injury and abdominal and skeletal injuries.[15] Toxicology indicated no alcohol or common drugs to be present in the system of the deceased at the time of the crash.[16]

It is clear the deceased died as a direct result of the injuries she received in the crash.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 50 year old mother of three children who, on the morning of 12 April 2012, was fit and healthy when she left home in her Toyota to take her 16 year old daughter to the bus stop for a birthday treat in the city.

The deceased was driving the Toyota south on Alexander Drive intending to continue through the intersection with Morley Drive, towards the bus station. As she approached the Morley Drive intersection on its eastern side she was faced with a green TCL and drove through the intersection in a southerly direction in the left hand lane for through

[15] Ex 1, tab 3 & 4
[16] Ex 1, tab 5

traffic. She was, according to a post person, driving at approximately 65 km/h towards the intersection.[17]

At the intersection we know a stolen Audi went through the intersection from right to left in front of her. It is not clear whether she saw that vehicle, but post-crash investigations indicate that at the time of the crash with CA502 the Toyota was travelling between 25-35km/h. This was not the original police forensic estimate but was accepted by the prosecution and court.

Oral evidence given at the criminal trial[18] by expert consulting engineers and a report provided to the inquest,[19] support the fact the Toyota was travelling at a speed through the intersection which indicated it was driving more slowly than would be expected of normal through traffic. While there was slight deviation between two sets of consulting engineers, overall, one can assess the pre-impact speed of the Toyota to be between 25-35km/h while that of CA502 was approximately 75km/h.[20]

Both experts were of the view the speed of the Toyota indicated it was travelling more slowly than would be expected if its driver had not registered an event in its direction of travel.

[17] Ex 3, t 5.11.13 p201
[18] Ex 4, t 12.11.13 p881 & t 14.11.13 p1099
[19] Ex 1, tab 17
[20] Ex 4, t 12.11.13, p877, 946

However, the deceased did not come to a stop as expected by the police driver. This makes it more likely the deceased was reacting to the lead vehicle (the Audi) which had passed through the intersection, but seemed to be unaware of CA502 with its lights and sirens activated.[21]

It could, however, explain why the police driver registered the vehicle to his left appeared to be stopping. He then dismissed it as an ongoing hazard and moved on.

Another driver on Alexander Drive, in the left turn filter lane at the Morley Drive eastern intersection stated she believed CA502 did not have any lights or sirens activated.[22] This is in contradistinction to all other witnesses, who were adamant CA502's police lights were activated, although some did not hear the sirens. The fact the siren was activated is confirmed by the radio recordings at POC, where the siren is clearly audible.[23]

I am satisfied the deceased slowed as a result of the Audi in the intersection but did not register CA502 behind the Audi, and consequently did not give way as required by the Road Traffic Code, but continued through the intersection believing it to be clear, or possibly still concerned as to the Audi. As she did, so CA502, also being driven from her right to left through the intersection, collided head on with

[21] Ex 4, t 13.11.13, p944
[22] Ex 3, t 6.11.13 p380
[23] Confirmed by Counsel Assisting by listening to the relevant recording.

the driver's side of the Toyota and caused a serious crash which resulted in the deceased's fatal injuries.

I am satisfied the police driver of CA502 had observed a potential hazard to his left when making his risk assessment as to the safety of continuing through the eastern intersection against the red TCL, but made a serious error of judgement. He believed the driver of that vehicle was giving way to CA502, as required by the Road Traffic Code, but did not confirm that vehicle was stopping before he continued through the intersection after the Audi.

The fact the police driver braked immediately prior to continuing through the eastern intersection, presumably in response to the presence of the Toyota as a potential hazard, was confirmed by the evidence of the motorist, previously referred to, travelling in the same direction as CA502, but stopped at the prior (western) set of red TCLs.

Having made that assessment the police driver's attention would have been focused forward and he accelerated through the intersection in the expectation the vehicle he had noted would stop. It did not and the crash occurred.

Immediately prior to the crash the police driver realised his error but it was too late to take significant evasive action. The motorist also confirmed the brake lights of CA502 were again activated at the time of the crash.

MANNER AND CAUSE OF DEATH

I am satisfied the deceased died as a result of the injuries she received in the crash with CA502 while it was accelerating through the intersection after the Audi.

I find death occurred by way of Accident.

COMMENTS OF THE ACTIONS OF POLICE WITH RESPECT TO THE DEATH OF THE DECEASED

In this case it is clear the actions of the police officers in CA502 caused the death of the deceased. However, those actions were undertaken during the course of legitimate law enforcement activities which require a police driver to make split second risk assessments, while driving a lethal weapon, with the intent of protecting life and property.

It is an inherently dangerous activity but one which most members of the general community support. It is also an activity with which most members of the community are closely involved. Most people are road users in one form or another, be it as drivers, passengers or pedestrians.

The emergency driving of emergency vehicles is very much a community issue. It is an issue which has increasingly attracted academic attention due to the competing tensions between law enforcement and public safety. The individual cost, in human terms to the community, when mistakes

occur, as they always will, is profound. As a result of that tension and attention, police policy with respect to emergency driving has been consistently revised, tightened and strengthened, restricted and supervised.

The comments I made in June 2014[24] with respect to any further restrictions of the EDPG in WA remain my view under the current version of EDPG. Essentially, it is my view the community expects and supports police law enforcement activities in the form of emergency driving.

The emphasis in most recent years has been around risk assessment while emergency driving, and the balance between what types of law enforcement warrant the risks inherent in police emergency driving for whatever reason. While there have been different interpretations of some of the more technical details of the various EDPG, especially apparent in 2008 – 2014, the continuing emphasis on risk assessment for police drivers, police passengers and POCCC has never been an issue.

Most of the restrictions apply as a result of a raft of safety concerns and breaches of the EDPG are a matter for the Commissioner of Police, to ensure compliance with a wider safety context, not necessarily the safety of driving in that particular set of circumstances. The most recent EDPG appears to be aimed at clarifying recent areas of confusion

[24] Inquest 13/14, K Samson, pgs.20-38

and continuing the emphasis on competent and relevant risk assessment.

More recent Western Australian statistics support propositions that while more pursuit type activities are commenced, many are abandoned where it appears unknown risks are unlikely to outweigh the known risks of continuing emergency driving at any given time. Wherever possible I accept police use other methods to apprehend dangerous activities in a less confronting manner. It must be remembered that the risk to police officers who engage in emergency driving on behalf of law enforcement is constant, one they face every day. It is not only the safety of members of the community which is of concern but also that of involved police personnel. Where possible police will use the air wing, vehicle disabling techniques, driver identification, or vehicle identification to enable apprehension of criminal activity by other means where feasible.

The significant factor with risk assessment is, of course, training. Knowledge of the relevant policies firstly for all police officers, but the ability to put them into practice by way of split second decision making and driving competence, especially for police drivers.

In the current case there appeared to be some confusion with the police driver and his passenger as to some of the

technical aspects of the relevant policy. I detected no such confusion around the need for continuous risk assessment.

The fact the police driver's risk assessment with respect to the driver of the Toyota giving way, was wrong, is also not in dispute.

Put in the context of the expert evidence at trial, obviously relied upon for the purposes of the inquest, it may be partially understandable, but emphasises the fine line between expectation and certainty in continuous time critical risk assessment and potentially lethal circumstances. It is not an enviable situation, but it is also one the public expects of trained police drivers.

Training helps with assessment in time limited conditions but it will never be full proof. That is little comfort in the overwhelmingly tragic circumstances of the present case where an innocent bystander is killed and a family dynamic changed forever. It possibly emphasises the fact that certainty is more important than expectation in the conditions on most roads, where the expectations of the driving of the general public will rarely be at the level of a trained police driver.

I accept all police officers are required to update their skills with respect to EDPG by way of refresher book top units, but consider practical driving skill testing to relevant

capabilities should also be considered for the most qualified levels of police driving. In addition there needs to be great emphasis on the fact that both a police driver and passenger have the ability to abort any particular set of circumstances. There is also the overriding supervision of POCCC by which police officers must abide, however, that generally gives a wider view of surrounding circumstances than that confronting the police driver and passenger on the ground. I accept in the current case neither the police driver or passenger saw any reason to abort, however, believe the ability for any police officer in a vehicle to abort emergency driving must be emphasised.

Some of the difficulty for the police in the current case was that surrounding crash investigation with respect to crush analysis. This led to the initial crash investigators estimating the speed of the Toyota as being greater than that agreed upon at trial for the time of impact. The fact the Toyota appeared to be moving more slowly than would normally be expected was of significance to the police driver's risk assessment in my view. It would have been preferable this was understood from the outset. Appropriate and up to date training in crush analysis technology would have been of benefit to MCI in the difficult circumstances of this case.[25]

[25] Ex 1, tab 17

The new current EDGP attempts to address more specifically the difficulty for police officers at intersections. This arises largely because of the difficulty at intersections with an apparent lack of understanding by many general motorists of the provisions of regulation 60 of the Road Traffic Code.[26]

It is clear a significant number of the driving public have forgotten their obligation to give way to emergency vehicles of all descriptions when displaying red or blue lights or sounding an alarm.

It also encompasses the difficulty with the visibility and audibility of emergency vehicle warning alerts. Evidence was heard during the course of the inquest as to a review undertaken with respect to the audibility of different types of siren for the purposes of police vehicles. I doubt, however, the difficulty of the rapid detection of the source of sirens will ever be fully resolved. Depending on the level of concentration of drivers, I suspect police drivers will always need to drive with the suspicion their emergency devices

[26] Very recently (post December 2016) I observed an incident at an intersection which showed some similarity to the facts of this case. A fully marked police car, with lights and sirens activated, approached a busy intersection facing a red TCL. The police car entered the intersection to the extent it would be visible, but not impede traffic, facing a green TCL. Not one vehicle gave way to the police vehicle. That police vehicle eventually made it to the middle of the intersection, still facing a red through TCL. It again positioned itself to be visible but not impede flowing traffic. This time one car stopped for the police vehicle. It was one of the first cars in the line of traffic, the rest of which did not give way to the police vehicle. Just as the police driver took his foot off the brakes of the police vehicle, so the stopped car accelerated heavily in front of the police vehicle. The police driver had to slam his brakes on so hard the whole of the rear of the police vehicle lifted into the air while the car sped off. The police then managed to clear the intersection. This, at an intersection leading to a small local shopping centre where there have been, in recent memory, two serious life threatening incidents, unrelated to motorists, one of which resulted in serious injury as well as a fatality. There are often similar incidents involving ambulances, although drivers appear generally to be more accommodating of ambulances, possibly because of their size and visibility. But frequently ignore fire trucks and vehicles despite their size and visibility.

may not be observable in the timeframe taken for some drivers to respond appropriately.

RECOMMENDATION

THE NEED FOR A PUBLIC EDUCATION CAMPAIGN TO REMIND THE DRIVING PUBLIC OF THEIR OBLIGATIONS UNDER THE ROAD TRAFFIC CODE.

60. Keeping clear of police and emergency vehicles

(1) A driver shall give way to, and make every reasonable effort to give a clear and uninterrupted passage to, every police or emergency vehicle that is displaying a flashing blue or red light (whether or not it is also displaying other lights) or sounding an alarm.

Points: XX Modified penalty: XX

(2) This regulation applies to a driver despite any other regulation that would otherwise require the driver of a police or emergency vehicle to give way to the driver.

I do not propose to recommend the family's request for a 40km/h speed cap for all police vehicles in intersections because reliance on such a rule may well preclude adequate risk assessment in some circumstances. Similarly, I do not propose to make a recommendation with respect to the use of bullbars on police vehicles. Police vehicles are frequently in positions of vulnerability and I consider appropriate

bullbars to be of significant value on police vehicles. That aside, the science of bullbars is extremely complicated and it would be totally inappropriate to make such a recommendation without considerable input from researchers and manufacturers, both of bullbars and vehicles.

E F Vicker
Deputy State Coroner
28 February 2017