Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 38/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***David John PIETRALA*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *on* ***27 August 2019*** *find that the identity of the deceased person was* ***David John PIETRALA*** *and that death occurred on* ***11 February 2016*** *at* ***Fiona Stanley Hospital*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Ms F Allen assisted the Coroner.
Ms R Hartley and Ms P Aloi (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. David John Pietrala (the deceased) died at Fiona Stanley Hospital on 11 February 2016 from multiple injuries after he lost control of the motorcycle he was riding and crashed. He was 34 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 27 August 2019. The documentary evidence adduced included reports by WA Police's Internal Affairs Unit (IAU)[4] and an initial collision assessment report by 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 they complied with relevant policies and procedures.

6. The following witnesses gave oral evidence at the inquest:

i. Mr Anthony Neale, (Mr Neale)[6];

ii. Detective Sergeant Graeme Keogh (Officer Keogh); and

iii. Detective Sergeant Craig Martin (Officer Martin).

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.

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[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 8, Report - IAU
[5] Exhibit 1, Vol. 1, Tab 28, Report - Initial collision assessment (MCIS)
[6] At the relevant time, Mr Neale was a police constable attached to the Murdoch police station. He subsequently retired from WA Police and is now a cyber security consultant with a major company, see: ts 27.08.2019 (Neale), p5

THE GUIDELINES

8. Emergency driving by WA Police officers 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]

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[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] Mr Neale was a qualified priority one driver at the relevant time, see: ts 27.08.2019 (Neale), p8
[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] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 19-20 & 29 and ts 27.08.2019 (Neale), p11

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]

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.[18]

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.[19]

17. Following a pursuit which results in serious injury or death, an investigation must be carried out by 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.[20]

[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: Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 16-18 & para 30
[17] Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.9.1
[18] Exhibit 1, Vol. 1, Tab 20, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4.9.1
[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-07.04.8.1 & TR-07.04.8.4

THE DECEASED

Background[21]

18. The deceased was born on 27 July 1981 in Ceduna, South Australia and had four brothers and a sister. He attended the Bindoon Agricultural College from year 8 to year 12 and after graduating, he worked in the farming industry on family properties and other stations.

19. The deceased was described by his family as a very smart person who was highly skilled with his hands and liked to fix things. He completed an apprenticeship as a heavy diesel mechanic. After working in the mining industry, he started his own business as a mobile diesel mechanic. He was described as a sensitive person who "*took things very much to heart*".

20. The deceased had a happy childhood and enjoyed the outdoors. He liked shooting, motorbikes, cars, his job and spending time with his family, with whom he was very close. He had owned a motorcycle for many years and was described as an experienced rider.[22]

21. It appears that the deceased may have used methylamphetamine, perhaps starting when he was working in the mining industry.[23] His family were unaware that he was taking antidepressant medication at the time of his death. Police enquiries with Medicare and the deceased's GP could not establish that the deceased had been prescribed this medication.[24]

22. On the evening of 10 February 2016, the deceased and his mother chatted on Facebook. She felt that the deceased was in a good frame of mind. The deceased was unemployed at the time, and his mother said he was making plans to move to Albany to stay with her and that he wanted to find work and "*sort his life out*".

23. Following the crash, an MCIS investigator spoke to a person who lived in the same block of flats as the deceased. She said she spoke to the deceased by phone on the night of his death and that he said he was going for a ride to "*clear his head*". Numerous attempts were made by the investigator to obtain a statement from this person, but she failed to attend appointments.[25]

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[21] Exhibit 1, Vol. 1, Tab 3, Report - MCIS (victimology report), pp1-13
[22] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p12
[23] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p8
[24] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p9
[25] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p9

Criminal and traffic record

24. In 2004, the deceased was involved in a vehicle crash that caused the death of another person. He was subsequently convicted of dangerous driving causing death and sentenced to nine months imprisonment, suspended for 18 months. The deceased's family felt that he was never the same after this incident, and despite his mother's urging, he declined to seek counselling.

25. With the exception of this conviction, the deceased's criminal and traffic record is minor. In January 2016, the deceased was convicted of the offences of riding a motorcycle with the wrong class of licence and wilfully misleading police. The deceased had previously been issued with a number of traffic infringements relating to speeding and at the time of his death, the deceased did not hold a valid driver's licence.[26,27,28,29]

THE ATTEMPT TO STOP THE DECEASED

Events leading up to the pursuit

26. At about 11.40 pm on 10 February 2016, Mr Neale and Constable Roberts (Officer Roberts) (the Officers) were conducting routine patrols on Stock Road, Bibra Lake. At that time, the Officers were attached to the Murdoch police station and were travelling in a 'class one police vehicle' (VM201). Mr Neale was a police constable at that time and was a qualified 'priority one' driver. Mr Neale was driving and Officer Roberts was in the front passenger seat. The weather was fine and roads were dry.[30,31]

27. As the officers were about 100 metres from the intersection of Stock Road and Spearwood Avenue, they saw a car and a 1,000 cc Honda motorcycle ridden by the deceased (the Motorcycle), travelling east on Spearwood Avenue. Both vehicles appeared to be travelling at about 70-80 kilometres per hour, which was over the posted speed limit. The car, which was slightly ahead of the Motorcycle, continued on Spearwood Avenue. The Motorcycle turned left and headed north on Port Kembla Drive.[32,33]

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[26] Exhibit 1, Vol. 1, Tab 3, Report - MCIS (victimology report), p3
[27] Criminal Record - David John Pietrala
[28] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p10 & p12
[29] ts 27.08.2019 (Keogh), p26
[30] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 2-6 & para 20 and ts 27.08.2019 (Neale), p7 & p15
[31] Exhibit 1, Vol. 1, Tab 9, Statement- Officer Roberts, paras 1-5
[32] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 6-10 and ts 27.08.2019 (Neale), p7
[33] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 7-10

The decision to pursue the deceased

28. VM201 turned left and was about 100 metres behind the Motorcycle as it headed north on Port Kembla Drive at a speed in excess of the posted speed limit. The Officers were unable to read the registration number on the Motorcycle's number plate and Mr Neale decided to intercept the deceased and question about him about his speed.[34,35]

29. Constable Roberts activated VM201s emergency lights and sirens and in accordance with the Guidelines, contacted the POC by radio at 11.43:29 pm to advise that they were attempting to intercept the deceased who had failed to stop.[36,37,38]

30. As required by the Guidelines, Mr Neale conducted a risk assessment. He noted the weather was fine, the road was dry, the deceased was wearing a helmet, jacket and long pants and he was riding on the correct side of the road with his lights on. At that time, there was no other traffic on Port Kembla Drive.[39,40]

31. Mr Neale's explanation for why he chose to intercept the Motorcycle rather than the car was:

> The motor car was in front of the motorcycle and they were both travelling along that Spearwood road when we saw them. When the motorcycle turned left, we turned left as well. I don't think there was any more rhyme or reason to it than that the motorcycle was behind the car.[41]

The crash

32. As the Officers continued north on Port Kembla Drive towards Phoenix Road, they lost sight of the Motorcycle. Officer Roberts then noticed that the deceased had turned right onto Phoenix Road and accelerated heavily. The Officers followed in VM201 and accelerated to the maximum speed permitted by the Guidelines. However, the Motorcycle pulled away as it went through the intersection of Phoenix Road and Sudlow Street and by then, was about 200 metres in front of VM201.[42,43,44]

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[34] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 14-17 and ts 27.08.2019 (Neale), p8 & p10
[35] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 11-12
[36] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 18 & 21 and ts 27.08.2019 (Neale), p8 & pp11-12
[37] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 13-18
[38] Exhibit 1, Vol. 1, Tab 32, POC audio transcript, (10.02.16 - 11.43:29 pm)
[39] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 19-20 & 29 and ts 27.08.2019 (Neale), p8 & pp10-11
[40] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 29
[41] ts 27.08.2019 (Neale), p17
[42] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 24-32 and ts 27.08.2019 (Neale), p8 & p13
[43] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 24-28
[44] Exhibit 1, Vol. 1, Tab 31, AVL data for VM201

33. As the Motorcycle accelerated along Phoenix Road, it travelled over the crest of a hill towards North Lake Road. The deceased then attempted to turn left onto North Lake Road. However, he lost control and the Motorcycle collided with the central grass median strip (that separates the north and south bound lanes of North Lake Road) and crashed.[45]

34. Meanwhile, as the Officers approached the North Lake Road intersection, they realised that the Motorcycle had crashed and was on fire. The deceased was lying on his stomach on the verge of the southbound lanes of North Lake Road. Officer Roberts radioed POC at 11.44.24 pm to advise that the crash had occurred. It follows that the pursuit had lasted less than 60 seconds.[46,47,48]

35. Mr Neale parked VM201 in front of the Motorcycle and ran to assist the deceased. Officer Roberts requested an ambulance at 11.44:46 pm before she ran to assist Mr Neale. Together, the Officers started CPR. A bystander, who identified herself as a nurse, used Mr Neale's torch and checked the deceased for injuries and took his pulse. Other police arrived to assist before ambulance officers took the deceased to Fiona Stanley Hospital.[49,50,51]

36. Despite the efforts of police, ambulance officers and hospital staff, the deceased could not be revived. He was declared dead at 12.45 am on 11 February 2016.[52]

37. Following the crash, the Officer in Charge of the Murdoch police station and an inspector from POC spoke with the Officers about what had happened. A short time later, Officer Martin (from IAU) subjected the Officers to a preliminary breath test at the scene. The Officers then attended the South Metropolitan Response Base in Bibra Lake and were each subjected to another breath test and a urine drug screening test. All of these tests showed the Officers had not consumed alcohol or common drugs.[53,54,55,56]

[45] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p2 & ts 27.08.2019 (Keogh), pp22-23
[46] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 32-40 and ts 27.08.2019 (Neale), p8 & p14
[47] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 36-41 & para 44
[48] Exhibit 1, Vol. 1, Tab 32, POC audio transcript, (10.02.16 - 11.44:24 pm)
[49] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 42-64 and ts 27.08.2019 (Neale), p8 & pp14-15
[50] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 44-62
[51] Exhibit 1, Vol. 1, Tab 30, St John Ambulance
[52] Exhibit 1, Vol. 1, Tab 4, Death in Hospital Form
[53] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p3 & ts 27.08.2019 (Keogh), p29
[54] Exhibit 1, Vol. 1, Tab 10, Statement - Mr Neale, paras 66-75 and ts 27.08.2019 (Neale), p14
[55] Exhibit 1, Vol. 1, Tab 9, Statement - Officer Roberts, paras 68-73
[56] ts 27.08.2019 (Martin), pp31-32

The cause of the crash

38. Investigators from MCIS attended the scene and spoke with the Officers. An initial report by MCIS confirmed that there had been no contact between VM201 and the Motorcycle.[57] A single locked wheel scuff mark with several areas of scrape/gouge marks on Phoenix Road leading onto North Lake Road and measurements were taken. The posted speed limit on Phoenix Road is 70 kilometres per hour.[58]

39. A vehicle travelling at the posted speed limit of 70 kilometres per hour would require between 26 and 64 metres to stop. The scuff mark was measured to be 142 metres long, indicating that the Motorcycle was travelling somewhere between 114 and 169 kilometres per hour shortly before the crash. It is not possible to arrive at a more exact speed because a variety of factors that can affect the way in which tyre marks occur.[59,60]

40. Officer Keogh, who prepared the MCIS incident report, noted that the scuff mark was relatively straight in appearance and extended over a considerable distance. This suggested "*an element of front wheel braking was present*". He noted that:

> *As such, a speed towards the upper end of the calculated range would be not be inconsistent with the physical damage.*[61]

41. At the relevant time, a car driven by Mr Simon Cook was stationary at the traffic lights that control the intersection between North Lake Road and Phoenix Road waiting to turn left onto Phoenix Road.[62]

42. Mr Cook says that he saw a blur to his left he identified as a motorcycle "*travelling at high speed*". He heard the Motorcycle's tyres screeching loudly and heard a loud bang. The Motorcycle then burst into flames and he saw the deceased lying on the other side of North Lake Road. Mr Cook says VM201 arrived on the scene about 30 seconds after the crash.[63]

43. The two passengers in Mr Cook's vehicle made similar observations.[64,65]

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[57] ts 27.08.2019 (Keogh), p29
[58] Exhibit 1, Vol. 1, Tab 28, Initial Collision Assessment Report, p2
[59] Exhibit 1, Vol. 1, Tab 28, Initial Collision Assessment Report, p2
[60] ts 27.08.2019 (Keogh), pp23-24
[61] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p11
[62] Exhibit 1, Vol. 1, Tab 11, Statement - Mr Cook, paras 6-7
[63] Exhibit 1, Vol. 1, Tab 11, Statement - Mr Cook, paras 9-16
[64] Exhibit 1, Vol. 1, Tab 12, Statement - Ms Vost, paras 8-14
[65] Exhibit 1, Vol. 1, Tab 13, Statement - Ms Wuttrich, paras 7-11

44. Toxicological analysis of samples taken from the deceased after his death found low levels of the benzodiazepine, diazepam and its metabolite (desmethyldiazepam), along with the antidepressant, mirtazapine. Common drugs were not detected but the deceased had an alcohol level in his blood of 0.046% and 0.093% in his urine.[66] It is unclear what effect these substances would have had on the deceased's ability to control the Motorcycle.

45. Following the crash, the Motorcycle was inspected by an investigator attached to WA Police's Vehicle Investigation Unit. The investigator found the Motorcycle had no defects.[67]

46. Officer Keogh concluded that that the crash occurred because the deceased was travelling too fast to negotiate the intersection of Phoenix Avenue and North Lake Road.[68]

47. On the basis of the evidence before me, I accept Officer Keogh's conclusion as to the cause of the crash.

CAUSE OF DEATH

48. The deceased was visually identified by his brother at the State Mortuary at 1.50 pm on 11 February 2016.[69]

49. On 12 February 2016, a forensic pathologist (Dr Moss), conducted a post mortem examination of the deceased's body. Dr Moss found severe injuries the deceased's head, chest and abdomen. There was no evidence of significant natural disease.[70]

50. At the conclusion of the examination, Dr Moss expressed the opinion that the cause of death was multiple injuries.

51. I accept and adopt the opinion of Dr Moss as to the cause of death.

52. I find that death occurred by way of accident.

[66] Exhibit 1, Vol. 1, Tab 7, ChemCentre Toxicology Report
[67] Exhibit 1, Vol. 1, Tab 25.2, Vehicle Examination Report, p1 and ts 27.08.19 (Keogh), p27
[68] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p11 and ts 27.08.19 (Keogh), pp28-29
[69] Exhibit 1, Vol. 1, Tab 2, Identification of Deceased Person Form
[70] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report, p1 & p6

INTERNAL AFFAIRS UNIT INVESTIGATION

53. After receiving a phone call about the incident, Officer Martin from IAU, attended the scene and subjected the Officers to breath testing. The tests were negative in each case.[71]

54. Officer Martin did not interview the Officers on the basis that there was "*nothing untoward*" in the evidence he examined, including the statements of each of the Officers. Officer Martin was asked why the police officers directly involved in this 'critical incident' were not interviewed. He said this was not standard practice where the available evidence did not indicate a breach of the Guidelines and that there were resource issues which meant that this could not occur in every case.[72]

55. I was surprised that the Officers were not interviewed after the crash. Although each of them provided a statement setting out the circumstances that led to the crash, had they been interviewed, further valuable information could have been gleaned.

56. For example, at the Inquest, Mr Neale was asked about the rationale for his decision to intercept the Motorcycle rather than a car, both of which he thought were speeding. Mr Neale was also asked whether he thought intercepting a motorcycle was more dangerous than intercepting a car, although admittedly he was not sure.[73] Had he been interviewed by IAU, Mr Neale could also have been asked about his knowledge of the Guidelines, so that a conclusion could be drawn as to whether, at the relevant time, he had a good understanding of them.

57. I accept that in situations like the present, the IAU 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.

58. In any event, Officer Martin examined the AVL data for VM201 as well as the transcripts of communications with POC. He also considered statements from the Officers and the civilian witnesses and the MCIS initial collision assessment report. Having done so, Officer Martin concluded that neither of the Officers had breached the Guidelines.[74]

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[71] Exhibit 1, Vol. 1, Tab 8, Report - IAU, p3 and ts 27.08.19 (Martin), pp31-32
[72] ts 27.08.19 (Martin), pp31-32
[73] Exhibit 1, Vol. 1, Tab 8, Report - IAU, p3 and ts 27.08.19 (Neale), p17
[74] Exhibit 1, Vol. 1, Tab 8, Report - IAU, p3 and ts 27.08.19 (Martin), pp35-36

COMMENTS ON THE ACTIONS OF POLICE

59. The evidence in this case establishes that at the relevant time, the deceased was riding at a speed well above the posted speed limit. His conduct after the Officers activated VM201s emergency lights and sirens indicated that he had no intention of stopping.

60. The deceased may have been motivated to evade police because he was disqualified from holding or obtaining a driver's licence at that time. He would also have been aware that he had consumed some alcohol and he may have been concerned that this would be detected.

61. In this case, the Officers were unable to obtain the Motorcycle's registration number because it was too far ahead of their vehicle. The decision to intercept the Motorcycle was therefore understandable.

62. The risk assessment conducted by the Officers took account of relevant factors and during the short pursuit, there was minimal other traffic on the road.

63. VM201 arrived at the crash scene about 30 seconds or so after the deceased had crashed. This indicates that the Motorcycle was some distance in front of VM201 when it crashed and is consistent with the evidence that the deceased was riding at a speed well above the posted speed limit at that time.

64. 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.

65. When the Officers arrived at the scene of the crash, they rendered first aid to the deceased and arranged for his urgent evacuation to hospital.

66. In all of the circumstances, I consider that the actions of the Officers to have been reasonable.

CONCLUSION

67. The tragic outcome in this case resulted from the deceased's decision to ride away from police. The evidence establishes that as a result of excessive speed, the deceased lost control of the Motorcycle and that during the subsequent crash, he sustained multiple fatal injuries.

68. It is impossible to comprehend the impact that the deceased's tragic death has had 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
3 September 2019