JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	10 DECEMBER 2020
DELIVERED	**:**	13 JANUARY 2021
FILE NO/S	**:**	CORC 341 of 2016
DECEASED	**:**	KNEALE, JAMIE DOUGLAS

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Collins appeared to assist the coroner.

Mr J Bennett and Ms K Dias (State Solicitor's Office) appeared on behalf of the Western Australia Police Force (the Police).

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Jamie Douglas KNEALE*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 10 December 2020, find that the identity of the deceased person was* ***Jamie Douglas KNEALE*** *and that death occurred on 30 March 2016 at Royal Perth Hospital from head injury in the following circumstances:*

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SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make the following order pursuant to section 49(1)(b) of the *Coroners Act 1996* (WA): There be no reporting or publication of the name, picture or any other identifying features of the witnesses referred to as Officer A and further, there be no reporting of the type of technology being used by Officer A on 29 March 2016, except in relation to his use of mobile phones.

Order made by: MAG Jenkin, Coroner (10.12.20)

INTRODUCTION

Overview

1. Shortly before 3.00 pm on 29 March 2016, Jamie Douglas Kneale (Mr Kneale) was riding a bicycle in Gosnells that was struck by a vehicle driven by an on-duty police officer, referred to in this Finding as "*Officer A*".

2. As a result of the collision, Mr Kneale was thrown to the roadway and sustained serious injuries. He was taken to Royal Perth Hospital (RPH), but died from head injury on 30 March 2016. Mr Kneale was 43-years of age.[1,2]

3. Officer A was subsequently charged with the offence of dangerous driving causing death; contrary to section 59 of the *Road Traffic Act 1974* WA (the RTA). Following a trial before a judge and jury in the District Court of Western Australia (the District Court Trial), Officer A was found not guilty of that charge and thereby acquitted.[3,4]

The nature of the inquest

4. Mr Kneale's death was a "*reportable death*"[5] and where, as here, it appears that the death was caused, or contributed to by any action of a member of the Police, an inquest is mandatory.[6] I held an inquest into Mr Kneale's death in Perth on 10 December 2020 (the Inquest), which members of his family attended.

5. The following witnesses gave evidence at the Inquest:

a. Officer A, (the driver of the vehicle that struck Mr Kneale);
b. Det. Sgt. Graeme Keogh, (Major Crash Investigation Section);
c. Det. Snr. Sgt. Hugh Le Tessier (Officer A's immediate superior); and
d. Mr Martin Downey, formerly with the Internal Affairs Unit.[7,8]

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[1] Exhibit 1, Vol. 1, Tab 4, Statement - Dr B Cross, paras 1-3 and RPH Life Extinct Form
[2] Exhibit 1, Vol. 1, Tab 1, P100, Report of Death
[3] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, p19
[4] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, para 55
[5] *Coroners Act 1996* (WA), s3
[6] *Coroners Act 1996* (WA), s22(1)(b)
[7] At the relevant time, Mr Downey was a Detective Sergeant with IAU. He retired from the Police in August 2018
[8] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 2-3

6. The documentary evidence at the Inquest included reports prepared by the Police, witness statements and other materials. Together, the Brief comprised one volume. The Inquest focused on the circumstances surrounding Mr Kneale's death, including the conduct and actions of Officer A.

Orders and certificate

7. Prior to the Inquest, counsel for the Police, Mr Bennett, requested a Non-Publication Order[9] with respect to the identity of a police officer referred to as "*Officer A*", and in relation to the types of technology being used by Officer A whilst carrying out his duties, other than mobile phones. Mr Bennett also requested an order that all persons, with certain limited exceptions, be excluded from the Inquest during Officer A's evidence.[10]

8. After considering submissions forwarded to the Court on behalf of the Police, and an email from Mr Kneale's sister setting out the family's position, I was persuaded that it was in the public interest for me to make the two orders sought by Mr Bennett.[11,12]

9. During the inquest, Officer A objected to answering questions about his use of mobile phones whilst driving on the ground that his answers may criminate him. On Officer A's behalf, Mr Bennett requested a certificate (Certificate) pursuant to section 47 of the *Coroners Act 1996* (WA) (the Act). The effect of a Certificate is to render the answers of the witness inadmissible in criminal proceedings against them.[13]

10. Before a coroner may issue a Certificate, it must appear to the coroner that is it expedient for the ends of justice to do so and the witness must answer the questions they have objected to answer to the satisfaction of the coroner. In this case, I formed the view that it was appropriate for me to grant a Certificate to Officer A, and I did so.[14]

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[9] Pursuant to s49(1)(b) of the *Coroners Act 1996* (WA)
[10] Pursuant to s45 of the *Coroners Act 1996* (WA)
[11] Submissions forwarded on behalf of the Police (02.12.20)
[12] Email from Ms S McGinn to Ms K Ellson (30.05.18)
[13] ts 10.12.20 (Officer A), pp15-17
[14] *Coroners Act 1996* (WA), ss47(2) & 47(3)

MR KNEALE[15,16]

11. Mr Kneale was born in Perth on 12 November 1972[17] and lived in a share house in Kelmscott. He had an older sister and was much loved by his parents and his family. He had returned to Perth in 2015 to help his mother care for his father, who has various health issues. Mr Kneale had previously lived in New Zealand, Queensland and Victoria and was a keen surfer who enjoyed gardening, cooking and being outdoors. He was also a supporter of the Carlton Football Club and loved dogs.

12. Mr Kneale had worked in the building industry as a labourer and as a sales representative and he had also been employed as a landscaper. He was described as a person with a very good sense of humour and as someone who liked to keep informed about world affairs. He was fit and healthy and although he had been taking prescription medication for depression for about three years, he was said to be: "*in a positive and happy place*" at the time of his death. He was also known to use marijuana.

13. Mr Kneale visited his parents at their home, located about 200 metres from the intersection of Hicks and Dorothy Streets in Gosnells, twice daily on most days. Mr Kneale had visited his parents on the morning of 29 March 2016 and was said to be happy because he was going to see about a job he was interested in. Mr Kneale's parents expected him to return that afternoon, but for reasons I will explain, he never did.

THE EVENTS OF 29 MARCH 2016

Road layout[18,19]

14. Dorothy Street in Gosnells runs southwest to northeast and intersects with Hicks Street, which runs southeast to northwest. There is a roundabout at the intersection, (see Figure 1), and the four roads leading into the roundabout are controlled by "*Give Way*" signs.

[15] Exhibit 1, Vol. 1, Tab 20, Statement - Mrs N Kneale, paras 8-20
[16] Exhibit 1, Vol. 1, Tab 7, Victimology Report - Major Crash Investigation Section, pp1-2
[17] Exhibit 1, Vol. 1, Tab 1, P100, Report of Death
[18] Exhibit 1, Vol. 1, Tab 6, MCIS Report, p3
[19] Exhibit 1, Vol. 1, Tab 43, MCIS Forensic Collision Report, p3

15. The approach from the southwest along Dorothy Street is along a slight decline, whereas the other approaches are relatively flat and the speed limit in the area is 50 km per hour. On 29 March 2016, the weather was fine and warm and the roadway was dry and in good condition.[20] One eye-witness said traffic at the time was "*busy*",[21] but another said traffic was "*light*" with only a "*few cars*".[22]

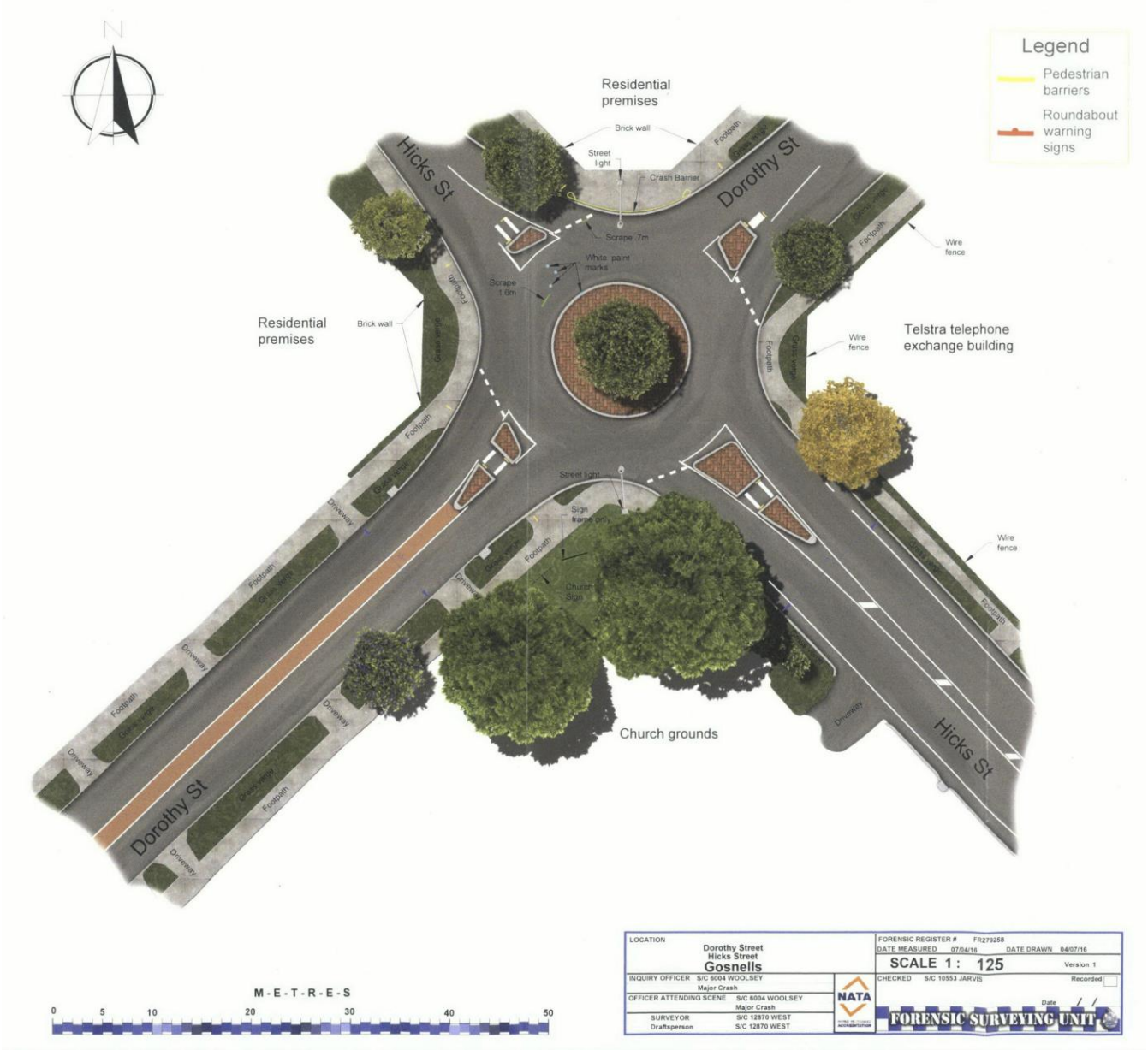

Figure 1: Roundabout at Dorothy and Hicks Streets, Gosnells[23,24]

[20] Exhibit 1, Vol. 1, Tab 13A, Statement - Ms S Davis, paras 69-70 & Tab 13B, Statement - Ms S Davis, paras 44-45
[21] Exhibit 1, Vol. 1, Tab 14, Statement - Ms N Franklin, paras 51 & 53
[22] Exhibit 1, Vol. 1, Tab 14, Statement - Ms L Oliver, para 35
[23] Exhibit 1, Vol. 1, Tab 38, Plan depicting Dorothy and Hicks Streets, Gosnells
[24] See also: Exhibit 1, Vol. 1, Tab 43, MCIS Forensic Collision Report, photograph at Appendix 1

The collision[25,26,27,28,29]

16. Sometime before 3.00 pm on 29 March 2016, Officer A, an on-duty police officer, had attended to some duties and was driving a police vehicle (the Vehicle) in a north-easterly direction on Dorothy Street. At 2.55 pm, whilst driving, Officer A handled his mobile phone when he read two text messages he received from a police colleague. At 2.57 pm, also whilst driving, Officer A sent a brief acknowledgement text message in reply to his police colleague.[30]

17. At the District Court Trial, Officer A was asked why he had not stopped the Vehicle in order to look at the text messages, and his reply was that because of his duties at the time, it was standard practice that when it was safe to do so, text messages received were immediately viewed.[31] With respect to the acknowledgement text message he sent, Officer A said that given the nature of the text messages he had received, the expectation was that he would send a response: "*straight away when practicable to do so*".[32]

18. Between 2.57 pm and 2.59 pm, Mr Kneale was riding a Hurricane bicycle (the Bicycle) in a north-westerly direction on Hicks Street towards the roundabout at the intersection with Dorothy Street (the Roundabout). He was not wearing a protective helmet.[33,34]

19. At the District Court Trial, Officer A's evidence was that as he approached the Roundabout, he took his foot off the Vehicle's accelerator and applied slight pressure to the brakes. Officer A said he noticed a female pedestrian to his right standing on the corner of Dorothy and Hicks Streets. He looked ahead and noticed no traffic and then looked right again and saw the female pedestrian had moved a couple of steps, but no oncoming traffic.[35]

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[25] Exhibit 1, Vol. 1, Tab 7, Report - MCIS, pp2-7 & 9-11 and ts 10.12.20 (Keogh), pp40-53
[26] Exhibit 1, Vol. 1, Tab 5.1, Report - IAU, pp4-9 & 13-18 and ts 10.12.20 (Downey), pp53-66
[27] Exhibit 1, Vol. 1, Tab 15 - Transcript, District Court District Court of Officer A, (Oliver), pp100-131
[28] Exhibit 1, Vol. 1, Tab 50 - Transcript, District Court District Court of Officer A, (Officer A), pp364-434
[29] ts 10.12.20 (Officer A), pp8-33
[30] Exhibit 1, Vol. 1, Tab 19, Statement - Police Officer D, paras 4-9
[31] Exhibit 1, Vol. 1, Tab 50 - Transcript, District Court District Court of Officer A, (Officer A), p375
[32] Exhibit 1, Vol. 1, Tab 50 - Transcript, District Court District Court of Officer A, (Officer A), p378
[33] Exhibit 1, Vol. 1, Tab 13A, Statement - Ms S Davis, paras 6-14 & Tab 13B, Statement - Ms S Davis, paras 5-12
[34] Exhibit 1, Vol. 1, Tab 14, Statement - Ms L Oliver, paras 2-13
[35] Exhibit 1, Vol. 1, Tab 50 - Transcript, District Court District Court of Officer A, (Officer A), p381-385

20. As Mr Kneale rode through the Roundabout, eye-witnesses saw him put up his hand as if to signal Officer A to stop. Officer A's evidence is that he did not see Mr Kneale until the Vehicle struck the rear wheel of the Bicycle. The collision caused Mr Kneale to be propelled onto the Vehicle's bonnet, from where he fell heavily onto the roadway, striking his head.[36,37]

21. Bystanders came to assist Mr Kneale and meanwhile, Officer A stopped the Vehicle and came to check on Mr Kneale, who was lying unconscious on his back. Officer A ran back to his car to get his mobile phone to call an ambulance, but a member of the public, who had been walking along Dorothy Street and had seen the collision, told Officer A she had already done so.[38,39]

22. At 2.59 pm, Officer A used his mobile phone to call a police colleague to say he had been involved in a traffic accident.[40,41]

23. With assistance from others, a member of the public placed Mr Kneale into the recovery position, and stayed with him until an ambulance arrived.[42] Plainclothes police officers, who had been performing duties nearby, arrived and were joined shortly afterwards by uniformed officers. Officer A underwent a breathalyser test at the scene, which was negative for alcohol.[43,44]

24. For the sake of completeness, I note that one of the witnesses to the collision thought that Mr Kneale may have been on the wrong side of Hicks Street as he approached the roundabout.[45] However, even if this were true, a driver approaching the Roundabout from the southwest on Dorothy Street would have had an unobstructed view of any approaching traffic.[46,47]

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[36] Exhibit 1, Vol. 1, Tab 13A, Statement - Ms S Davis, paras 15-24 & Tab 13B, Statement - Ms S Davis, paras 13-17
[37] Exhibit 1, Vol. 1, Tab 14, Statement - Ms L Oliver, paras 14-21
[38] Exhibit 1, Vol. 1, Tab 13A, Statement - Ms S Davis, paras 24-53 & Tab 13B, Statement - Ms S Davis, paras 18-37
[39] Exhibit 1, Vol. 1, Tab 14, Statement - Ms L Oliver, paras 22-34
[40] Exhibit 1, Vol. 1, Tab 18, Statement - Police Officer B, paras 2-8
[41] Exhibit 1, Vol. 1, Tab 19, Statement - Police Officer D, paras 10-14
[42] Exhibit 1, Vol. 1, Tab 16, Statement - Ms N Franklin, paras 18-38
[43] Exhibit 1, Vol. 1, Tab 17, Statement - Det. Sgt. C, paras 2-22
[44] Exhibit 1, Vol. 1, Tab 18, Statement - Police Officer B, paras 9-22
[45] Exhibit 1, Vol. 1, Tab 13A, Statement - Ms S Davis, para 9 & Tab 13B, Statement - Ms S Davis, para 7
[46] Exhibit 1, Vol. 1, Tab 40, Statement - Sen. Const. D Harston, para 7 (photos 4-16)
[47] Exhibit 1, Vol. 1, Tab 43, MCIS Forensic Collision Report, p6

Treatment at the scene[48,49,50]

25. Ambulance officers arrived at 3.03 pm, having come upon the scene whilst on their way to another job. When they arrived, Mr Kneale was lying on his side on the roadway and had a large abrasion to the back of his head with underlying contusion. Mr Kneale was exhibiting "*decerebrate posturing*",[51] which usually indicates severe brain damage.

26. The ambulance officers noted a "*boggy mass*" to the back of Mr Kneale's head and that he was sweating. His pulse and respiration rates were elevated and his oxygen saturation, initially measured at 92%, increased to 96% after he was given oxygen. His pupils were non-reactive and his Glasgow coma score[52] was three, a potentially fatal rating.

27. As Mr Kneale was being placed into the back of the ambulance, Officer A, who was described as "*distraught*", came over and asked how Mr Kneale was.

28. At 3.10 pm, ambulance officers inserted an intravenous cannula and gave Mr Kneale ondansetron, a medication used to prevent nausea and vomiting. Because of the nature of his injuries, the ambulance officers decided to take Mr Kneale direct to RPH and transported him on his side to protect his airway.

29. The ambulance left the scene at 3.14 pm and arrived at RPH at 3.35 pm, with the St John Ambulance Patient Care Record noting: "*prolonged travel time, as large accident on Tonkin Hwy*".

30. Given the nature of Mr Kneale's injuries and the fact that the State Major Trauma Unit is located at RPH, the decision to take him straight there was clearly correct. On the basis of the available evidence, I am satisfied that the treatment provided to Mr Kneale by the ambulance officers was appropriate.

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[48] Exhibit 1, Vol. 1, Tab 10, Statement - Ms K Chambers, paras 3-15 & 17
[49] Exhibit 1, Vol. 1, Tab 11, Statement - Mr M Menz, paras 3-18
[50] Exhibit 1, Vol. 1, Tab 12, St John Ambulance - Patient care record, pp1-2
[51] An abnormal body posture where the arms and legs are held straight out and the head and neck arch backwards
[52] The Glasgow coma score is a rating used to assess patients with an altered state of consciousness

Treatment at RPH and organ donation[53,54]

31. On arrival at RPH, Mr Kneale was diagnosed with a severe traumatic brain injury. He was ventilated and given vecuronium and suxamethonium (muscle relaxants used during ventilation), propofol (a sedative), and fentanyl (an opioid pain medication), before being taken for an urgent CT scan of his head.

32. The CT scan showed Mr Kneale had sustained non-survivable head injuries including: a subarachnoid haemorrhage, a fracture to the base of the skull and a right frontal/temporal subdural haematoma. He was admitted to the intensive care unit and after undergoing a test known as a cerebral angiogram, Mr Kneale was declared brain dead at 4.00 pm on 30 March 2016.[55] On the basis of the evidence before me, I am satisfied that Mr Kneale's treatment at RPH was appropriate.

33. In accordance with his wishes, Mr Kneale's organs were retrieved for donation on 1 April 2016. In its 2019/2020 Annual Report, the Australian Organ and Tissue Donation and Transplantation Authority had this to say about the importance of organ and tissue donation:

> For someone who is seriously ill, an organ or tissue transplant can mean the difference between life and death, being healthy or sick; between seeing or being blind; or between being active and never walking again. Transplantation enables people to resume an active role in their family, workplace and community. Organ donation gives someone who has organ failure a second chance at life…With around 1,700 Australians on a waiting list for an organ transplant, and a further 12,000 people on dialysis, the generous act of organ donation has far-reaching effects, changing the lives of those needing a transplant and their families.[56]

34. Mr Kneale's selfless gift, was facilitated by his family in truly awful circumstances, was of enormous benefit to a number of people. Both Mr Kneale and his family are to be highly commended for their generosity.

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[53] RPH Discharge summary, (01.04.16)
[54] RPH Medical Notes - A7268767, (29.03.16 - 01.04.16)
[55] Exhibit 1, Vol. 1, Tab 4, Statement - Dr B Cross, paras 1-3 and Life extinct form
[56] See: https://donatelife.gov.au/sites/default/files/content-2019-20_ota_annual_report-final.pdf

CAUSE AND MANNER OF DEATH

Post mortem examination and results[57,58,59]

35. A forensic pathologist, (Dr Kueppers), conducted a post mortem examination of Mr Kneale's body. The examination noted that many of Mr Kneale's organs had been retrieved for donation and that he had sustained head injuries including: scalp bruising, lacerations, fractures of the skull and a traumatic brain injury.

36. Toxicological analysis of a sample of plasma taken from Mr Kneale after he arrived at RPH detected medications consistent with his recent medical care, namely: lignocaine (local anaesthetic) and metronidazole (an antibiotic). The analysis also detected benzodiazepines and cannabinoids but was negative for opioids and alcohol.

37. The level of cannabinoids in the plasma sample could not be quantified, because:

> There was insufficient volume of hospital ante mortem plasma sample (Lab No. 15F6931001) to undertake a full drug screen or the confirmation / quantification of cannabinoids.[60]

38. A sample of Mr Kneale's urine was found to contain carboxytetrahydrocannibinol (a cannabinoid metabolite), lignocaine (and its metabolite), metronidazole and the antidepressant, citalopram. Common drugs and alcohol were not detected.

Cause and manner of death

39. At the conclusion of her post mortem examination, Dr Kueppers expressed the opinion that the cause of Mr Kneale's death was head injury. I accept and adopt Dr Kueppers' opinion and in view of the circumstances and the provisions of section 53(2) of the Act,[61] I find that death occurred by way of accident.

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[57] Exhibit 1, Vol. 1, Tab 8 - Post Mortem Report, p7
[58] Exhibit 1, Vol. 1, Tab 8 - Supplementary Post Mortem Report, p1
[59] Exhibit 1, Vol. 1, Tab 9 - Toxicology Report
[60] Exhibit 1, Vol. 1, Tab 9 - Toxicology Report
[61] See later discussion in the section headed: "*Did Officer A cause or contribute to Mr Kneale's death*"

POLICE INVESTIGATIONS

Overview

40. Because of the seriousness of the injuries sustained by Mr Kneale as a result of the collision, the matter fell within the relevant category of critical incidents involving police. Investigations were commenced by the Major Crash Investigation Section (MCIS) and the Internal Affairs Unit (IAU).[62]

41. The MCIS investigation focused on whether Officer A should be charged with any criminal offence(s), whilst the IAU investigation considered whether Officer A had complied with the *Police Regulations 1979* (WA) (the Regulations) and relevant policies, procedures and training. Reports relating to both the MCIS and the IAU investigations were provided to the Court.[63,64]

42. On 31 March 2016, Officer A's lawyer advised the Police that, in exercise of his rights, Officer A declined to be voluntarily interviewed by officers from MCIS. Officer A participated in two compelled "*managerial interviews*" with IAU investigators on 1 April 2016 and 9 June 2016 respectively.[65,66]

Scene examination[67]

43. Following the collision, police officers attended the collision scene and took photographs and measurements of relevant physical signs, including marks on the road surface. A forensic collision report prepared by MCIS (the MCIS Report) noted that the speed of Officer A's vehicle as it entered the Roundabout could not be determined from the physical evidence. However, the MCIS Report noted that:

> A witness to the crash describes the speed of the Vehicle as it entered the roundabout to be between 20 to 30 km per hour.[68]

[62] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, pp1-2
[63] Exhibit 1, Vol. 1, Tab 6, MCIS Report and ts 10.12.20 (Keogh), p41
[64] Exhibit 1, Vol. 1, Tab 5.1, IAU Report and ts 10.12.20 (Downey), p54
[65] Exhibit 1, Vol. 1, Tab 29, Statement - Det. Sgt. G Buck, para 15
[66] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, para 19 and ts 10.12.20 (Downey), pp60-61
[67] Exhibit 1, Vol. 1, Tab 43, MCIS Forensic Collision Report, pp1-15
[68] Exhibit 1, Vol. 1, Tab 43, MCIS Forensic Collision Report, p6

44. The MCIS Report also noted that the same witness had described the speed of the Bicycle as 20 to 30 km per hour, although this estimate was regarded as "*high*". Another eye witness said Mr Kneale: "*wasn't going really fast but he wasn't dawdling either*".[69] On the basis of the physical evidence, the MCIS Report concluded that the Bicycle had entered the Roundabout before the Vehicle. In terms of visibility for vehicles approaching the Roundabout, the Report noted:

> Visibility for vehicles approaching the roundabout from the southwest on Dorothy Street and looking to the right through the roundabout and towards the southeast approach along Hicks Street is relatively clear and unobstructed.[70]

Mobile phone usage[71,72,73,74,75]

45. The IAU investigation determined that Officer A received two text messages from police colleagues and sent one text message in reply, in the period before his vehicle arrived at the intersection of Dorothy and Hicks Streets. The text message sent by Officer A was the word "*Rog*", which is short for "roger" and used to acknowledge receiving a message.[76]

46. When interviewed by IAU investigators, Officer A admitted that whilst driving, he had handled his mobile phone to view two text messages he received and had used his mobile phone to send a brief text message in reply. However, Officer A was adamant that he had received and sent the text messages respectively, before he reached Hicks Street.

47. Using information obtained from Officer A's electronic devices and a timed reconstruction drive along the route Officer A had followed prior to the collision, police investigators established that Officer A had sent a one word text message about 10 seconds before he reached the intersection of Dorothy and Eudoria Streets.[77]

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[69] Exhibit 1, Vol. 1, Tab 13A, Statement - Ms S Davis, para 16
[70] Exhibit 1, Vol. 1, Tab 43, MCIS Forensic collision report, p6 and ts 10.12.20 (Keogh), pp60-62
[71] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 32 & 43 and ts 10.12.20 (Downey), pp59-62
[72] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, pp6-13
[73] Exhibit 1, Vol. 1, Tab 35, Telstra call records (29.03.16)
[74] Exhibit 1, Vol. 1, Tab 39B & 39C, MCIS timeline and electronic device records
[75] ts 10.12.20 (Officer A), p15-28
[76] ts 10.12.20 (Officer A), p17-18
[77] When travelling northeast along Dorothy Street, Eudoria Street is the major intersection before Hicks Street

48. For ease of reference, times shown in the police timeline use the 24-hour clock and seconds as well as hours and minutes are displayed.[78] The timeline that emerges is as follows:[79,80]

14.55.31 hours	Officer A receives first text message
14.55.36 hours	Officer A receives second text message
14.57.41 hours	Officer A sends text message
14.57.51 hours	Officer A reaches Eudoria Street
14.58.41 hours	Officer A reaches Hicks Street
14.59.13 hours	First "000" call by member of the public (cuts out)
14.59.37 hours	Second "000" call by member of the public
14.59.41 hours	Officer A calls a police colleague

49. On the basis of the timeline, the collision appears to have occurred shortly after 14.58.41 hours (i.e.: 2.58 pm), given that the first "000" call was made 32 seconds later. The timeline shows that although Officer A had been using his mobile phone prior to the collision, the last time he used it was about 50 seconds before he reached Hicks Street.

Vehicle examinations

50. Following the collision, a police vehicle examiner inspected the Vehicle and the Bicycle. The Vehicle was found to have no defects other than those related to the collision. The Bicycle was found to have defects related to the collision and it was noted that its warning bell, although fitted, was inoperative.[81,82,83]

Officer A's alcohol and drug tests

51. As noted, Officer A was subjected to a breathalyser test at the scene which was negative for alcohol.[84] Subsequently, the IAU investigator Detective Sergeant Martin Downey (as he then was), subjected Officer A to alcohol and drug testing, and those tests were negative for alcohol and illicit drugs.[85,86]

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[78] For example 15 seconds past 2.45 pm would be shown as 14.45.15 hours
[79] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, pp6-13
[80] Exhibit 1, Vol. 1, Tab 39, Statement - Ms G Amankwah & the two charts attached to her statement
[81] Exhibit 1, Vol. 1, Tab 43, MCIS Forensic collision report, p4
[82] Exhibit 1, Vol. 1, Tab 40, Statement - Sen. Const. D Harston, paras 1-6
[83] Exhibit 1, Vol. 1, Tab 40, Vehicle examiners report, pp1-11
[84] Exhibit 1, Vol. 1, Tab 6, MCIS Report, p9 and ts 10.12.20 (Keogh), p44
[85] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, p19
[86] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 4-11

Conclusion reached by MCIS investigation

52. The MCIS investigation considered physical evidence from the scene, the results of the vehicle examinations, digital analysis of data from electronic devices and interviews with eye witnesses and others. The MCIS investigation concluded that Officer A had failed to see and give way to Mr Kneale, when he clearly had an obligation to do so.[87,88]

53. On the basis of the timeline I have referred to, the MCIS report concluded:

> [Officer A] was operating a mobile phone to send a SMS whilst driving the Vehicle. There is no evidence that he was doing so as he approached or entered the roundabout.[89]

Investigation by the IAU

54. In his first managerial interview with IAU investigators on 1 April 2016, Officer A stated:[90,91]

- He was driving on Dorothy Street approaching Hicks Street;
- He looked to his left and right at Hicks Street;
- He saw a female standing on the right-hand corner;
- He continued through the roundabout and a cyclist appeared from his right;
- He slammed on his brakes but the Vehicle hit the cyclist;
- He stopped to help and could see the cyclist had head trauma;
- The cyclist was placed into the recovery position and "000" was called;
- He called a police colleague and stayed at the scene;
- He was given a breathalyser, which was negative for alcohol;
- He was not using any electronic devices just prior to the collision;
- He did not see the cyclist until he was right in front of him;
- He cannot explain why he didn't see the cyclist; and
- He simply doesn't know how the cyclist ended up in front of him.

[87] Exhibit 1, Vol. 1, Tab 6, MCIS Report, pp3-7 & 9 and ts 10.12.20 (Keogh), p44
[88] ts 10.12.20 (Downey), p59
[89] Exhibit 1, Vol. 1, Tab 6, MCIS Report, p9
[90] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 23-31
[91] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, pp13-15

55. In his second IAU managerial interview on 9 June 2016, Officer A was asked about the two text messages he had received and the single text message he had sent on 29 March 2016. Officer A said that the text messages were received and sent before he had travelled to the intersection of Dorothy and Eudoria Streets. Officer A was adamant that he was not distracted when he reached the intersection of Dorothy and Hicks Streets.[92,93,94]

Conclusion reached by MCIS investigation

56. After reviewing all of the available evidence, the IAU Report stated:

> The only conclusion which can be drawn from all the circumstances is that [Officer A] was not paying proper attention to his driving when he entered the intersection.
>
> There is no reason why [Officer A] should not have seen [Mr Kneale] had he been driving the vehicle in a safe manner. [Mr Kneale] approached the intersection from the right-hand side and [Officer A] had an obligation to give way to [Mr Kneale].[95]

OFFICER A's CONDUCT

Consideration of criminal charges

57. After a review of the evidence by the MCIS and following consultations with the Office of the Director of Public Prosecutions, it was decided to charge Officer A with the offence of dangerous driving causing death; contrary to section 59 of the RTA. Officer A was served with the relevant paperwork on 18 July 2016.[96,97]

58. As for Officer A's use of his mobile phone whilst driving, it was determined that because of the involuntary nature of his managerial interviews, there was insufficient evidence to prosecute him for that offence.[98]

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[92] ts 10.12.20 (Officer A), pp11-12
[93] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 33-42 and ts 10.12.20 (Downey), p61
[94] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, pp15-16
[95] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, p18
[96] Exhibit 1, Vol. 1, Tab 29, Statement - Det. Sgt. G Buck, para 20
[97] Exhibit 1, Vol. 1, Tab 48, Statement of material facts & Prosecution notice
[98] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, p19

59. With respect to the District Court Trial, the MCIS report noted:

> [Officer A] gave evidence in his defence, which included admission of the use of the mobile phone whilst driving, but not at the time of the crash and failing to see Mr Kneale when he entered the roundabout. Following a six-day District Court trial, the jury returned a verdict of not guilty. It would appear from the questions that the jury came back to the Judge with, that they could not find that [Officer A's] inattention reached the point of dangerous driving as defined and they applied the offered defence of 'Mistake of Fact'.[99]

60. Mr Downey was directed to attend the District Court Trial in order to determine whether any new information emerged and/or whether, during his evidence before the District Court, Officer A deviated from what he had said during the managerial interviews.[100]

61. Mr Downey's assessment was that Officer A's evidence at the District Court Trial was consistent with what he had said during his managerial interviews. In a statement he provided to the Court, Mr Downey said:

> I found Officer A's sworn testimony to be consistent with his managerial interviews.[101]

Consideration of Regulation breaches[102,103]

62. The IAU Management Team (the Team), consisting of the Officer-in-Charge of the IAU and two Detective Inspectors, reviewed all of the available evidence. The Team concluded that Officer A's conduct constituted three beaches of regulation 402(e), two of which related to his use of his mobile phone whilst driving, with the third related to his manner of driving at the time of the collision. The Team also concluded that Officer A had breached regulation 601(2) which relates to conduct likely to bring discredit or unbecoming of a member of the Police.

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[99] Exhibit 1, Vol. 1, Tab 6, MCIS Report, p10
[100] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 56 and ts 10.12.20 (Downey), p58
[101] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 57 and ts 10.12.20 (Downey), p58
[102] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, pp19-21
[103] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 44-49 and ts 10.12.20 (Downey), pp59-64

63. With respect to the four breaches of the Regulations, Officer A was issued with an Assistant Commissioner's Warning Notice (the Notice) on 18 August 2016. The Notice was issued as a final reminder to Officer A that:

> [A]ny further incidents of unprofessional conduct by Officer A is likely to jeopardise his continued employment and engagement with the Western Australian Police.[104,105]

Did Officer A cause or contribute to Mr Kneale's death?

64. The inquest into Mr Kneale's death was mandatory because of the operation of section 22(1)(b) of the Act, which provides:

> (a) A coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and…
>
> (b) it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

65. Section 22(1)(b) is enlivened when the issue of causation or contribution in relation to a death arises as a question of fact, irrespective of whether there is fault or error on the part of any member of the Police.

66. In this case, the evidence establishes that at the relevant time, Officer A was the driver of a vehicle which collided with the rear wheel of the bicycle Mr Kneale was riding. That collision caused Mr Kneale to fall onto the roadway, and in doing so, he sustained a catastrophic head injury from which he subsequently died.

67. However, section 53(2) of the Act relevantly provides:

> The finding of the coroner on an inquest into a death 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.

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[104] Exhibit 1, Vol. 1, Tab 5.1, IAU Report, pp21-22
[105] Exhibit 1, Vol. 1, Tab 5.2, Statement - Mr M Downey, paras 50-52 and ts 10.12.20 (Downey), pp63-63

68. Section 59 of the RTA (the Offence) is designated as a "*crime*" and is thereby an "*indictable*" offence.[106] In this case, the Offence is clearly one in which the question of whether Officer A caused Mr Kneale's death was an issue. Therefore, any finding I make must not be inconsistent with Officer A's acquittal in relation to the Offence at the District Court Trial.

69. After carefully considering the evidence, I find it difficult to understand how it is possible that Officer A did not see Mr Kneale until immediately prior to the collision, if as Officer A says, he was not distracted in any way at the relevant time. Nevertheless, that is the effect of what Officer A said during his IAU managerial interviews, and of the evidence he gave at both the District Court Trial and at the Inquest.[107]

70. In his evidence at the District Court Trial, Officer A said that as he approached the Roundabout, he touched the Vehicle's brakes, checked and double-checked the road to his front and his right looking out for vehicles, and only proceeded onto the Roundabout when it was safe to do so. During Officer A's cross-examination at the District Court, the following exchange took place:

> *Prosecutor:* So how is it you didn't see Mr Kneale at any point during this checking and double-checking, looking to your right, looking in front, seeing that the coast was clear? How could you possibly have done all of those things and not seen Mr Kneale?
>
> *Officer A:* A question I have asked myself for I don't know how long.
>
> *Prosecutor:* And you still don't accept that you weren't looking?
>
> *Officer A:* I was looking.[108]

71. It is deeply regrettable that there appears to be no rational explanation for why Officer A did not see Mr Kneale. I can only imagine how much more difficult it must be for Mr Kneale's family to cope with their loss, in circumstances where although the physical cause of his death is known, the circumstances which led to the collision remain unexplained.

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[106] *Interpretation Act 1984* WA, s67
[107] ts 10.12.20 (Officer A), pp32-33
[108] Exhibit 1, Vol. 1, Tab 50 - Transcript, District Court District Court of Officer A, (Officer A), pp422-423

72. At the District Court Trial, Officer A said that at the time of the collision, the practice amongst police officers performing certain duties was for those officers to handle their mobile phones to view text messages whilst driving: "*when it was safe to do so*". Similarly, there was an expectation that a response to such text messages would be sent: "*straight away when practicable to do so*".[109,110]

73. In my view, however desirable it may have been for operational reasons for police officers undertaking certain duties to immediately view and send text messages whilst driving, that practice cannot be justified on safety grounds, with research studies concluding that: "*using a mobile phone while driving (especially texting) is highly distracting*".[111]

74. Detective Senior Sergeant Le Tessier (Officer Le Tessier), was Officer A's immediate superior at the relevant time, having assumed that role shortly before Mr Kneale's death. Officer Le Tessier said that to his knowledge there had never been an official policy or practice which authorised the use of electronic devices (including mobile phones) by the officers under his command.[112]

75. Nevertheless, on 6 April 2016, as a direct result of Mr Kneale's death, Officer Le Tessier introduced a new standard operating procedure (SOP) which prohibited technical equipment (including mobile phones) from being turned on or off, inspected or touched whilst an officer was controlling a motor vehicle on a roadway. Further, the SOP provided that: "*technical equipment may only be used when that use is not in contravention with the Road Traffic Code*".[113]

76. At the inquest, Officer A acknowledged that it is unsafe to use a mobile phone whilst driving.[114] That must be correct and the obvious safety issues relating to mobile phones were recognised by the Western Australian Government, which recently increased penalties for motorists using mobile phones whilst driving.[115]

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[109] Exhibit 1, Vol. 1, Tab 50 - Transcript, District Court District Court of Officer A, (Officer A), pp375 & 378
[110] ts 10.12.20 (Officer A), p20
[111] See: https://research.qut.edu.au/carrsq/wp-content/uploads/sites/45/2017/12/Mobile-phone-distraction-email.pdf
[112] ts 10.12.20 (Le Tessier), pp37-38
[113] Exhibit 2, Use of technical equipment whilst operating motor vehicles (06.04.16)
[114] ts 10.12.20 (Officer A), p24 and see also: ts 10.12.20 (Keogh), p43
[115] *Road Traffic Code 2000*, regulation 265

77. When announcing the new penalties, the Minister for Police and Road Safety observed:

> These increased penalties send a strong message to drivers who engage in deliberate risk taking behaviour. I want to make it clear to motorists, that using your mobile phone to text or read emails or FaceTime while you're driving is incredibly dangerous. We need to change the culture of many drivers. We've done it before with drink driving, we've done it with seatbelts and speeding. Now we are doing it with mobile phones. It may take some time to persuade people to be responsible, but we have to do it in order to make our roads safer.[116]

78. At the conclusion of the evidence at the Inquest, Mr Bennett made submissions to the Court about the proper construction of section 53(2) of the Act. He noted that the prosecution case at the District Court Trial was that Officer A's manner of driving at the relevant time was dangerous, at least in part because it was so inattentive that it constituted a danger to the public.[117,118]

79. Mr Bennett submitted that in light of Officer A's acquittal, and because of the terms of section 53(2) of the Act, it would not be permissible for me to make a finding that Officer A's manner of driving was inattentive at the relevant time. I agree with the thrust of that submission, but as I indicated at the Inquest, it is appropriate for me to set out the evidence as to how the collision occurred and to refer to the fact that Officer A has no explanation for why he did not see Mr Kneale prior to that time.

80. In any case, as a consequence of the statutory provisions I have outlined, any finding I make must not be inconsistent with Officer A's acquittal with respect to the Offence. Therefore, other than finding that, as a matter of fact, Officer A contributed to Mr Kneale's death, I make no further finding with respect to Officer A's manner of driving on 29 March 2016.

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[116] Press release by The Hon. Michelle Roberts, Minister for Police and Road Safety (02.02.20)
[117] ts 10.12.20 (Bennett), pp67-70
[118] Handout to the Jury, District Court Trial of Officer A

Police contact with Mr Kneale's family

81. Mr Kneale's family provided a written statement to the Court which was read aloud at the Inquest by counsel assisting, Ms Rachel Collins. The terms of the statement are as follows:

> We would like to thank Detective Sergeant Keogh of the Major Crash Investigation Section. During the two years we were in contact he showed absolute professionalism and kindness at all times.
>
> We are, however, disappointed in our other dealings with the WA Police. After being initially promised transparency with the process it became clear that the main priority was protecting the Police Officer involved. Whilst we understand the need to keep his identity suppressed, the truth surrounding his actions should not have been kept hidden.
>
> We hope that recommendations from this inquest may better equip WA Police for dealing with the victims should a similar event happen in the future.
>
> Family of Jamie Kneale[119]

82. Although Officer Keogh's contact with the family was clearly appropriate and welcomed by Mr Kneale's family, it is unfortunate that the family were left feeling that the subsequent approach of the Police was primarily focused on protecting Officer A, and that their needs were effectively overlooked.[120]

83. As I will outline, this perception was compounded by the fact that there was very limited contact between Mr Kneale's family members and senior police officers. To further complicate matters, court orders necessary for the proper conduct of the District Court Trial prevented Officer A's identity from being disclosed and from the perspective of Mr Kneale's family, this greatly inhibited their ability to properly and openly grieve the loss of a beloved family member.[121,122]

[119] Email from Ms S McGinn to Counsel assisting (09.12.20)
[120] Email from Ms S McGinn to Ms K Ellson (30.05.18)
[121] Exhibit 3, Letter to Court from A/Asst. Commr. P Dallimore, (14.12.20), p2
[122] Email from Ms S McGinn to Ms K Ellson (30.05.18)

84. In a letter to the Court dated 14 December 2020, Acting Assistant Commissioner Paul Dallimore (Officer Dallimore) confirmed that there had been three meetings between members of Mr Kneale's family and the Police.[123]

85. The first meeting took place on 30 March 2016, when Assistant Commissioner Paul Steel (Officer Steel) offered his commiserations to family members when he met with them at RPH. The family say that although Officer Steel promised: "*absolute transparency with the way the matter would be handled*", he also impressed upon the family the importance of not discussing the matter publicly, including on social media.[124,125]

86. The second meeting occurred on 17 March 2017 when Officer Le Tessier (who was an Acting Inspector at the time) met with family members. The third and final meeting took place on 23 March 2018, when family members met with the Commissioner of Police, Mr Chris Dawson.[126]

87. In his letter, Officer Dallimore had this to say about police communications with Mr Kneale's family:

> At the conclusion of the inquest, I became aware that the family of Mr Kneale had provided the court with a written statement which, amongst other matters, outlined a significant level of dissatisfaction with the lines of communication between senior levels of the WA Police and themselves.
>
> …
>
> On reflection, not involving Commissioned police officers in frequent and on-going communication with the family of Mr Kneale was a failing by WA Police in their handling of this matter.[127]

[123] Email from Ms S McGinn to Ms K Ellson (30.05.18)
[124] Exhibit 3, Letter to Court from A/Asst. Commr. P Dallimore, (14.12.20), p2
[125] Email from Ms S McGinn to Ms K Ellson (30.05.18)
[126] Exhibit 3, Letter to Court from A/Asst. Commr. P Dallimore, (14.12.20), p2
[127] Exhibit 3, Letter to Court from A/Asst. Commr. P Dallimore, (14.12.20), pp1-2

88. I wholeheartedly agree with Officer Dallimore's assessment of the quality of communication between the Police and members of Mr Kneale's family. Clearly given the complexities of this matter, there should have been early, frequent and ongoing contact between the family and a senior police officer.

89. I note with approval, Officer Dallimore's letter extends an invitation to Mr Kneale's family to meet with him to discuss their concerns and to provide an opportunity for the Police to hear any suggestions they may have for how the Police could have communicated more effectively. It will be a matter for Mr Kneale's family as to whether they take up this offer, but I hope they do. I believe that hearing directly from the family, even at this late stage, would be of benefit to the Police.

90. It can be expected that following a tragic death, friends and family members of the deceased will be in shock and emotions will be raw. In those circumstances, although certain official actions may be necessary for legal or operational reasons, those actions may sometimes be perceived as harsh or uncaring.

91. In my view, in order to ensure that the potential for any further trauma is minimised, it is critical that police officers tasked to liaise with a deceased person's family, be reminded of the importance of treating those persons with sensitivity and empathy. I urge the Police to redouble their efforts in this regard. Further, the Police should make every effort to ensure that all communications with a deceased's family are as open and transparent as possible.

92. The complicated arrangements that were necessary in this case may not be common, but when they do occur, special care is needed to ensure that communication with family members is effective. In this way, although a deceased's family may disagree with an official action, at least the rationale for the action can be carefully explained. For the reasons I have outlined, in this case it would have been appropriate for a commissioned officer to have initiated unprompted early (and ongoing) contact with Mr Kneale's family.[128]

[128] See also: ts 10.12.20 (Keogh), pp49-50

Apologies

93. It appears that an apology was delivered to Mr Kneale's family on behalf of the Police, but it was tendered some considerable time following his death and only after the family had requested it. An apology in those circumstances, whilst no doubt still welcome, has the potential to be less effective than an unprompted apology delivered closer to the relevant event.[129]

94. I am aware that concerns about civil liability in relation to an incident where death has occurred may inhibit individuals from making an apology when they might otherwise wish to do so. This is understandable, and in some cases may be the result of legal advice the person receives.

95. In broad terms, Part 1E of the *Civil Liability Act 2002* (WA), (the CLA) permits an apology to be made by or on behalf of a person in connection with any incident giving rise to a claim for damages. Further, an apology in accordance with the CLA does not constitute an express or implied admission of liability and is not relevant to the determination of fault or liability in relation to the incident and is inadmissible in any civil proceeding.[130]

96. The CLA defines the term "*apology*" to mean:

> [A]n expression of sorrow, regret or sympathy by a person that does not contain an acknowledgement of fault by that person.[131]

97. It seems to me that a person involved in an incident that causes another person's death, and who is contemplating making an apology, may find some comfort in the provisions of Part 1E of the CLA. Obviously the question of whether it is appropriate, in any given circumstance, to offer an apology and further, the terms of any such apology, are matters for the individual concerned.

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[129] ts 10.12.20 (Downey), p64
[130] *Civil Liability Act 2002* (WA), ss5AF - 5AH
[131] *Civil Liability Act 2002* (WA), s5AF

RECOMMENDATIONS

98. In light of the observations I have made in this matter, I make the following recommendation:

Recommendation No.1

Where it appears that the death of a person is caused or contributed to by any action of a member of the Western Australian Police Force (the Police), then in order to ensure that communications between the Police and the deceased's family members are as effective and timely as possible, the Police should task a commissioned police officer to undertake early, regular and ongoing contact with the deceased's family members. One purpose of this ongoing and regular contact would be to ensure that, as far as is reasonably practicable, family members are informed of relevant official actions and further, are given an opportunity to express their views on those actions.

CONCLUSION

99. At about 3.00 pm on Tuesday, 29 March 2016, Mr Kneale was riding his bicycle towards his parents' home in Gosnells. He was heading there to help his mother care for his father. He never arrived. Instead, Mr Kneale, who was then 43-years of age, was knocked off his bicycle by a vehicle driven by Officer A, an on-duty police officer.

100. As a result of the collision, Mr Kneale sustained catastrophic head injuries and he died at RPH on the afternoon of 30 March 2016. Mr Kneale was a much loved family member, whose loss is keenly felt.

101. During his life, Mr Kneale had expressed his wish to be an organ donor. Despite the awful circumstances they were confronted with, Mr Kneale's family facilitated this selfless gift and thereby helped numerous people. I can only hope that this knowledge may provide Mr Kneale's family and friends with some solace as they continue to cope with his unexpected and tragic death.

MAG Jenkin
Coroner
13 January 2021