IN THE CORONER'S COURT OF THE) No CD 224 of 2005
AUSTRALIAN CAPITAL TERRITORY)

INQUEST into the death of

CLEA KATHLEEN ROSE

Coroner's Report of Findings

Coroner K M Fryar

19 December 2007

1. Clea Kathleen Rose (born [redacted] 1984), a much loved daughter, sister and friend, was struck by a stolen car driven by a 14-year-old juvenile at approximately 12.10am on Saturday 30 July 2005. Tragically she died on 20 August 2005 as a result of the injuries she received.

Facts

2. Having regard to all the evidence before me I am satisfied that the following are the facts of the incident. In the early hours of Saturday 30 July 2007 Constable Cooper was the driver of an unmarked silver Holden Commodore Police sedan with Constable Bobolas as his passenger. They had been briefed by Sergeant Matt Corbitt that evening in respect of targeting car parks and stolen vehicles in the Civic area.

3. Both constables had completed training in respect of, and held appropriate qualifications in relation to, undertaking urgent duty and pursuit driving and since their training neither had been referred to the training officer for recertification or remedial or corrective purposes. The police vehicle driven by Constable Cooper that evening was of an appropriate classification (in accordance with the National Guidelines) to be engaged in urgent duty driving and pursuit activities.[1] There is no evidence that the experience or driving competence of Constable Cooper had any influence on what happened.

4. Shortly after midnight on 30 July 2005 Constables Cooper and Bobolas drove into the car park at the intersection of London Circuit and Constitution Avenue and as they did so they saw a white Holden Commodore sedan (which in fact was stolen) on Constitution Avenue exiting the car park. The car contained three youths who had just broken into two cars parked adjacent to the Legislative Assembly building off London Circuit. When the youths saw the police car the driver BL, with the encouragement of his passengers, decided to "take off" in an attempt to avoid apprehension.

5. BL drove the stolen Commodore out of Constitution Avenue, turned left onto London Circuit heading towards Northbourne Avenue, reaching a speed of not less than 80 kph. The police followed them, with the intention of stopping the vehicle to make enquiries. Neither officer knew the driver or realised at the time that he was a juvenile.

[1] Many red herrings to the central concern have been raised in this matter, including the possibility of an issue regarding the classification of the vehicle, and the training and understanding of the police officers involved of the pursuit guidelines. These are matters that have no relevance at all to what actually happened, and are, accordingly, matters on which I am unable to make a comment.

6. It is simply wrong to say that the evidence was that Constable Cooper knew the vehicle was attempting to evade him from the moment it turned onto London Circuit. His evidence was very clear and thoroughly tested in cross-examination and I have no reason to reject it.[2] The fact that it may have been BL's actual intention at that stage to evade police is a different matter that we know of now.
7. At somewhere along London Circuit, between its intersections with Akuna Street and Ainslie Avenue, Constable Bobolas activated the warning devices fitted to the police vehicle. It was the officers' intention by doing this, not only to alert the driver of the Commodore of their presence and instruct him to stop, but also to alert others in the immediate area of impending danger.
8. BL drove through a red light at the Pitts car park entrance, and became aware that he was unable to continue through the Northbourne Avenue intersection due to traffic build up at a red light facing him at that intersection. At that moment he therefore made the fateful decision to turn the vehicle into East Row. He had driven along that road earlier in the evening and was aware of pedestrians in the area.
9. After turning into East Row BL put his "foot on the accelerator" and drove reaching a speed of approximately 90 kph. As the vehicle approached the intersection of Alinga and Mort Streets, Clea Kathleen Rose was attempting to cross Mort Street (from west to east) with her friends Tessa Flaherty and Tara Edwards. Ms Flaherty and Ms Edwards saw the white Holden Commodore approaching at speed, and stopped. Ms Rose, however, continued across the road and was struck by the vehicle.
10. Immediately prior to colliding with Ms Rose, BL applied the brakes of the Commodore and skidded, slowing to a speed calculated to have been approximately 76 kph. This skid caused white smoke to emanate from the tyres of the vehicle. However BL did not stop after the collision, choosing instead to accelerate along Mort Street, crossing Bunda Street and continuing into Braddon.
11. As a result of being struck by the Commodore Ms Rose was thrown a distance of approximately 23 metres, coming to rest on the eastern side of Mort Street near the Platform 9 bus shelter.

[2] T p.471 and following

12. Meanwhile Constables Cooper and Bobolas had seen the vehicle turn right into East Row and at that stage had lost sight of it. The police vehicle stopped at the red light at Pitts car park before proceeding and turning into East Row. By the time Constable Cooper turned the police car into East Row the Commodore had established a considerable gap and was close to Bunda Street. On entering East Row Constable Bobolas saw a cloud of smoke down Mort Street near where the Commodore was passing the Greater Union Cinemas.
13. By this stage the officers were aware that the driver was attempting to avoid apprehension and that they were now engaged in a pursuit in accordance with the AFP National Guidelines relating to urgent driving and pursuits. Their views as to the precise point the pursuit actually commenced varied slightly, but as a matter of practicality the different opinions did not affect the outcome or the course of the pursuit.
14. As the police car travelled down East Row towards Alinga Street at approximately 55 kph both police officers were aware of the pedestrian traffic and identified community safety as a high priority. As they reached or were approaching the intersection with Alinga Street Constable Bobolas contacted Police Communications by radio and notified they were involved in a police pursuit. He was of the view that this was the first practicable opportunity he had to do so, given the many competing matters requiring their attention and the very short space of time it actually took to travel the distance from London Circuit to the East Row/ Alinga street intersection.[3]
15. The evidence does not support Mr Bradfield's submission that *"the pursuit commenced at the intersection of London Circuit and Akuna Street when [BL's] vehicle attempted to evade police by speeding on to London Circuit".*[4] Further, the mere fact that BL drove away at speed along London Circuit, and is then followed by police, does not automatically make it a "police pursuit", otherwise every motorist exceeding the speed limit who is pulled over by a following police vehicle could be said to be involved in a police pursuit, and that is clearly not the case. The evidence also does not support a finding that

    BL's manner of driving was adversely influenced by the actions of the police, either by their following him at speed or activating the police lights and sirens. BL's evidence was that he made the decision to drive faster when he first knew that the police were following him, when

[3] T p.426 line20 following; p.428 line37

he turned left onto London Circuit.[5] His intention always was to avoid being caught by the police.[6] At no stage did BL say that if the police had stopped following he would have stopped driving.

16. In some ways it does not really matter how what actually happened is described or classified. Defining it as a "police pursuit", or not, does not change the horrible consequence of BL's behaviour. Additionally, for Sergeant Sobey to say with hindsight that he would have called off the pursuit had he been available as the pursuit controller is irrelevant to the manner and cause of Ms Rose's death, as by the time the police car was turning into East Row tragically Ms Rose had already been struck by the vehicle driven by BL.
17. As they drove down East Row and Mort Street the police were not aware that Ms Rose had been hit by the Commodore, nor did they see her on the side of the road. It appears that her final position of rest was obscured from them by a taxi driven by Mr Canh Nguyen and the gathering pedestrians, none of whom waved down the police car as it passed. Constables Cooper and Bobolas first became aware of the accident after they recovered the abandonned Commodore in Braddon, noticed the collision damage and were advised by police radio of the casualty.

18. It became evident that the system of CCTV cameras in the Civic area did not work appropriately that evening. Although if the system were fully functioning it may have been helpful in the investigation, further comment in this regard is unwarranted in the context of this inquest.
19. Clea Kathleen Rose died at Clare Holland House on Saturday 20 August 2005 as a result of the injuries she sustained from the collision.

Jurisdiction of the Coroner

20. Section 13 of the *Coroners Act 1997* ('the Act') relevantly provides as follows:

> " *A Coroner shall hold an inquest into the manner and cause of death of a person who - ...*
>
> *(h) dies after an accident where the cause of death appears to be directly attributable to the accident; ..."*

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[4] Rose Family Submissions p.12 para 2.3.5
[5] T p.347 line 38; p.357 line 43
[6] T p.351 line 10; p.352 line 1; p.353 line 23

It is pursuant to that section that I am required as Coroner to hold an inquest into Ms Rose's death. There was never any doubt that I would. Ill-informed speculation in the early days following Ms Rose's death may have mistaken that requirement with the option a coroner has whether or not to hold a hearing as part of the inquest process.

21. Section 34 of the Act allows as follows:

> " *For an inquest or inquiry, a Coroner may conduct a hearing*."

Further section 14 allows that –

> *"(1) A Coroner may decide not to conduct a hearing into a death if, after consideration of information given to a Coroner relating to the death of a person, the Coroner is satisfied that-*
> *(a) the manner and cause of death are sufficiently disclosed; and*
> (b) *a hearing is unnecessary."*

After considering all the matters before me at the time I did decide to hold a hearing, so that oral evidence could be called in addition to the voluminous documentary evidence already before me, in the hope it would further assist my enquiries, and allow a full and public examination of relevant matters.

22. The ambit of the Coroner's job is succinctly set out in section 52 of the Act -

> *"(1) A Coroner holding an inquest must find, if possible-*
> *(a) the identity of the deceased; and*
> *(b) when and where the death happened; and*
> *(c) the manner and cause of death;*
> *...*
> *(3) At the conclusion of an inquest or inquiry, the Coroner must record his or her findings in writing.*
> *(4) A Coroner may comment on any matter connected with the death, fire or disaster, including public health or safety or the administration of justice."*

- and further in sub-section 57(3) -

> " *A Coroner may make recommendations to the Attorney-General on any matter connected with an inquest or inquiry, including matters relating to public health or safety or the administration of justice*."

23. The limited focus of the *Coroners Act 1997* was canvassed by the Full Court of the ACT Supreme Court in *The Queen v Coroner Maria Doogan and others; ex parte Australian Capital Territory* -

" In litigation inter partes the nature of the questions that the judicial officer is required to determine can generally be found in the pleadings, but Coronial inquiries have no pleadings and, strictly speaking, no parties. The task of a Coroner is not to determine if anyone is entitled to some legal remedy, is liable to another or is guilty of an offence. The Coroner's task is to inquire into the matters specified in the relevant sections of the Coroners Act 1997 ('the Act') and make, if possible, the required findings and any comments that may be appropriate. ...

...However, a Coroner is not free to enlarge his or her own jurisdiction by the adoption of terms of reference,...

The Act is generally concerned with the resolution of relatively straightforward questions such as 'what was the cause of this death?' or 'what caused this fire?'. It does not provide a general mechanism for an open-ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred. Specific provisions of the Act confer jurisdiction on coroners to enquire into stipulated questions, require them to make certain findings, and empower them to make comments." [7]

24. The Court continued regarding the Act [8] -

" *[s.18] does not authorise the coroner to conduct a wide-ranging enquiry akin to that of a Royal Commission, with a view to exploring any suggestion of a causal link, however tenuous, between some act, omission or circumstance and the cause or non-mitigation of the fire. As Nathan J said in Harmsworth v The State Coroner, such discursive investigations might never end and hence never arrive at the findings actually required by the Act. It would also be difficult to contain such enquiries within reasonable bounds whilst at the same time ensuring due fairness. Once evidence of a particular issue were admitted, those who feared that such evidence might form the basis for adverse comments concerning their conduct would inevitably wish to challenge it and to call other evidence to rebut or qualify it. Yet the admission of further evidence might raise further issues and hence generate applications for still more evidence to be called. Thus, a coroner might be constantly torn between the need to contain the scope of the enquiry and the need to ensure that all interested parties were treated fairly. More fundamentally, the section does not confer jurisdiction to conduct inquiries of that scope.*

[7] *[2005] ACT SC 74*, paragraph 12 and following
[8] at paragraph 28 and following

A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the 'common sense' test of causation affirmed by the High Court of Australia in March v E & MH Stramare Pty Ltd (1991) 171 CLR 506. The application of that test will obviously depend upon the circumstances of the case, and, in the context of a Coronial inquiry, it may be influenced by the limited scope of the inquiry, which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame. …

There will, of course, be many cases in which the issue of causation will necessarily involve an examination of a person's conduct. … Hence, a coroner might well hear evidence suggesting that a cyclist's death had been caused not merely by a collision with a motor vehicle, but also by the antecedent conduct of the driver of that vehicle in failing to stop at a stop sign adjacent to an intersection. However, the limited jurisdiction conferred by s 18(1) would not authorise the coroner to inquire into any perceived failures in relation to general policy relating to the siting of stop signs or the enforcement of traffic regulations. The particular siting and design of the relevant intersection may be a different matter. The application of the common sense test of causation will normally exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices."

25. The court went on to say that a requirement to find, if possible, (in that case) not only the cause and origin of the fire but also the circumstances in which it occurred, "…*is not augmented by any conferral of jurisdiction to enquire into such circumstances"*. In relation to the right to make comments the Supreme Court was concerned to point out that the power to make comments does not enlarge the scope of the coroner's jurisdiction to conduct an inquiry and again quoted Nathan J in *Harmsworth v The State Coroner* [9] -

" The power to comment, arises as a consequence of the obligation to make findings… it is not free-ranging… The powers to comment… are

[9] (1989) VR 989 at page 996

inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendations. It arises as a consequence of the exercise of a coroner's prime function, that is to make 'findings'...."

26. That principle is wholly applicable to this matter. My prime function is to make the findings required by section 52 of the Act in relation to the death of Clea Kathleen Rose. It is true that I may also make comments and appropriate recommendations. However that power is very limited and tied entirely to the findings I must make. Any comments or recommendations must be in relation to matters that are essentially connected to the death, not in relation to matters that are somehow peripherally related.

27. Given the fact (as will be discussed below) that the vehicle that hit Ms Rose was being followed by a police car, it has been clear from the early days following the incident that the family and elements of the media have sought that my inquiry be extended to the content and sufficiency of the AFP Pursuit Guidelines. The Commonwealth Ombudsman wrote to me on 6 June 2006 expressing his view that there were issues of public interest that could (and I presume he was of the view, should) be explored further in my inquiry, including the issues of *" ... whether there had been full compliance with the AFP Pursuit Guidelines, the adequacy of the Guidelines in the light of this incident, and the parents' concerns about the findings reached in the AFP investigation."*

28. I have always maintained, and still maintain, that such a broad inquiry is beyond my jurisdiction. I simply do not have the wide-ranging powers of inquiry such as have been granted to, for example, the Ombudsman himself.

29. Although Mr Bradfield, counsel for the Rose family, had assured me that it was accepted by the family that the policy concerning the Pursuit Guidelines was beyond the ambit of my jurisdiction, it is apparent from the written submissions made by him on behalf of the family at the conclusion of the hearing (and in particular regarding the recommendations they seek that I make) that there remains a misunderstanding as to the extent of my jurisdiction.

30. Having regard to the ACT Supreme Court's decision in the matter of *R v Coroner Maria Doogan & Ors*[10] it is clear that the ambit of my jurisdiction turns on the specific findings I am required to make in relation to Ms Rose's death pursuant to the Act. Despite the fact that the car that collided with Ms Rose was being followed by police, and that this may be a circumstance related in some way to how Ms Rose's death occurred, I am not required, or indeed authorised or able, to inquire into the surrounding circumstances of the pursuit, let alone the public policy that relates to the AFP Pursuit Guidelines, except to the limited extent of determining what, as a question of fact, actually occurred on 30 July 2005. I am certainly not entitled to comment or make recommendations on such matters. Expressions of opinion by the media, the Ombudsman, or counsel appearing for the family that the law should be otherwise, do not change the law.

Investigation

31. Detective Sergeant Ian Faulds and Detective Sergeant Daryl Neit are the investigators who have assisted me throughout this inquest. Both of those officers are senior members of the Australian Federal Police and have significant experience and expertise in relation to traffic accident and coronial investigations.

[10] supra

32. They were not appointed pursuant to section 59 of the *Coroners Act* 1997. The arrangement in this particular case was also not one that was necessarily facilitated by section 63 of the Act. Rather, their assistance was provided as a result of a general arrangement with the Australian Federal Police to assist coroners in the Australian Capital Territory. There is no reason in law precluding such a co-operative arrangement and, on a practical level, no issue arises concerning my control or conduct of the investigation into this death by reason of the informality of the process.

33. Prior to the hearing there had been some speculation in the media concerning the police investigation of this incident, and in particular whether the police present had in fact interviewed all witnesses available at the scene. As a result, in September last year, I made a further call for any witnesses who had not already given their statement to the investigators to come forward, but despite the publicity given to my call and the matter generally, no additional witness came to light.

34. From a perusal of the brief of evidence it appears that the investigators were thorough in pursuing statements from any eyewitnesses to the accident of which they were made aware, even those obliquely referred to in the statements of other witnesses. Certainly no outstanding issue in that respect, based on evidence, has been raised.

35. Further, it became known that immediately following the accident certain witnesses approached the media, rather than the police, apparently for purposes of self-aggrandisement and certainly not for the purpose of assisting the coronial or any other inquiry in this matter. Accordingly, it is evident to me that any concerns that were previously expressed that witnesses had not been spoken to primarily stemmed from the unfortunate actions of those particular people, and not from any actual failure of the police to properly carry out the investigation.

36. There is no evidence that any witness exists who was not spoken to by investigating police or given the opportunity to provide a statement. Nor is there any evidence that I do not have before me all witness statements that have been given to the investigating police. As it transpired 62 witnesses gave statements to the investigating police in relation to their

observations of both the vehicle that hit Ms Rose and the following police vehicle in the areas from London Circuit to Lonsdale Street, Braddon.[11]

37. During the hearing there were further concerns expressed by the witness Tessa Flaherty in her evidence about the conduct of certain police at the scene of the accident. However that issue was fully explored during the hearing and, in my view, adequately explained by the evidence that followed. In my opinion that issue had no impact on the integrity of the investigation.

38. On the first day of the hearing Mr Bradfield referred to concerns that the family had regarding the issue of "police investigating the police". This was no surprise as it was a concern previously expressed by the family and brought to my attention (and the attention of investigating police) as early as the end of August 2005, only a short while after Ms Rose had died, by way of an article in the Canberra Times. *"However, Clea's family said that while they had faith in the judicial processes, they wanted a full, open and transparent investigation into what happened. 'When something like this goes wrong, we are less than confident about police investigating police. We would much rather have an inquest, and I will be requesting that one goes ahead,' Mr Dunn said."*[12]

39. Further, the solicitors for Ms Rose's family wrote to me on 22 June 2006. They stated: *"We suggest that where the Police are investigating themselves there is an overarching issue (which we believe is not restricted by the decision in R v Coroner Maria Doogan: ex parte ACT & Ors(sic), of public*

confidence being maintained in the system of police investigations and cases involving deaths in controversial situations involving a statutory authority, in this case being the ACT Police Service."

40. Mr Bradfield again raised the issue at a directions hearing on 27 October 2006[13], suggesting that an independent report may be called for after reading the brief, and that the Rose family were concerned about "police investigating the police"[14]. He did however at that stage eschew any suggestion that there was a cover-up by the police investigators –

"MR TODD: Your Honour, if I could just respond for a moment. I mean as your Honour quite rightly puts it, if there's an allegation of cover-up by the police put on behalf of the family

[11] Exhibits 34 – 36, 38 – 75, 77 – 89, 91 - 98
[12] Canberra Times, 30 August 2005
[13] Transcript 27/10/2006 pages 6 - 7
[14] T p.7 line 11 and following

then they should fairly put it. But ultimately the suggestion that's impliedly or implicitly made at the moment is that the police investigation and the assistance your Honour has been given is somewhat flawed…

MR BRADFIELD: That's not the submission.

MR TODD: … because they are members of the Australian Federal Police. …

MR BRADFIELD: But certainly that's not the submission."[15]

41. As a general proposition the idea of an organisation investigating the involvement of its own in such an incident as the one in question here is a reason for caution and for close scrutiny to be applied especially to any report or result of such an investigation. Put quite simply, however, that is precisely what has happened in this matter by the process of this inquest.

42. For example, the Commonwealth Ombudsman was directly involved in the oversight of the preparation of the AFP Professional Standards report. As I understand it, one of his roles in that respect would be to satisfy himself of the propriety of the investigation concerning the involvement of police. However in the correspondence he forwarded to me[16], after raising some initial concerns about the investigation, he concluded that there was no need for further investigation of the issues surrounding the incident. Although he has subsequently raised matters he felt need further examination, it appears he was satisfied that there was no problem with the integrity of the investigation, and indeed of the officers that were conducting it. That specifically was never an issue raised by him.

43. My reference to the failure of the Ombudsman to raise concerns about the propriety of the investigation conducted by the Australian Federal Police should not be taken to indicate a failure on my part to appreciate my obligation to satisfy myself of the propriety and extent of the investigation. Having carefully considered all of the evidence, as tested through cross-examination by experienced counsel, I am left in no doubt that the investigation was properly conducted.

44. No expressed concern regarding the investigation was ultimately substantiated on the evidence. There was no evidence that further material was available that should have been before me but was not. There was no actual evidence to support any proposition that Detective Sergeant Faulds or Detective Sergeant Neit had prejudged the issues concerning the

[15] T p.7 - 8

involvement of the police officers in this incident, or had attempted to influence witnesses in their evidence, or that they had been selective in the evidence presented to me. Indeed the evidence was totally to the contrary, particularly in the context that both senior officers were fully aware from the beginning of the scrutiny under which they and their investigation would be placed.

45. The most serious allegation by Mr Bradfield against Detective Sergeant Faulds, that he had "modified or slanted evidence"[17] was found ultimately to be without basis. Mr Bradfield did eventually withdraw (somewhat equivocally) that allegation, but only at the insistence of Mr Purnell SC.[18] However he renewed his personal attack on Detective Sergeant Faulds in his written submissions, further accusing him of being "less than frank and forthcoming" in his evidence[19]. I note that no such allegation (that he was lying) was actually put to the detective during cross-examination.

46. It was also alleged that Detective Sergeant Faulds had attempted to influence Tessa Flaherty in her evidence. However a closer examination of her evidence in relation to her conversation with the officer purportedly concerning "video footage of the vehicles being eight seconds apart" [20] (which is where the allegation of his attempt to sway or influence her evidence comes from) results in a perfectly plausible explanation being apparent to what is, on her own admission, some confusion by the witness.[21] *"I don't know whether the 8 seconds apart was in relation to the camera footage or whether it was in relation to the witness statements that my Dad's saying."* Further, taking into account the detective's evidence on this aspect, it appears that Ms Flaherty's recollection in this regard is faulty, not surprisingly given the distressing nature of the incident.

47. At no stage have I been concerned that there was any inadequacy in the police investigation, caused by any perceived conflict of interest or otherwise, or that the integrity of the investigation (and therefore my inquiry) was compromised in any way. Had I become so I would then have had a basis for approaching government with a request that I be provided with the extraordinary resources required to engage alternative

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[16] 6 June 2006, enclosing letters to ACT Chief Police Officer 8 December 2005 and 6 March 2006
[17] T p.140 line 18
[18] T p.174 lines 29 - 40
[19] Bradfield submissions p. 5
[20] Exhibit 82 and T p. 272

investigators. Despite being asked on many occasions throughout the hearing to point out any deficiency in the investigation to me, counsel for the family could not.

48. The personal, and at times vitriolic, attack by counsel for the family on the credibility of the officers who assisted me (and therefore on the credibility of my inquest) was, in the end, without foundation. There was nothing that arose from the evidence to suggest that the investigation was tainted in any way. The only conclusion that I could draw to explain the extraordinary approach in this regard was that it reflected more on the preconceived and (therefore) biased position of others, rather than a position based upon the evidence.

Findings

49. In accordance with section 52 *Coroners Act 1997* I make the following formal findings:

- Clea Kathleen Rose, born [redacted] 1984, died at Clare Holland House at 6am on 20 August 2005.
- The manner of her death was an irreversible global brain injury.
- The cause of her brain injury (and accordingly her death) was that at about 12.10am on Saturday 30 July 2005 as she was attempting to cross East Row, Civic as a pedestrian, she was struck by a stolen vehicle driven by BL. At the time BL, in the company of two other juveniles, was attempting to avoid being apprehended by the police.

50. I also find that the 'pursuit' by the police did not contribute to the cause of Ms Rose's death. I do not make any formal recommendations about the AFP Pursuit Guidelines. As I have already said, that is a matter that is beyond the purview of the coronial inquest, and in any event I note that a separate enquiry into them has recently been conducted.

51. The only comment I will make is in relation to the position of pursuit controller. In this case Sergeant Sobey was the nominated pursuit controller at the time of the incident, although the evidence is that when Constable Bobolas called the pursuit in Sergeant Sobey was unavailable as he was on another call. I have found that this fact was not ultimately relevant to the outcome in this particular matter. However clearly the existence of a nominated pursuit controller is a measure put in place pursuant to the guidelines as a public safety check. It is entirely foreseeable that the nominated pursuit controller may be temporarily unavailable from

[21] T p.312, 313

time to time and it seems sensible that a system be in place that provides for a deputy or backup pursuit controller for such occasions. If such a system is indeed in place, it would appear to need clarification.

I certify that the preceding fifty one (51)
paragraphs are a true copy of the
Report of Findings of Coroner K M Fryar

Associate: N E Bilinsky
19 December 2007