CORONERS COURT
NEW SOUTH WALES

Inquest:	Inquest into the death of Leif James
Hearing dates:	11-12 August 2015
Date of findings:	28 August 2015
Place of findings:	Coroner's Court, Glebe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-Death in course of police operation-police pursuit-New South Wales Police Safe Driving Policy-critical incident guidelines
File number:	2013/331891
Representation:	**Counsel Assisting** P Aitkin instructed by L Molloy, Crown Solicitors Office **Commissioner of Police** R Hood instructed by M Nibbs, Officer of the General Counsel, representing Commissioner of Police and the NSW Police Force

NON PUBLICATION ORDER PURSUANT TO SECTION 74 *CORONERS ACT NSW 2009* OF THE NSW POLICE FORCE SAFE DRIVING POLICY

IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. Leif James died on 31 October 2013 as a result of injuries he suffered as a passenger in a motor vehicle collision. The vehicle he was in was a stolen vehicle and was being pursued by police.

2. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

   (a) the identity of the deceased;

   (b) the date and place of the person's death;

   (c) the physical or medical cause of death; and

   (d) the manner of death, in other words, the circumstances surrounding the death.

3. The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred "*in the course of police operations*". (s.23, s.27).

> *"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police ...... have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and*

warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."[1]

4. This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. This Inquest has been a close examination of the police actions on the day of Mr James's death and pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

5. Section 82 of the Act also permits a Coroner to make recommendations that are necessary or desirable in relation to any matter connected with a death that relates to issues of public health and safety.

Leif James

6. Mr James was only 18 years old at the time of his death. He was the only child of Rachel James and Desmond Poutama. He was born in New Zealand.

7. In primary school in New Zealand Mr James demonstrated his sporting ability at rugby union, rugby league and touch football. During his high school years he lived between New Zealand and Sydney. Throughout his high schooling he did well at sport.

8. Most recently Mr James had been living with his mother and stepfather in Queensland and was working as a casual labourer. His death occurred during a visit to friends in Sydney. His death came as a completely unexpected and devastating shock to his family and they continue to grieve.

Facts in outline

9. During the night of 29 October 2013 the blue Subaru Liberty that Mr James was in when the fatal collision occurred, was stolen from outside a house at Narrabeen.

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[1] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

10. At about 10am the following morning Mr Peter Simon arrived at Mr Jaden Rose's house driving the vehicle. Mr James was at Mr Rose's house and accepted an offer to go with Mr Simon in the car. There is no evidence to establish whether Mr Simon discussed whether the car was stolen or whether Mr James at any point knew that the car was stolen.

11. Shortly after 1pm that day, the owner of the car's father-in-law rang and told the owner that he'd seen the car driving in Frenchs Forest. The owner rang "000" and reported the sighting.

12. The VKG log shows that a broadcast was made at 1:34pm about the stolen Subaru.

13. The VKG log then shows a broadcast from "Northern Beaches 131", advising they were in pursuit of the stolen vehicle, and were turning left onto Warringah Rd. Shortly after "Northern Beaches 270" broadcast that it was also in pursuit, and was travelling on the Wakehurst Parkway. "North Western Metro 275" then came on the radio advising it was pursuing the Subaru eastbound on Wakehurst Parkway. Almost immediately following there was a broadcast that the Subaru had crashed.

14. The pursuit lasted 80 seconds. In-car video is available from 2 of the 3 police vehicles involved in the pursuit and VKG transmissions during the course of the pursuit are also available.

15. The first car to be involved was "Northern Beaches 131", a Lancer driven by Constable Harte, with Constable Thompson as passenger. They spotted the Subaru on the Forest Way and activated their lights and sirens and announced they were in pursuit. They passed Senior Constable Gifford, who was waiting in "North Western Metro 270" at the intersection of Forest Way and Warringah Rd. He then followed them by turning left onto Warringah Rd, also under lights and sirens. The third car, "North Western Metro 275" driven by officer Caracoglia followed under lights and sirens from Warringah Rd onwards.

16. At the intersection of Warringah Rd and Wakehurst Parkway, the Subaru suddenly veered

left into Wakehurst Parkway. This left "Northern Beaches 131" in the right hand lane, but allowed "North Western Metro 270' and "North Western Metro 275", both Highway Patrol cars, to pursue. The Subaru then proceeded through a red light, at the intersection of Wakehurst Parkway and Frenchs Forest Road West, followed by the two police vehicles who slowed to go through the intersection. The Subaru then lost control on a right hand bend and slid into the path of an oncoming ute, causing the fatal injuries to Mr James.

17. Crash investigation reconstruction estimated the speed of the Subaru immediately prior to impact at about 120kph, having lost control at about 135kph. The posted speed limit for that section of road was 80kph.

18. Mechanical and visual inspection of the Subaru revealed no defects that would have contributed to the collision.

Issues

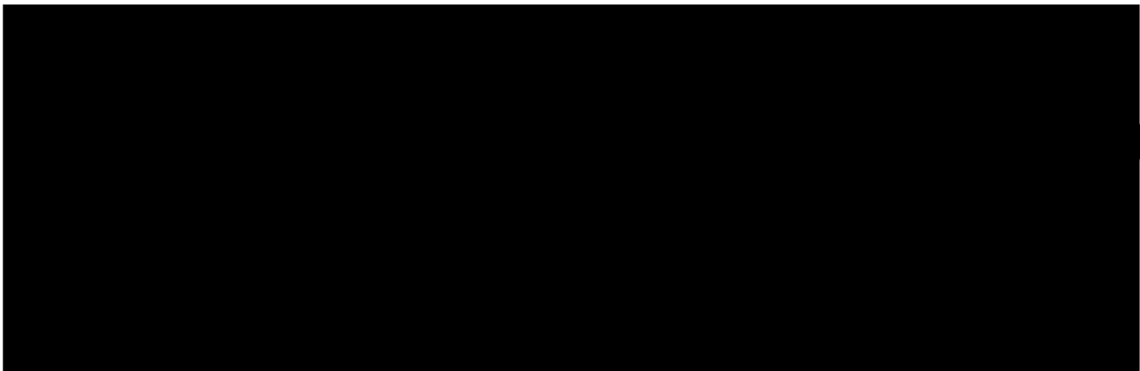
19. The issues in this Inquest are whether the pursuit of the Subaru was carried out in accordance with the NSW Police Force Safe Driving Policy, Pursuit Guidelines and whether the subsequent investigation was in accordance with the Critical Investigation Guidelines.

NSW Police Force Safe Driving Policy, Pursuit Guidelines

20. The police pursuit policy is set out in the NSW Police Force Safe Driving Policy, Pursuit Guidelines. These guidelines were the subject of comprehensive scrutiny in the Inquest into the death of Hamish Raj by Deputy State Coroner Dillon on 7 April 2014. That inquest resulted in a series of recommendations that are now being considered at ministerial level. I endorse the recommendations that were made and particularly relevant to this inquest is the question of whether police should pursue suspected stolen vehicles.

21. In this case it is not in dispute that "Northern Beaches 131" was in technical breach of the Safe Driving Policy for the very short period of time

22. This breach had no impact on the pursuit or the tragic outcome of the pursuit. It did not create any additional risk or danger to the Subaru. I am informed by the representative for the NSW Commissioner of Police that the breach has been noted and the relevant parties have been informed to ensure that there is no repetition of this.

23. 

Once again I endorse the recommendations made by Deputy State Coroner Dillon in the Hamish Raj inquest, that relate to termination of pursuits.

Critical Incident Guidelines

24. The Critical Incident Guidelines require an independent investigation of police involved in Critical Incidents. A "Critical Incident" means an "incident involving a member of the NSW Police Force which resulted in the death of or serious injury to a person" arising from a number of circumstances, including, for example (but not exhaustively), a police pursuit, while the person was in police custody, or arising from a NSW Police Force operation .[2] The Critical Incident Guidelines provide a definition as to when an officer is to be considered a "directly involved officer" under the Critical Incident Guidelines for the purpose of the investigation. A "directly involved officer" is defined in the Critical Incident Guidelines as:

[2] Critical Incident Guidelines, Version 5, p 9

"A directly involved officer is any officer who by words, actions or decisions, in the opinion of the SCII, contributed to the critical incident under investigation. An officer who is present, and does not involve themselves in activities which has contributed to the incident occurring is not directly involved. Mere presence at the scene is not enough."[3]

25. The two officers who initiated this pursuit in Northern Beaches 131, Constable Harte and Constable Thompson, were determined to be "witnesses" and not "directly involved officers" in the critical investigation of this matter. Those officers provided statements, rather than participating in an interview. Those statements appeared to include a less detailed account of the circumstances of the pursuit, and the decisions made, than the evidence provided in the directed interviews conducted with the "directly involved officers", Senior Constable Gifford and Senior Constable Caracoglia.

26. There are further differences in the way "directly involved officers" are managed during a Critical Incident Investigation, when compared to "witnesses." For example, "directly involved officers" participate in a directed interview pursuant to Regulation 8 of the *NSW Police Regulations 2008*, (which has certain possible legal implications in any later disciplinary or legal proceedings), have a support person present, and have mandatory drug and alcohol testing. Whilst not appearing to impact upon this matter, that determination could have had significant consequences for an officer who is determined to be a "witness" rather than a "directly involved officer" and whose conduct is later examined in disciplinary or legal proceedings.

27. The determination to treat officers Harte and Thomson as "witnesses" rather than "involved officers", in circumstances where they were in the vehicle that commenced the pursuit, was a poor decision. The decision to initiate a pursuit will be reviewed by a Coroner at Inquest. In my view, any police officer in a motor vehicle involved in a vehicle pursuit should be treated as "directly involved officer" for the purpose of the Critical Incident Investigation. Mr Hood has informed me that the Commissioner of Police and New South Wales Police Force agrees with that position and that the Police Force will incorporate this into Critical Incident Investigation training. Accordingly, I need not make a recommendation in that regard.

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[3] Critical Incident Guidelines, Version 5, p 31

Findings: s 81 Coroners Act 2009

I find that Leif James died on 31 October 2013 at Royal North Shore Hospital, St Leonards, NSW as a result of a head injury he received in a collision that occurred during a police pursuit on 30 October 2013.

Recommendations: s 82 Coroner's Act 2009

To the Minister for Justice and Police

I recommend that a copy of these findings be forward to the Minister for Justice and Police for consideration together with the recommendations in the matters of Hamish Raj, Jason Mark Thomson and Trent Lenthall.

Magistrate C Forbes
Deputy State Coroner
28 August 2015