



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 17th day of June, the 27th day of August, the 8th and 22nd days of October 2020, the 12th day of January and the 8th day of April 2021, the 13th day of September 2022 and the 12th day of October 2023, by the Coroner's Court of the said State, constituted of Naomi Mary Kereru, Coroner, into the death of Afrikah Rose Pearl Philp.

The said Court finds that Afrikah Rose Pearl Philp aged 17 years, late of 6/16 Crozier Terrace, Oaklands Park, South Australia died at Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 20th day of October 2017 as a result of multiple injuries. The said Court finds that the circumstances of her death were as follows:

1. Introduction

- 1.1. Afrika Rose Pearl Philp was born on 28 April 2000 and died on 20 October 2017 at the Flinders Medical Centre (FMC). She was 17 years old.
- 1.2. Ms Philp died from injuries sustained in a vehicle collision in the early hours of 6 October 2017. Ms Philp was the driver of the vehicle and her boyfriend, Dylan Maddison, was the passenger.
- 1.3. For a period of approximately four minutes prior to the collision police were pursuing the vehicle driven by Ms Philp in an attempt to apprehend her. It was for that reason that Ms Philp's death was considered a death in police custody pursuant to section 21 of the Coroners Act 2003 (the Act), for which an Inquest was mandatory.

2. Cause of death

- 2.1. A pathology review was undertaken by Dr Iain McIntyre and discussed with pathologist, Dr Karen Heath, both of Forensic Science of South Australia (FSSA).¹ The suggested cause of death was '*multiple injuries*'.
- 2.2. As part of the post mortem process, toxicological analysis of Ms Philp's blood was undertaken. Two toxicology reports were prepared, one for the major crash investigation and one for the coronial process. The results detailed in the two reports were the same, except for a small difference in the quantities, which was attributable to rounding of the figures.
- 2.3. The post mortem toxicological analysis was undertaken by Joanna Rositano.² The report prepared for the major crash investigation was undertaken by Penny Kostakis.³ Alcohol was not detected in a sample of antemortem blood taken at 6:30am on 6 October 2017, however 0.067mg/L of methylamphetamine, 0.014mg/L of amphetamine, and 43µg of 11-nor-9-carboxy-THC were detected. Both ketamine and quetiapine were detected in quantities consistent with therapeutic concentrations.
- 2.4. I find that the cause of Ms Philp's death was multiple injuries. I will address Ms Philp's injuries in more detail, later in the Finding.

3. Procedural history

- 3.1. The Inquest opened before Deputy State Coroner Elizabeth Sheppard on 17 June 2020. Initially, the Inquest was to proceed on the papers only. After consideration of the materials, her Honour indicated that she would be assisted by the oral evidence of the pursuing police officer, Brevet Sergeant Toby Shaw, and the Pursuit Commander, Inspector Steven Anderson. The further hearing of the Inquest was adjourned to a date to be fixed.
- 3.2. In this adjourned period, correspondence received by the Coroners Court from the solicitor for the Commissioner of Police (the Commissioner), revealed that an active internal police investigation relating to, inter alia, the appropriateness or otherwise of the actions of Brevet Sergeant Shaw in the police pursuit of Ms Philp, was underway. There were two adjournments for this investigation to be completed. There was also

¹ Exhibit C2a

² Exhibit C4a

³ Exhibit C3a

the interruption of the COVID-19 pandemic. Upon being notified of the completion of this investigation, a summons to produce a copy of the report under section 23 of the Act was issued on 21 December 2020. As it was foreshadowed that this summons would be resisted by the Commissioner, Deputy Coroner Sheppard published Reasons for her decision to issue the summons.⁴

- 3.3. For reasons that are unnecessary to detail in this Finding, the Commissioner sought judicial review of the decision of Deputy Coroner Sheppard. The judicial review was dismissed by his Honour Justice Blue of the Supreme Court on 25 March 2022⁵ and the investigation report, titled the Conduct Investigation Report (CIR), was produced to the Coroners Court.⁶
- 3.4. As Deputy Coroner Sheppard retired in the intervening period, the matter came before me to hear final submissions on 13 September 2022. Upon the receipt of the CIR, and the findings of the investigation therein, a decision was made that oral evidence was no longer required.

4. Background and family history

- 4.1. Ms Philp was the daughter of Tracey Philp and Kevin Kelly. Her stepmother was Lynda Jones. Ms Philp had one older half-sibling, Maikel Philp.
- 4.2. Ms Philp was removed from the care of her biological mother at the age of 6 years. She was placed into temporary care along with Maikel, and was cared for in the short term by commercial carers. Ms Philp then moved to Victoria to live with her maternal aunt, while her brother moved to the Northern Territory to live with his biological father. A 12-month Care and Protection Order was granted on 18 January 2007 for Ms Philp. An extended Care and Protection Order was sought and granted in January 2008. The terms of this Order saw Ms Philp placed under the Guardianship of the Minister until she was 18 years. Ms Philp returned to South Australia in her teenage years. Prior to her death, Ms Philp had been living independently and was supported by Families SA.
- 4.3. A detailed summary of Ms Philp's early childhood was provided in the application for the Care and Protection Order dated 4 January 2008.⁷ Further information on Ms Philp's childhood was provided in the affidavits of her mother Tracey Philp,⁸ and

⁴ Reasons for the issuance of a summons to the Commissioner of Police to Produce Documents, 24 December 2020

⁵ *Commissioner of Police v Coroners Court of South Australia* [2022] SASC 26, Judgment of the Honourable Justice Blue

⁶ Exhibit C53

⁷ Exhibit C43ac

⁸ Exhibit C9

the affidavit of her stepmother Lynda Jones.⁹ Suffice it to say, Ms Philp's formative years featured a transient lifestyle and emotional abuse and neglect. It is unsurprising that her family members reported Ms Philp had begun using cannabis from the age of about 10 years and that she used 'pills' and 'ice' in her early teenage years.¹⁰

5. Medical history

- 5.1. According to hospital records, Ms Philp had a medical history that included asthma, depression, anxiety, post-traumatic stress disorder (PTSD) and bipolar disorder. Ms Philp also had a history of seizures and suspected epilepsy.
- 5.2. As will be detailed below, Mr Maddison described Ms Philp suffering a seizure just prior to the collision. Accordingly, the SAPOL Major Crash investigating officer, Brevet Sergeant Di-Ann Salotti, undertook a review of Ms Philp's medical records.
- 5.3. The review of Ms Philp's case notes identified that Ms Philp attended a number of different healthcare providers complaining of seizures. This included the Women's and Children's Hospital (WCH) on 8 April 2016. Ms Philp reported a 10-month history of similar convulsions lasting 5 to 15 minutes. Ms Philp told doctors that these seizures commenced in June 2015 after a motor vehicle accident. Ms Philp was referred for a sleep-deprived electroencephalogram¹¹ (EEG) which was conducted on 27 May 2016.
- 5.4. On 30 May 2016, Ms Philp again presented to the WCH complaining of seizures and was referred for a further EEG which was conducted on 3 August 2016. The WCH casenotes showed that the EEG on 27 May 2016 was normal for age, however Ms Philp refused to undergo a photic stimulation at that time. This investigation was ultimately performed on 3 August 2016 and no epileptiform activity was seen.
- 5.5. On 12 August 2016, Ms Philp was taken to FMC by ambulance after having a witnessed seizure during police arrest.
- 5.6. On 18 November 2016, Ms Philp suffered a seizure whilst under arrest after allegedly breaching her bail and assaulting a security guard. She was taken to the FMC, assessed, and discharged into the custody of police and referred to her general practitioner to organise a CT scan.

⁹ Exhibit C10

¹⁰ Exhibit C10, pages 10-11

¹¹ A test to measure the electrical activity of the brain

- 5.7. Ms Philp spent approximately two weeks in hospital from 18 February to 3 March 2016 for surgery to her ankle following a fall. There was no complaint or reference to any seizures or epilepsy during this inpatient stay.
- 5.8. Due to her history of seizures and the suggestion that Ms Philp may have suffered an epileptic seizure just prior to the collision, an expert opinion and report was sought from the Director of Epilepsy Services at the Royal Adelaide Hospital (RAH), neurologist Dr Michelle Kiley.¹² It was the opinion of Dr Kiley that Ms Philp did not suffer epilepsy, but rather psychogenic non-epileptic seizures (PNES). Dr Kiley explained PNES to be:
- ‘... a form of conversion disorder or functional neurological illness whereby an underlying psychological stressor can manifest with physical symptoms and mimic true neurological conditions. PNES is seen more commonly in young women and there are often quite significant background psychosocial stressors.’¹³
- 5.9. Dr Kiley formed the opinion that Ms Philp suffered from PNES based on the description of past seizure activity which she opined was not consistent with a classic seizure pattern, but highly consistent with PNES.¹⁴ Accordingly, Dr Kiley did not comment adversely on the lack of a formal diagnosis of epilepsy following seizure related presentations and investigations.
- 5.10. Based on the expert report of Dr Kiley and her characterisation of the pathology of PNES, in conjunction with the nature of the seizure activity as clinically recorded, combined with the child protection information relating to the neglect and abuse Ms Philp suffered as a child, there was a sufficient basis to find that Ms Philp suffered from PNES and not epilepsy. I so find.

6. Events leading to 20 October 2017

- 6.1. I turn now to the circumstances leading to the injuries that caused Ms Philp’s death.
- 6.2. Ms Philp was in a relationship with Dylan Maddison who was on home detention bail at the time of the collision on 6 October 2017. Mr Maddison was 24 years old at the date of Ms Philp’s death.
- 6.3. On 5 October 2017, Ms Philp was in company with Mr Maddison at his grandmother’s house. Ms Philp was told to leave by Sonia Maddison, Mr Maddison’s aunt. In her

¹² Exhibit C52

¹³ Exhibit C 52, page 3

¹⁴ Exhibit C52, page 3

statement, tendered to the Court,¹⁵ Ms Maddison stated that Ms Philp appeared in a heightened state and was rambling saying ‘*what’s your problem with me*’ and ‘*why won’t you let me be with my man*’. She threatened to assault Ms Maddison and was heard to tell Mr Maddison to ‘*Get the scissors and cut it off*’,¹⁶ referring to his home detention bracelet. Mr Maddison cut his home detention bracelet off and he and Ms Philp left the address.

- 6.4. Correctional Services then telephoned, and Ms Maddison informed them that her nephew had left his home detention premises. Police were notified and contacted Ms Maddison to confirm what had occurred and began an investigation into the breach of home detention bail by Mr Maddison. Ms Philp and Mr Maddison attended the suburb of Davoren Park where Mr Maddison stole a blue Ford Falcon sedan which belonged to Victoria Fox.¹⁷
- 6.5. At 3:02am on 6 October 2017, Mr Maddison was performing burnouts in front of his grandmother’s house in the stolen Ford sedan. The police were called and responded to the incident, however the vehicle had driven off by the time police arrived. Ms Philp and Mr Maddison then drove the vehicle to Ben Williamson’s house in Edwardstown. Mr Williamson, who provided a statement to the Court,¹⁸ indicated that the pair stayed at his place for approximately half an hour and told him that they were going to dump the car and return to his house to stay the night. According to Mr Williamson, Mr Maddison told him that he needed to get to Victor Harbor. They asked him for cannabis, but he said that he did not have any. He thought that they left between 4:30am and 5am. Ms Philp reportedly assured him that they would return by 6am.
- 6.6. At 4:48am the stolen Ford sedan was detected driving 79km/h in a 60km/h per hour zone in a southerly direction on Main South Road, Morphett Vale by Brevet Sergeant Shaw, who was undertaking speed detection duties.¹⁹ Brevet Sergeant Shaw estimated that prior to detecting the speed of the vehicle, it had been travelling between 95km/h and 105km/h. Ms Philp was driving, and Mr Maddison was in the front passenger seat. Brevet Sergeant Shaw pursued the Ford in his police vehicle, activating his lights and sirens at 4:49am. The Ford failed to stop.

¹⁵ Exhibit C5

¹⁶ Exhibit C5, page 2

¹⁷ Exhibit C7

¹⁸ Exhibit C8

¹⁹ Exhibit C20

- 6.7. At about 4:50am, Brevet Sergeant Shaw sent a radio transmission to the Police Communications Centre. He reported a '*fail to stop*' and indicated that he was calling the code for the '*police pursuit high risk driving*'. He reported that he was pursuing a dark coloured Ford travelling South at 110km/h on Main South Road, Morphett Vale approaching Beach Road.²⁰ I will provide an explanation of the SAPOL General Order relating to High Risk Driving below.
- 6.8. In accordance with the High Risk Driving General Order, Constable Tracey Bradfield, who took the report from Brevet Sergeant Shaw, pressed the alarm button that, in the normal course, sounded an alarm causing a message to be displayed on a monitor located in the Police Communications Centre. This would also serve the purpose of notifying the State Shift Manager that a patrol was engaged in a pursuit. However, unbeknownst to Constable Bradfield, the light and monitor displays were not activated, meaning the State Shift Manager did not become aware of the pursuit at that time.
- 6.9. The pursuit followed Main South Road until the location at which the collision occurred. The maximum speed reached by Brevet Sergeant Shaw was 149km/h at the southern end of the Expressway. Ms Philp's vehicle was seen to have been travelling faster than Brevet Sergeant Shaw's vehicle along the Expressway. Mr Maddison, in his interview with police, recalled seeing the speedometer reaching between 150 or 160km/h.²¹
- 6.10. At about 4:52am, the Dispatching Officer in the pod next to Constable Bradfield became aware that there was a police pursuit underway, but noticed that the alarm, light and monitor display had not been activated. The officer alerted Constable Bradfield who again pressed the alarm button, this time activating the alarm, light and monitor display. This resulted in Inspector Stephen Anderson, the State Chief Manager, activating the South Coast Talk-Group on his console and assuming the role of Pursuit Commander.
- 6.11. Looking at the timeline recalled in Mr Williamson's statement, it must have been around that time, or shortly after, that Mr Williamson was speaking on the phone with Ms Philp. She informed him that they were in Seaford, and that they were near the Victor Harbor turnoff. She also mentioned South Road, Commercial Road, and the landmark of a Bunnings Warehouse store. Mr Williamson stated that he was on

²⁰ Exhibit C20, pages 2-3

²¹ Exhibit C38, page 18

loudspeaker. Ms Philp told him that she needed to get to Victor Harbor, but the police were right behind her and asked, '*which way do I go?*'.²² Mr Williamson could hear sirens, a loud bang, and then everything went quiet. Mr Williamson could then hear people asking if someone was okay.

6.12. Just prior to the collision, at the intersection of Main South Road and Seaford Road the Ford was observed to attempt a right-hand turn at high speed, lose control and collide with a concrete retaining wall outside a Bunnings hardware store. Footage was received into evidence depicting the Ford sedan driving towards the intersection, around another stationary vehicle at the lights waiting to turn right, which was driven by Mr John Armstrong, and then lose control. The time on the footage was 4:52:57am.²³ The police vehicle was then seen approaching the camera and turning the same corner. It was approximately 15 seconds behind the Ford. The actual collision between the vehicle driven by Ms Philp and the retaining wall was not captured on the footage, as it was outside the view of the camera.

6.13. Mr Armstrong, who was stationary at the intersection, provided a statement and described feeling his car move with the force of the Ford speeding past him, at what he estimated was over 100km/h.²⁴ He saw the rear of the vehicle move out to the left and then swing right. The brake lights came on at about that time, and the vehicle continued to rotate anticlockwise. The right side of the vehicle then travelled up onto the footpath on the southern side of the road and collided with a retaining wall. The vehicle was then seen to bounce off the wall, and continued to rotate clockwise as it travelled north, and stopped on the centre of the westbound traffic lanes. Ms Philp was attended to by police and paramedics until about 6:08am. She was placed into an ambulance and taken to the FMC, arriving at 6:25am.

7. Arrival at Flinders Medical Centre

7.1. On arrival at the FMC, Ms Philp was deeply unconscious with a blown right pupil and a left-sided scalp laceration. Amongst her injuries was a severe traumatic brain injury with diffuse generalised cerebral oedema and extensive subarachnoid haemorrhage, a right subdural haemorrhage, and basal skull injuries. Ms Philp also had a right comminuted humerus fracture, right pneumothorax, right pubic rami, pelvic fractures and lumbar spine 3rd and 4th vertebra transverse process fractures. Ms Philp's

²² Exhibit C8

²³ Exhibit C43ae

²⁴ Exhibit C11

pneumothorax was drained through a finger thoracotomy, and she was taken to theatre for a decompressive craniectomy and reduction and fixation of her fractured humerus. An extraventricular drain was inserted on 8 October 2017 and on 18 October 2017 her pelvic fractures were reduced following a small improvement in her level of consciousness.

- 7.2. On 17 October 2017 there was a sudden increase in bleeding into the extraventricular drain and a repeat CT scan of the brain showed a right internal carotid artery aneurysm thought to be of traumatic origin. At this point it became evident that Ms Philp's injuries were non-survivable, and her drain was removed. She proceeded to brain death and died at 9:01am on 20 October 2017.

8. Vehicle examination

- 8.1. A vehicle examination report was conducted by Mr Eliot McDonald, Senior Vehicle Examiner within SAPOL Major Crash, who formed the opinion that the vehicle had been in good condition at the time of the collision. The statement and report of Sergeant Marc Fulcher is included in the brief of evidence.²⁵ Sergeant Fulcher is a technical examiner from SAPOL Major Crash. He was asked to determine the likely pre-impact speed of the vehicle driven by Ms Philp. The report had a detailed analysis of photographs of the scene taken by Brevet Sergeant Salotti and referred to in her comprehensive report.²⁶ Sergeant Fulcher also attended the scene himself. The instrument cluster that housed the speedometer and engine revolution gauge was seized by Sergeant Fulcher. The speedometer needle was fixed at a position of about 85km/h and the engine revolution gauge was fixed in the position of about 2500 revolutions per minute.
- 8.2. The speed of 85km/h frozen on the speedometer was consistent with Sergeant Fulcher's analysis of the vehicle's speed at the time of impact, based on the critical speed yaw calculation. That calculation gave an estimated speed between 81 and 105km/h as the Ford turned right from Main South Road onto Seaford Road. It is likely that the vehicle was travelling nearer to the upper range of 105km/h as it turned, as it would have been losing speed during the turn as it continued towards the point of impact. Further, although the frozen speedometer needle should not be relied upon in isolation, it is

²⁵ Exhibit C41

²⁶ Exhibit C34

Sergeant Fulcher's opinion that the speed of 85km/h would be relatively close to the vehicle's actual speed on impact.

- 8.3. The speed of the police vehicle driven by Brevet Sergeant Shaw was known, along with the speed and location of the police vehicle throughout the pursuit.²⁷ From stationary, Brevet Sergeant Shaw's vehicle accelerated initially at 4:48:38am and again at 4:49:46am, so 1 minute and 8 seconds later. The lights and sirens were initiated. At that time Brevet Sergeant Shaw was driving at 115km/h with a maximum speed of 149km/h at 4:52:39am. Brevet Sergeant Shaw's vehicle then slowed to stationary, as he stopped nearby the collision at 4:53:40am, 5 minutes and 2 seconds after he began the pursuit, and 3 minutes 54 seconds after the lights and sirens were initiated.

9. Dylan Maddison

- 9.1. Two police interviews were conducted with Mr Maddison. The first was conducted on 7 October 2017,²⁸ and the second was on 3 January 2018.²⁹ In both interviews Mr Maddison referred to Ms Philp having a fit or seizure immediately before the collision.
- 9.2. Mr Maddison in his first interview told police that Ms Philp had suffered an epileptic seizure due to the flashing lights on the police vehicle behind them and also due to panic and stress.³⁰ He also told police in his second interview that on past occasions he had witnessed Ms Philp have five or six fits in a night.³¹ He thought that she was seeing a doctor in the Seaford area about her epilepsy and may have been prescribed Seroquel.
- 9.3. In the first interview Mr Maddison stated that Ms Philp was only accelerating away from police to get away from the blue and red flashing lights and that otherwise she was driving normally. The evidence of the speed of the vehicle driven by Ms Philp suggested otherwise. When the vehicle she was driving initially came to the attention of Brevet Sergeant Shaw, she was driving 79km/h in a 60km/h zone.
- 9.4. Mr Maddison told police in the second interview that Ms Philp was having a fit as she went around the corner immediately before the collision, not before the corner.³² He told police that as she took the corner her foot went from slightly accelerating to going

²⁷ Exhibit C40

²⁸ Exhibit C38

²⁹ Exhibit C39

³⁰ Exhibit C38, pages 16-20

³¹ Exhibit C39, page 13

³² Exhibit C39, page 62

flat foot. He said that he grabbed the steering wheel to assist, and tried putting the car into park, but it did not work. The car then collided with the wall.

- 9.5. I note the account of Mr Williamson in his statement, as already mentioned, that he was on the telephone with Ms Philp until the point of the collision. There is no suggestion from Mr Williamson that during their conversation Ms Philp was experiencing a seizure. If Ms Philp did suffer a seizure that contributed in some way to her losing control of the vehicle, it must have occurred immediately before the collision as the vehicle was already in a turning motion. This account was consistent with that given to police by Mr Maddison.

10. Authority in relation to the Conduct Investigation Report (CIR)

- 10.1. Section 5 of the Police Complaints and Discipline Act 2016 (the Discipline Act), requires the Commissioner of Police to ensure that a separate section (the Internal Investigation Section) is constituted within SAPOL to carry out investigations under the Discipline Act in relation to the conduct of designated officers (usually SAPOL members). Disclosure of those officers who are investigated is limited or prohibited under the Discipline Act, except with certain authorisation. In this matter, the Commissioner of Police provided authorisation pursuant to sections 43(3)(a) and 46(1) of the Discipline Act to disclose that a conduct investigation was undertaken and the names of the SAPOL members in connection with the CIR.³³
- 10.2. Relevant to the high-speed pursuit of Ms Philp, the CIR³⁴ contained a comprehensive review of the events that unfolded on the morning of 6 October 2017, setting out the facts as detailed earlier in this Finding and reaching certain conclusions. The two issues relevant to Ms Philp's death were:
- Whether Brevet Sergeant Shaw failed to terminate the pursuit in accordance with the General Order; and
 - Whether Constable Bradfield may have not made a timely notification to the pursuit commander (by the pressing of the alert button), which may have impacted upon the continuation of the pursuit as a proper risk assessment was not made by the pursuit commander.

³³ Letter to Coroner Kereru, dated 27 September 2023 from Commissioner of Police

³⁴ Exhibit C53

11. High risk driving

- 11.1. As highlighted by Deputy State Coroner Sheppard, deaths which occur following high-speed pursuits have attracted, and will continue to attract, careful scrutiny in this Court and elsewhere for obvious reasons.³⁵ One of the most important issues to establish in Ms Philp's death was whether the pursuit should have been ceased when speeds of up to 149km/h were reached, thereby preventing the collision which resulted in Ms Philp's death.
- 11.2. The Operational Safety High Risk Driving General Order³⁶ requires the Communication Centre operator to immediately acknowledge a pursuit and advise the pursuit commander.³⁷ This requirement is underpinned by the safety philosophy of the General Order to minimise the risk of danger to the public, victims, offenders and police, and safely manage high risk driving incidents.³⁸
- 11.3. When Brevet Sergeant Shaw engaged in the pursuit of the vehicle being driven by Ms Philp at about 4:50am, he transmitted via radio that he was engaging in a pursuit. There was a delay in the pursuit commander being notified of the pursuit due to the notification alarm not being activated, as mentioned above. Constable Bradfield stated that she had pressed the alarm, but for some unknown reason it did not activate.³⁹ The Dispatching Officer noticed that the alarm had not been activated, and this was brought to the attention of Constable Bradfield. The button was pressed again, activating the alarm, and notifying the pursuit commander, Inspector Anderson.⁴⁰ It was shortly after Inspector Anderson became aware of the pursuit that the collision occurred. The CIR established that there was a delay of 2 minutes and 9 seconds before the pursuit commander became aware of the incident.⁴¹

³⁵ Reasons for the issuance of a summons to the Commissioner of Police to Produce Documents, 24 December 2020

³⁶ Exhibit C43t

³⁷ Exhibit C43t, page 22

³⁸ Exhibit C43t, page 5

³⁹ Exhibit C30

⁴⁰ Exhibit C31

⁴¹ Exhibit C53

12. Conclusions

12.1. For the purposes of making findings as to the cause and circumstances of Ms Philp's death, I agree with the conclusions reached in the Significant Incident Investigation, namely:

‘[Brevet Sergeant] Shaw was performing speed detection duties when he observed the speeding Ford sedan and detected it at a speed of 79km/h. He attempted to stop the vehicle and activated his police vehicle's emergency lights and siren. As defined in General Order Operational Safety-High Risk Driving, he engaged in a police pursuit. He continually transmitted his locations and speeds informing all other police patrols updates in relation to the incident. AVL data corresponded with the transmissions that [Brevet Sergeant] Shaw was making and indicates that continual risk assessments were being made, by the variations in speed at different intersections. [Brevet Sergeant] Shaw's actions were appropriate and complied with General Orders.’⁴²

12.2. Further, I agree with the conclusions reached in the CIR,⁴³ namely that Constable Bradfield's failure to properly activate the alert button on the first occasion was a technical error. I am of the view that the mistake made by Constable Bradfield did not affect the management of the pursuit.

12.3. I find that Ms Philp's death, while tragic, was not preventable.

13. Recommendations

13.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Police Pursuit

In witness whereof the said Coroner has hereunto set and subscribed her hand and

Seal the 12th day of October, 2023.

Coroner

⁴² Exhibit C43, page 13

⁴³ Exhibit C53