



Coroner's Court of Western Australia

**RECORD OF INVESTIGATION INTO DEATH**

Ref No: 27/19

I, *Barry Paul King*, Deputy State Coroner, having investigated the deaths of **Glenys Joy Forbes** and **Kevin Hugh Forbes** with an inquest held at the **Perth Coroner's Court** on **24 July 2019**, find that the identities of the deceased persons were **Glenys Joy Forbes** and **Kevin Hugh Forbes** and that their deaths occurred on **17 September 2016** at the corner of **Warwick Road and Ballantine Road in Warwick** and **Royal Perth Hospital** respectively from **multiple injuries** in the following circumstances:

**Counsel Appearing:**

Ms F Allen assisted the Deputy State Coroner  
Ms R Hartley (State Solicitor's Office) appeared for Western Australia Police

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## SUPPRESSION ORDER

**On the basis that it would be contrary to the public interest, there is to be no reporting or publication of the details of any of the versions of the WA Police Emergency Driving Policy and Guidelines, including, but not limited to, any cap on the speed at which police officers are authorised to drive.**

### INTRODUCTION

1. On the evening of 17 September 2016, 60 year old Glenys Joy Forbes (Mrs Forbes) and her 66 year old husband Kevin Hugh Forbes (Mr Forbes) were passengers in a car travelling north on Ballantine Road in Warwick. The car belonged to their 25 year old son, Michael Forbes (Michael), and he was driving.
2. As the members of the Forbes family approached the T-intersection with Warwick Road, a 16 year old boy was driving a Ford Falcon sedan (the Ford) at high speed west on Warwick Road while being pursued by police officers in a police car with the call-sign NZ104 (NZ104).
3. Michael stopped his car at the stop sign at the T-intersection with the intention to turn right. He checked for oncoming traffic and pulled out into the intersection to make the turn. As he did so, the Ford came over a hill and crashed into the driver's side of Michael's car.
4. Mrs Forbes died at the scene from injuries that she had sustained in the crash.
5. Mr Forbes was taken to Royal Perth Hospital (RPH) where he died from his injuries shortly after arrival.
6. Michael was also taken to RPH with serious injuries. He survived after a protracted admission at RPH and rehabilitation at Fiona Stanley Hospital.

7. Shortly before the crash, the Police Operations Centre Communications Controller (POCCC) at the Police Operations Centre (POC) had instructed the police officers in NZ104 by radio to abort the pursuit.
8. The deaths of Mrs and Mr Forbes were reportable deaths under section 3 of the *Coroners Act 1996* (the Act) because they appeared 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.
9. Under s19 of the Act, I had the jurisdiction to investigate the deceased's deaths because it appeared to me that the deaths were or may have been reportable deaths.
10. As it appeared that the police officers who pursued the Ford may have caused or contributed to Mrs and Mr Forbes deaths, I was obliged under s22(1)(b) of the Act to hold an inquest. The purpose of the requirement to hold an inquest is to ensure that, where police officers may have been in some way involved in a person's death, their actions are subjected to independent scrutiny.
11. I held an inquest into the deaths on 24 July 2019 at the Perth Coroner's Court.
12. The main issues at the inquest were whether the police officers had complied with the Western Australia Police (WAPOL) Emergency Driving Policy and Guidelines in place at the time (the Policy), why they did not stop their pursuit of the Ford following the POCCC's instruction and whether they had caused or contributed to the deaths.
13. The documentary evidence adduced at the inquest primarily comprised a brief of evidence,<sup>1</sup> including a report to the State Coroner prepared on 4 September 2017 by Detective Senior Constable Stasiuk of the major crash investigation section of WAPOL.<sup>2</sup>

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<sup>1</sup> Exhibit 1

<sup>2</sup> Exhibit 1, Tab 12

14. Oral evidence was provided by (in order of appearance):
  - a. Senior Constable James Armstrong, the driver of NZ104;
  - b. Inspector Mark Bordin, the POCCC who managed the pursuit undertaken by the officers in NZ104;
  - c. Shaun Arnup, a passenger in a car on Warwick Road, who had witnessed the crash;
  - d. Detective Senior Constable Stasiuk;
  - e. First Class Constable Luke Jackson, the other police officer in NZ104; and
  - f. Detective Inspector Bret Radford, an officer with the WAPOL internal affairs unit, who investigated the actions of Senior Constable Armstrong and First Class Constable Jackson.
15. Following the evidence, I indicated to counsel that I was satisfied that Senior Constable Armstrong and First Class Constable Jackson acted within the Policy, so I did not intend to be critical about their conduct. Neither counsel made submissions.
16. I have, however, come to the view that WAPOL should reconsider the Policy and the relevant training of police officers with a view to reducing the risk associated with similar incidents.
17. For convenience, I shall refer to 'Evade-Police incidents' (as described in the Policy) as 'pursuits'.

### **THE EVENTS LEADING UP TO THE DEATHS**

18. At about 7.20 pm on the evening of Saturday 17 September 2017, Senior Constable Armstrong and First Class Constable Jackson left the Warwick police station, where they were both attached to the local policing team, in NZ104. They were planning to visit a

justice of the peace in Marangaroo in order to get documents signed.<sup>3</sup>

19. Senior Constable Armstrong was driving. He was certified under the Policy for pursuit driving. NZ104 was an unmarked grey Ford Falcon sedan. It was deemed by WAPOL to be suitable for the pursuit of other vehicles.<sup>4</sup>
20. At about 7.25 pm, the officers in NZ104 were stopped at traffic lights on Wanneroo Road as they were waiting to turn east into Marangaroo Drive. They were in the left lane of two turning lanes. Beside them as they waited was the Ford.
21. The officers could see that there were two people in the Ford and that the driver was male and the passenger was female. First Class Constable Jackson noted that the driver looked young. He checked the Ford's registration number on the on-board computer and found that the car was registered to a man of no fixed place of abode in Mandurah. The registered owner was much older than the driver appeared to be, and he was subject to an arrest warrant.
22. The officers decided to follow the Ford along Marangaroo Drive from a distance while First Class Constable Jackson conducted further checks on the computer in relation to the possible identity of the driver.
23. First Class Constable Jackson found that none of the persons associating with the Ford's owner fitted the description of the driver, so the officers decided to stop the Ford to check the driver's identification. Senior Constable Armstrong increased the speed of NZ104 and caught up to the Ford.
24. The Ford turned right off Marangaroo Drive into a service station and the officers followed it. The Ford went through the forecourt of the service station past the pumps and turned left back onto Marangaroo Drive,

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<sup>3</sup> Exhibit 1, Tabs 18 and 19

<sup>4</sup> Exhibit 1, Tab 13

where it accelerated. It was then heading west and its speed increased to an estimated 90-100 km per hour. The posted speed limit on Marangaroo Drive was 70 km per hour.

25. The officers followed the Ford. They activated the lights and sirens on NZ104 and placed a portable blue flashing light on the roof.
26. The Ford did not stop or slow down in response to the lights and sirens. As was required under the Policy at that time, First Class Constable Jackson used the radio in NZ104 to call a dispatcher at the POC to indicate that a vehicle was evading interception and to request authorisation to engage in pursuit driving. He made that call at 7.30.27 pm.<sup>5</sup>
27. The dispatcher at the POC requested POCCC, Inspector Bordin, to attend the dispatcher's console in relation to the possible pursuit, and First Class Constable Jackson told the dispatcher that they were in Marangaroo.<sup>6</sup>
28. At that stage, the Ford had moved into the single slip lane to turn left onto Wanneroo Road at the intersection with Marangaroo Drive. It was forced to stop because another vehicle was stopped in front of it at a give-way sign. Senior Constable Armstrong positioned NZ104 to the side and rear of the Ford, and First Class Constable Jackson prepared to get out in order to apprehend the driver. As he opened the passenger door and started to step down, the vehicle in front of the Ford drove away, and the Ford also turned left onto Wanneroo Road and took off. It was then 7.31 pm.<sup>7</sup>
29. The officers in NZ104 followed the Ford south on Wanneroo Road to the intersection with Warwick Road. The Ford then turned right onto Warwick Road in contravention of a red right-turn arrow, with the officers

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<sup>5</sup> Exhibit 1, Tab 13

<sup>6</sup> Exhibit 1, Tab 13

<sup>7</sup> Exhibit 1, Tab 13

in pursuit. This was about 10 seconds after they had both turned onto Wanneroo Road.<sup>8</sup>

30. The Ford accelerated away in the right lane of the two west-bound lanes on Warwick Road, reaching speeds greatly in excess of the 70 km per hour posted speed limit. The traffic was relatively light.
31. At 7.31.37 pm, the officers in NZ104 were also travelling at extreme speeds on Warwick Road and were keeping the Ford in sight, but it was pulling away from them.
32. At the time, First Class Constable Jackson was providing details of the background of the pursuit to the POC [REDACTED]  
[REDACTED] He called out the speed of NZ104 to the dispatcher and thereby brought it to Senior Constable Armstrong's attention, who reduced speed in order to bring NZ104 under the speed cap in the Policy.
33. The dispatcher called NZ104 at 7.31.44 pm to make contact; Inspector Bordin had reached the dispatcher's console by then. Inspector Bordin instructed the dispatcher to tell the officers in NZ104 to abort the pursuit. His instruction to the dispatcher could be overheard on the radio in the background as the dispatcher called NZ104.<sup>9</sup>
34. Three seconds later, the dispatcher again called NZ104, and three seconds after that he called again and said, 'downgrade please downgrade'. He then received a call from First Class Constable Jackson at 7.31.52 pm asking for permission to exceed the speed cap under the Policy.<sup>10</sup>
35. Four seconds later, First Class Constable Jackson called the POC. As he made contact, he was heard to swear. He then told the dispatcher that there had been a traffic accident and he asked for an ambulance. The officers

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<sup>8</sup> Exhibit 1, Tab 13

<sup>9</sup> Exhibit 1, Tab 13

<sup>10</sup> Exhibit 1, Tab 13

had witnessed the crash of the Ford into Michael Forbes' car.

## **THE CRASH**

36. With NZ104 in pursuit, the Ford had gone over the crest of a hill and down towards the intersection of Warwick Road and Ballantine Road at high speeds. It is apparent that Michael had checked for oncoming traffic before pulling out of Ballantine Road but, due to the speed at which the Ford was travelling, could not have seen it coming over the crest in time to delay pulling out.
37. It is also likely, according to Senior Constable Stasiuk, that Michael had looked to his right and had seen that no traffic was approaching. He had then been more focussed on the possibility of traffic approaching from the left where there were roads feeding into Warwick Road. In other words, the more dangerous direction would have seemed to have been the left.<sup>11</sup>
38. Eye-witness Mr Arnup was sitting in the front passenger seat of a car stopped at traffic lights at the intersection of Warwick Road and Coolibah Drive. He testified that everything happened so fast and that the Ford came 'flying over the hill.'<sup>12</sup> Detective Senior Constable Stasiuk said that he could not see Michael having any chance to evade what happened.<sup>13</sup>
39. Airbag information from the Ford indicated that only about four seconds elapsed between the time when the Ford came over the hill and the time of collision. The driver of the Ford took his foot off the accelerator and applied the brakes, which reduced his speed by about 30 km per hour, but he was unable to avoid Michael's car.<sup>14</sup>

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<sup>11</sup> ts 49 – 50 per Stasiuk, S

<sup>12</sup> ts 36 – 37 per Arnup, S M

<sup>13</sup> ts 47 per Stasiuk, S

<sup>14</sup> Exhibit 1, Tab 46

40. The impact of the Ford on the driver's side of Michael's car caused significant damage and caused the car to spin several times before it came to rest on the central median strip about 32 metres from the point of impact.<sup>15</sup>
41. As noted above, Mrs Forbes died at the scene and Mr Forbes was taken to RPH by ambulance, where he died from his injuries a short time later.<sup>16</sup>
42. Michael sustained multiple serious injuries, including traumatic brain injury, and required several medical interventions and lengthy rehabilitation. He was left with ongoing disabilities.<sup>17</sup>
43. An 18 year old female passenger in the Ford also sustained injuries, but they were not life-threatening.<sup>18</sup>
44. The 16 year old driver of the Ford ran from the scene and managed to evade Senior Constable Armstrong, who chased him on foot; however, he was arrested about 90 minutes after the crash.<sup>19</sup>
45. The driver was charged with two counts of manslaughter in relation to the deaths of Mrs and Mr Forbes, as well as charges of dangerous driving causing grievous bodily harm to Michael and dangerous driving causing bodily harm to his female passenger.
46. On 19 May 2017, the driver pleaded guilty to those charges, and on 26 June 2017 he was sentenced to a total of eight years and six months imprisonment.
47. Of note in the sentencing process were admissions that the driver was trying to get away from NZ104 because he did not have a licence, there was a warrant for his arrest for breaching bail, and there was \$25 worth of cannabis

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<sup>15</sup> Exhibit 1, Tab 12

<sup>16</sup> Exhibit 1, Tabs 3 and 8

<sup>17</sup> Exhibit 1, Tab 149

<sup>18</sup> Exhibit 1, Tab 48

<sup>19</sup> Exhibit 1, Tab 12

in the Ford.<sup>20</sup> He admitted that, before driving the Ford, he had used methylamphetamine and cannabis.<sup>21</sup>

48. The sentencing judge also noted the appalling deprivations which the driver had endured as a child.<sup>22</sup>

### **CAUSE OF DEATH AND HOW DEATH OCCURRED**

49. On 20 September 2016 and 22 September 2016, forensic pathologist Dr J White performed post mortem examinations of Mrs Forbes and Mr Forbes.
50. In relation to Mrs Forbes, Dr White found multiple severe injuries, including fracturing of the skull, several ribs, the vertebral column and the pelvis, with associated brain injury and injuries to the chest and abdominal organs. Dr White formed the opinion, which I adopt as my finding, that the cause of death was multiple injuries.<sup>23</sup>
51. In relation to Mr Forbes, Dr White found multiple severe internal injuries, including bilateral rib fractures, fracturing of the breastplate, pelvis and thoracic and cervical spine, with multiple injuries to the chest and abdominal organs. Dr White formed the opinion, which I adopt as my finding, that the cause of death was multiple injuries.<sup>24</sup>
52. I find that both deaths occurred by way of unlawful homicide.

### **DID THE POLICE OFFICERS COMPLY WITH THE POLICY?**

53. Detective Sergeant M D Downey of the WAPOL internal affairs unit (IAU) conducted an investigation into the actions of Senior Constable Armstrong and First Class

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<sup>20</sup> WA v CPH, Children's Court of WA, 26/6/2017 p.22

<sup>21</sup> WA v CPH, Children's Court of WA, 26/6/2017 p.47

<sup>22</sup> WA v CPH, Children's Court of WA, 26/6/2017 pp.46 – 47

<sup>23</sup> Exhibit 1, Tab 5A

<sup>24</sup> Exhibit 1, Tab 10A

Constable Jackson with a view to determining whether they had complied with the Policy. Detective Sergeant Downey identified two possible breaches of the Policy: exceeding the speed cap without authorisation and failing to downgrade from a pursuit when called upon to do so.<sup>25</sup>

54. In relation to the first possible breach, Detective Sergeant Downey found that the speed cap had been exceeded, but he accepted that the breach was inadvertent, that the duration of time where the speed cap was exceeded was very short, and that Senior Constable Armstrong had taken immediate steps to reduce speed.<sup>26</sup>
55. In relation to the second possible breach, Detective Sergeant Downey accepted that, due to background noises such as the sirens and the likelihood that they were talking to each other, neither Senior Constable Armstrong nor First Class Constable Jackson had heard Inspector Bordin say 'tell them to abort' or the dispatcher say 'downgrade please downgrade'.<sup>27</sup>
56. The results of Detective Sergeant Downey's investigation were the exoneration of Senior Constable Armstrong and First Class Constable Jackson of the possible breaches of the Policy.<sup>28</sup>
57. In my view, Detective Sergeant Downey's conclusions were justifiable, particularly in relation to the question of whether the officers had heard the instructions to abort or downgrade. This is so because a close consideration of the transcript of the radio calls establishes that First Class Constable Jackson and the dispatcher were talking over each other when the dispatcher instructed the officers to downgrade.<sup>29</sup>

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<sup>25</sup> Exhibit 1, Tab 13

<sup>26</sup> Exhibit 1, Tab 13

<sup>27</sup> Exhibit 1, Tab 13

<sup>28</sup> Exhibit 1, Tab 13

<sup>29</sup> Exhibit 1, Tab 13; ts 34 – 35 per Bordin, M

## COMMENTS ON THE POLICY IN ACTION

58. As Detective Sergeant Downey had retired from WAPOL by the time of the inquest, Inspector Brett Ranford of the IAU provided oral evidence in his place. Inspector Ranford implicitly confirmed Detective Sergeant Downey's conclusions.<sup>30</sup>
59. Inspector Ranford said that, in carrying out an investigation, the IAU looked at all of the officers' conduct, including the decision to try to stop the Ford. However, he said that the process of the investigation was to compare the officers' actions against the Policy. He said that the decision by the officers to stop the Ford was justified and that he would have expected them to have made enquiries of the driver given the information they had and the fact that the driver looked so young.
60. Inspector Ranford said that, once the Ford had taken off at speed, there were 'a million and one reasons' why the officers could make their decision to terminate or continue the pursuit. He said that 'a lot rests on the shoulders of those two individuals in the car'.<sup>31</sup>
61. Inspector Ranford agreed that the POCCC provides oversight to the officers. He said that the POCCC has 'his own heap of considerations that he's assessing from his own perspective because he's looking for a resolution strategy and lessening the risk to the community'.<sup>32</sup>
62. Inspector Ranford agreed with the rather self-evident propositions that, in the present case in which the pursuit lasted less than two minutes, the events happened very, very quickly. There was not a lot of time to abort the pursuit before something was going to go wrong and, at the speeds they were going, something was 'going to happen'. He said that it was 'extremely risky for everyone involved: the police, the public, all road users, of course'.<sup>33</sup>

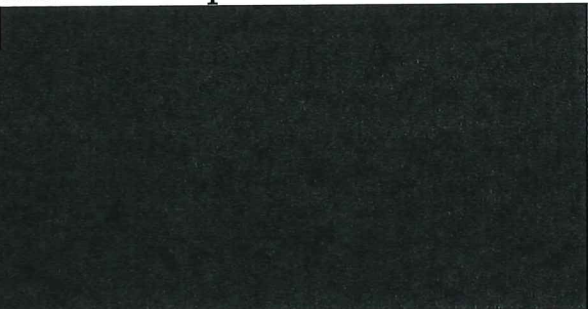
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<sup>30</sup> ts 67 per Ranford, B

<sup>31</sup> ts 71 per Ranford, B

<sup>32</sup> ts 71 per Ranford, B

<sup>33</sup> ts 72 per Ranford, B

63. When asked about the frequency of incidents of evading police intercepts that have durations of less than two minutes, Inspector Ranford said that he did not have the figures, but that it does happen a lot.<sup>34</sup>
64. Inspector Bordin said the speed cap under the Policy is normally the peak limit for a pursuit driver, who is in a vehicle with adrenalin flowing through his or her body while he (Inspector Bordin) is in a sterile place in order to sit back and look at judgement options.<sup>35</sup>
65. Inspector Bordin said that he had overseen at least 2000 pursuits as POCCC. He said that in at least 30% of them he had instructed the police officers to abort.
66. In the present case, Inspector Bordin instructed NZ104 to abort the pursuit because of the speed involved, the demographics of the area (of which he was familiar), the time of night, the known intersections that come out onto that main arterial road, other road users,<sup>36</sup> and the fact that they had the Ford's registration number.<sup>37</sup>
67. The Policy in its iteration in September 2016 was amended in April 2019. 
68. In my view, the Policy requires reconsideration in relation to both its content and its form.

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<sup>34</sup> ts 72 per Ranford, B

<sup>35</sup> ts 32 per Bordin, M

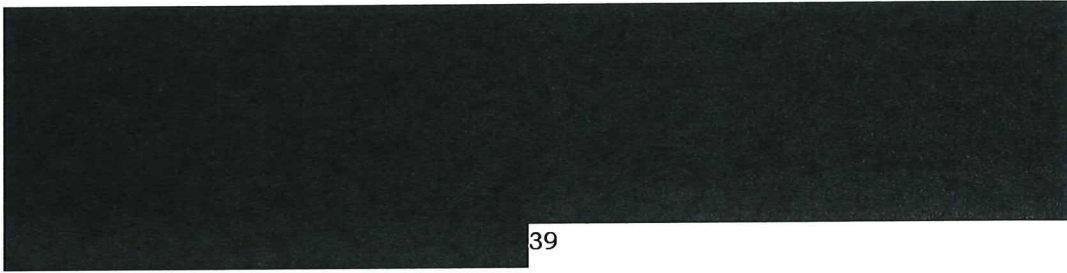
<sup>36</sup> ts 32 per Bordin, M

<sup>37</sup> ts 30 per Bordin, M

<sup>38</sup> Exhibit 1, Tabs 52 and 51; ts 30 – 31 per Bordin, M

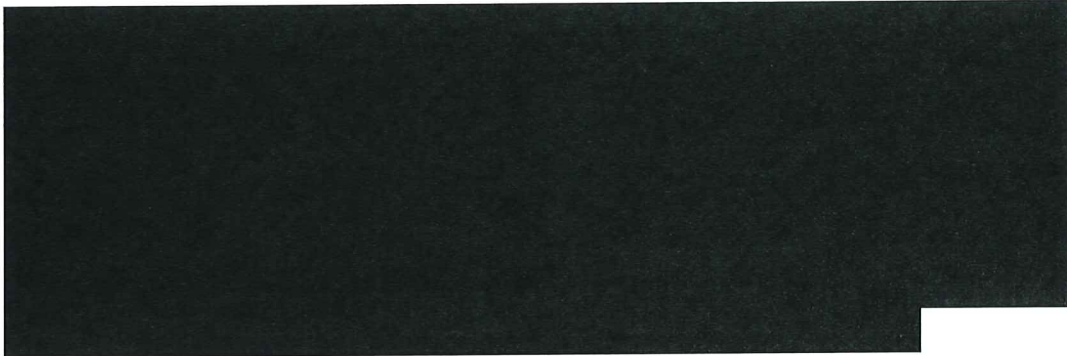
## COMMENTS ON THE CONTENT OF THE POLICY

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70.



71. However, until the POCCC has assumed effective oversight of a pursuit, the decision whether to terminate the pursuit is entirely in the hands of the police officers who are required to be undertaking continuous risk assessment.
72. In my view, the problem with that is that police officers become involved in high speed pursuits in which a significant percentage of the officers have no time to obtain pertinent information upon which to make objective decisions before it is too late. The Policy itself acknowledges that problem by the very role of the POCCC. That around a third of pursuits are terminated by the POCCC confirms it.
73. The inherent risks involved in pursuits can be extreme, depending on the time, location, speeds, and so on. Those risks are compounded by the delay of the oversight by the POCCC and the nature of the radio communication, which can be unreliable in the short-term as was demonstrated by this case.

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<sup>39</sup> Exhibit 1, Tabs 52 and 51

74. Statistics obtained from the National Coronial Information System indicate that, for the years 2010 to 2016, at least 25% of the 64 fatalities from police pursuits in Australia occurred within the first minute of the pursuit, and about another 40% occurred between one minute and five minutes after the pursuit commenced.
75. It is obvious that, despite the existence of the Policy, the risks in pursuits include injury and death. The WAPOL statistics for accidents, injuries and fatalities during pursuits occurring from January 2016 to June 2018 are somewhat confusing due to a change in recording process in December 2017, but the statistics do seem to show that the number of incidents in each year is relatively similar.<sup>40</sup>
76. It is also worth noting that the risks necessarily include psychological injuries, such as post-traumatic stress disorder, to police officers who may witness, and feel involved with, the results of pursuits that end tragically. Senior Constable Armstrong alluded vaguely to such issues.<sup>41</sup> Psychological trauma is not currently reflected in the available statistics.
77. It is difficult to see how any of this can be justified unless the risks of not pursuing a vehicle can be seen to be greater than the risks of pursuing it. 

78. 

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<sup>40</sup> Exhibit 3

<sup>41</sup> ts 19 per Armstrong, J

<sup>42</sup> Exhibit 1, Tab 52

[REDACTED] For example, their reason for engaging in the pursuit was that the Ford did not stop, which was seen as 'something fairly serious'.<sup>43</sup> That view could only be speculative since the reason for not stopping could have been relatively minor, as it turned out to be.

79. I note from a WAPOL report issued on 24 February 2017 in response to specific questions from the State Coroner for the purposes of a joint inquest, that a mere failure to stop was identified as potentially serious enough to offer justification for a pursuit. I have difficulty with that proposition as a matter of logic.

80. It is also apparent that, despite an attempt by the dispatcher at the POC to obtain the reason for the pursuit from the officers,<sup>44</sup> the problems with the radio communication coupled with the significant time constraints meant that the police officers did not provide that information. As a result, Inspector Bordin did not have the opportunity to consider it.

81.

[REDACTED]

### **COMMENTS ON THE FORM OF THE POLICY**

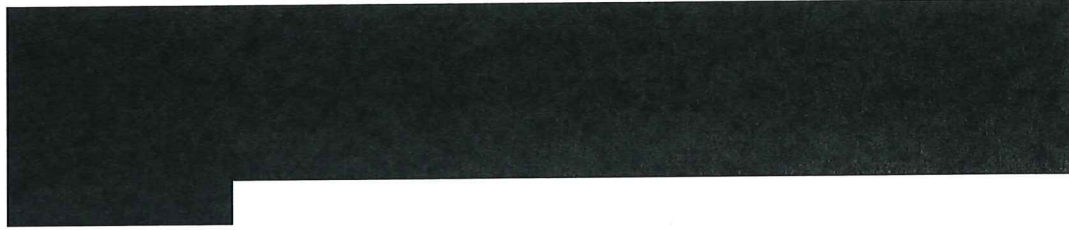
82.

[REDACTED]

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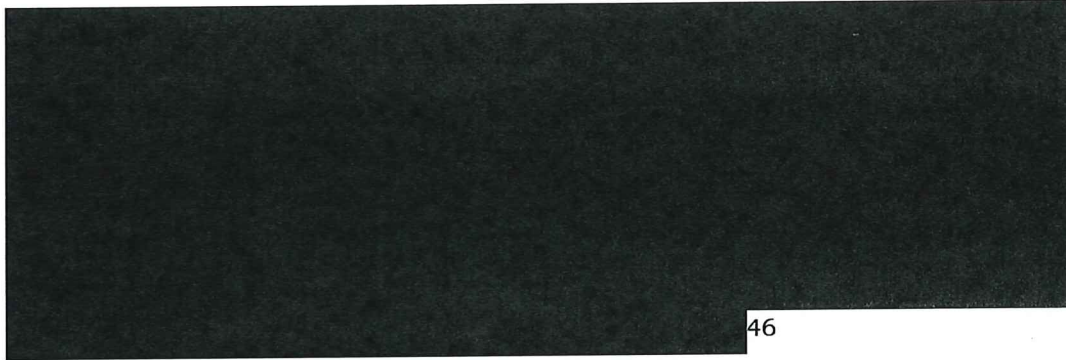
<sup>43</sup> ts 18 per Armstrong, J

<sup>44</sup> Exhibit 1, Tab 13



83. In my view, the layout of the Policy is repetitive and confusing, the terms are prolix, vague and open to interpretation, and the concepts offer little in the way of effective guidance to police officers who are caught up in the adrenalized drama of a high speed pursuit and who are expected to make critical, split-second decisions.

84.



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85. The Policy might be contrasted with the provisions of the equivalent policy in Queensland (the Queensland Policy), parts of which are models of simplicity and clarity. For example, in relation to justifying a pursuit, the Queensland policy spells out in simple, concrete terms which matters are 'pursuable' and which matters are not. In addition, the Queensland policy contains an easily comprehensible algorithm or flow chart for decision-making and risk assessment.<sup>47</sup>

86. I wish to clarify that I am not recommending that WAPOL adopt the principles in the Queensland policy. The evidence before me does not allow for a sufficiently detailed consideration of the benefits and detriments of so doing. Nor have I considered policies from other jurisdictions in Australia.

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<sup>45</sup> Exhibit 1, Tab 51

<sup>46</sup> Exhibit 1, Tab 51

<sup>47</sup> Queensland Police, Operational Procedures Manual, Chapter 15, p. 15-16 and 18  
[www.police.qld.gov.au/corporatedocs/OperationalPolicies/opm.htm](http://www.police.qld.gov.au/corporatedocs/OperationalPolicies/opm.htm)

87. I also need to acknowledge that there are reasonable arguments to support the policy of police pursuits of vehicles which evade police intercepts.
88. However, given the purpose of the Policy; that is, to provide the requirements and guidance applying to a potentially high-risk activity, it behoves WAPOL to ensure that the form of the Policy is as clear and concise as possible. The Queensland policy shows that it can be done.
89. In these circumstances, I make the following recommendation:

### **RECOMMENDATION**

**I recommend that WAPOL consider amending the Emergency Driving Policy and Guidelines to provide clear, concise instructions to police officers with respect to circumstances where commencing pursuits is and is not appropriate and where pursuits, once commenced, should be terminated.**

### **CONCLUSION ON POLICE INVOLVEMENT**

90. The question of whether the actions of the police officers in NZ104 caused or contributed to the deceased's deaths involves difficult notions of semantics and logic.
91. From a legal perspective, there can be no doubt that the actions of the driver of the Ford in failing to stop and in driving off at high speeds were the root cause of the crash and the deaths. The officers acted in accordance with their duties by initially attempting to stop him and as noted, they acted in general accordance with the Policy in pursuing him. There is no suggestion that they caused the driver to drive off at high speeds or that they interfered with his driving and thereby directly contributed to the crash.

92. However, it is well understood that a small percentage of drivers who are directed to stop by police officers attempt to evade the officers.
93. It is also understood that pursuing such drivers involves risks to the officers and the drivers of the target vehicles, as well as to passengers in the target vehicles, other road users and pedestrians. That understanding underpins the risk assessment and the POCCC oversight provided in the Policy.
94. It follows that, by commencing, or continuing in, a high speed pursuit, police officers are necessarily part of the creation or continuation of those risks. Of course, the higher the speeds, the greater the risks to all concerned.
95. On that reasoning, it follows that, by pursuing the Ford, the police officers in NZ104 were involved to some unquantifiable degree, albeit blamelessly and unintentionally, in what was ultimately the needless escalation of risks that culminated in the tragic deaths of the deceased. However, it strains the language to say that they caused or contributed to the risk.
96. The officers in NZ104 should be commended for their bravery and their devotion to duty, but in my view they should not have been placed in that situation.
97. It is difficult to think of another example of police operational action that has as significant a potential for severe risk as pursuits while at the same time having a similar potential for little or no benefit from the action. For that reason, I repeat my comments that WAPOL should provide clearer guidance to officers.
98. While it may not be possible to engage in pursuits without incurring a level of risk, the evidence indicates that more could and should be done to reduce the current level.

## CONCLUSION

99. The circumstances surrounding the deaths of Mrs and Mr Forbes were shocking and tragic on every level.
100. Because of the nature of the inquest, the evidence and this finding focused on the actions of the police officers and the policy under which they engaged in the pursuit of the Ford.
101. It is clear that police pursuits are problematic in that they put WAPOL in the horns of a seemingly intractable dilemma. Police are condemned where a pursuit ends in tragedy and are condemned if they do not attempt to stop drivers who fail to stop when directed.
102. WAPOL has understandably taken the approach of attempting to stop evasive drivers while at the same time attempting to keep risks to a minimum. While I appreciate the difficulties of reconciling those conflicting goals, and I am not so naïve as to believe that my recommendation would, if adopted, resolve the dilemma, in my view changes to the Policy should be considered for the reasons expressed.

  
B P King  
Deputy State Coroner  
17 October 2019

