JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Rosalinda Vincenza Clorinda Fogliani, State Coroner
HEARD	**:**	9-11 DECEMBER 2019
DELIVERED	**:**	30 DECEMBER 2020
FILE NO/S	**:**	CORC 427 of 2017
DECEASED	**:**	Child JM

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr T Bishop assisted the State Coroner.

Mr E Cade and with him Ms A Ishak (State Solicitor's Office) appeared on behalf of the Western Australia Police Force and Department of Communities.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of ***Child JM*** *(Subject to a Suppression Order) with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 9 – 11 December 2019, find that the identity of the deceased child was* ***Child JM*** *and that death occurred on 1 April 2017 at Royal Perth Hospital from multiple injuries in the following circumstances:*

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SUPPRESSION ORDERS

Made on 21 August 2019: **Suppression of the deceased child's name from publication and any evidence likely to lead to the deceased child's identification or the identification of any other child held in care. The deceased child is to be referred to as Child JM.**

and

Made on 9 December 2019: **Non Publication of the speed cap on police vehicles and any other specific detail of Police Policies and Procedures.**

INTRODUCTION

1. On 1 April 2017, Child JM was a passenger in a motor vehicle that had been stolen during a burglary the day before. The vehicle was being driven by his friend. Police tried to stop the vehicle, and it became involved in a series of Evade Police Intercept Driving incidents (formerly known as police pursuits).

2. The driver of the vehicle continued to accelerate away from police and entered an intersection at high speed in contravention of a red traffic light, colliding with another vehicle. Child JM suffered catastrophic injuries as a result of the collision and later that night he tragically died at Royal Perth Hospital. He was 16 years of age.

3. Child JM's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (the Coroners Act) and it was reported to the coroner as required by the Coroners Act. By reason of s 19(1) of the Coroners Act I have jurisdiction to investigate the death.

4. Immediately before death, Child JM was a "*person held in care*" within the meaning of s 3 of the Coroners Act, by reason of being in the care of the Chief Executive Officer of the Department of Communities, subject to a Protection Order (Until 18), under the *Children and Community Services Act 2004* (Children and Community Services Act).[1]

[1] Exhibit 2, tab 46.

5. By reason of Child JM being a person held in care, under s 22(1)(a) of the Coroners Act, an inquest was mandated into his death.

6. As this matter involved a death immediately following an Evade Police Intercept Driving incident, under s 22(1)(b) of the Coroners Act, for this reason also, an inquest was mandated into Child JM's death, because it appeared that the death was caused, or contributed to, by an action of a member of the Police Force. Therefore the coroner is required to examine the actions of police.

7. A death may have that appearance where there is a temporal nexus between an action of a member of the Police Force in connection with the deceased person, and the events leading to death.

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

9. My primary function is to investigate the death. It is a fact-finding function. Under s 25(1)(b) and (c) of the Coroners Act, I must find, if possible, how death occurred and the cause of death.

10. Under s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with the death including public health, safety or the administration of justice. This is the ancillary function.

11. Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

12. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct

when deciding whether a matter has been proved on the balance of probabilities.

13. I held an inquest into Child JM's death on 9 to 11 December 2019. I heard from 15 witnesses and received the following exhibits into evidence:

    a) Exhibit 1, containing tabs 1 to 35; and

    b) Exhibit 2, containing tabs 36 to 46.

14. After the inquest, between 28 January and 3 February 2020, I received the following additional exhibits into evidence:

    a) Exhibit 1, tabs 9A, 9B, 10A, 11A, 14A, 14B, 17A, 17B, 18A, 28A; and

    b) Exhibit 2, tabs 46A to 58.

15. My findings appear below.

BACKGROUND

16. Child JM was born on 26 October 2000. He had a twin sibling, with whom he was very close, and he also had two younger siblings. Sadly his home environment was unsettled. His parents' relationship was marred by instances of domestic violence and drug use.[2]

17. Child JM's father was imprisoned when he was four years old, and his mother experienced difficulty looking after the children, having insurmountable problems of her own to address. The Department of Communities became involved, and Child JM's history of contact with that department, and Protection Orders made, is outlined under the heading: *History of Protection Orders*, below.[3]

[2] Exhibit 2, tab 46.
[3] Ibid.

18. In 2010 Child JM was diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Unsocialised Conduct Disorder, Post-Traumatic Stress Disorder and specific development disorder of scholastic skills. He was a troubled child with complex emotional and medical needs. Regrettably his conditions were exacerbated by his use of cannabis, alcohol, tobacco and inhalants. As he grew older, his behaviour became increasingly difficult to manage.[4]

19. Adding to his difficulties, Child JM's grandfather sadly died in 2013, and this had an especially adverse impact on him. Child JM's grandfather was a father figure in his life, and appears to have been one of the few persons who was able to successfully guide his behaviour.[5]

20. Child JM's risk taking behaviors were complicated by his unaddressed mental health issues. Concerns were elevated when he began to display self-harming behaviour. The Department of Communities made sustained efforts to provide Child JM with stable and secure environment, but for reasons outlined later in this finding, this proved difficult.[6]

21. Not unexpectedly, Child JM's education was adversely affected. He unfortunately displayed aggression towards his school teachers and administrators. He disengaged from his education at an early stage. He left school in year nine and moved to PCYC based education with arrangements made by the Department of Communities. Efforts to help him stabilise continued.[7]

22. Just before Child JM died, he was waiting to start full-time employment as an apprentice brick layer, and he appeared to have achieved a measure of stability and purpose in his life. Numerous departmental officers, family members and extended family members had over the years tried to help him; the records reflect their tenacious efforts.

[4] Exhibit 1, tab 5.
[5] Exhibit 1, tab 5.
[6] Exhibit 2, tab 46.
[7] Exhibit 1, tab 5; Exhibit 2, tab 46.

23. Unfortunately, Child JM had gravitated towards a friendship with the person who drove the vehicle that he was a passenger in, on the night he died. This friendship appears to have magnified Child JM's feelings of alienation and aggression. Shortly before his death, with this friend he was involved to varying degrees in some instances of anti-social behaviour, for which his friend was later charged and convicted.[8]

24. Child JM's family were shocked by his death. It is and will remain a source of great sorrow for them.

HISTORY OF PROTECTION ORDERS

25. Child JM had two periods within the care of the Department of Communities under s 37 of the Children and Community Services Act:

    a) he was taken into care on 7 March 2013, with interim orders for Provisional Protection and Care made on 20 March 2013, and he was subsequently formally made subject to a Protection Order (Time Limited) between 10 February 2014 and 9 February 2016; and

    b) he was again taken into Provisional Protection and Care on 29 June 2016 and he was subsequently formally made subject to a Protection Order (Until 18) on 9 September 2016.[9]

26. Child JM's mother loved him dearly, but she experienced difficulties in looking after him. She herself had a range of vulnerabilities and she endeavoured to engage with treatments to assist her in addressing them and developing her parenting capacity. Child JM unfortunately experienced a lack of boundaries that impacted adversely on his capacity to manage his behaviours.

27. Child JM to come to the attention of police and the Youth Justice system. Whilst it is not necessary for me to outline all of these instances, the below

[8] Exhibit 1, tans 5 and 6.
[9] Exhibit 2, tab 46.

information outlining the attempts by the Department of Communities to find a stable and secure environment for Child JM ought to be read in the light of this background as it better places into context his absconding behaviour, and the challenges faced by his carers.

28. The details of these Protection Orders appear below.

Protection Order (Time Limited)

29. The first period of care for Child JM was between 7 March 2013 and 9 February 2016. He came to the attention of the Department of Communities after he was admitted to Armadale Hospital on 26 February 2013, for injuries sustained after falling off his bicycle. When he was ready to be discharged the next day, the hospital ascertained that his mother would not receive him back into the home due to his disruptive behaviour, and they contacted the Department of Communities.[10]

30. Inquiries by the Department of Communities led them to assess Child JM's mother as lacking the capacity to care for and protect him. Following a Safety and Wellbeing Assessment that referenced his increasing illicit drug use and unaddressed mental health concerns, and taking account of the difficulties in developing a Safety Plan in the absence of family support, on 7 March 2013 the Department of Communities brought Child JM into care, under s 37 of the Children and Community Services Act.[11]

31. On 20 March 2013 interim orders were granted for Child JM to remain in Provisional Protection and Care. The next day Child JM was admitted to a secure care center, to address his risk taking behaviour, self-harm and mental health concerns. It was also planned to assist him with reengaging with his education and developing life skills. Account was properly taken of his need for ongoing family contact.[12]

[10] Ibid.
[11] Ibid.
[12] Ibid.

32. By 10 April 2013, Child JM was transitioned to residential care, and he returned to his schooling. The Department of Communities continued to monitor Child JM's progress in residential care through Safety and Wellbeing Assessments and related plans, and also prepared proposals for contact with his family and eventual reunification.[13]

33. On 5 and 16 June 2013 Child JM's mother alerted the Department of Communities about her concerns regarding his medical and social treatment within the residential care. Also on 5 June 2013, Child JM met with an Independent Children's Representative and expressed his preference to be placed back into the care of his mother.[14]

34. On 11 June 2013 the Department of Communities conducted a Child Assessment Interview with Child JM and on 26 June 2013 after further interventions, the Department of Communities received more detailed information from Child JM's mother about her concerns, and they initiated relevant inquires. The matter was complicated by Child JM absconding on occasion, and displaying problematic behaviours.[15]

35. The Department of Communities kept monitoring the situation, and considering options for alternative placements. It is noted that in July 2013 Child JM self-selected to live with his mother and the Department of Communities agreed to withdraw its application for a Protection Order (Time Limited). Unfortunately however, the home environment remained volatile.[16]

36. Following an assessment this withdrawal application was not accepted and the matter was set down for a hearing. At this juncture, Child JM's mother and the Independent Children's Representative objected to the Department of Communities' withdrawal application. The general consensus was that Child JM needed care and protection.[17]

[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.

37. Child JM remained in residential care and steps were taken to dissuade him from absconding. On 7 and 11 October 2013, Child JM's mother again reported concerns about her son's treatment and on both occasions the Department of Communities initiated a Safety and Wellbeing Assessment and assessed the alleged incident. Two further Safety and Wellbeing Assessments followed as a result of other alleged incidents raised by Child JM's mother, and the residential care operators.[18]

38. The incidents concerned alleged aggressive and/or harmful behaviours towards Child JM. On 21 October 2013, the Department of Communities referred all four alleged incidents the subject of the above assessments to the Western Australia Police Force. However, Child JM did not wish to be interviewed, and in the circumstances it was determined that harm was not substantiated towards him.[19]

39. Child JM continued to abscond from his residential care and on 31 October 2013, Child JM's placement there was formally closed. On 1 November 2013 the Department of Communities placed Child JM with his grandparents, but regrettably he absconded from there and displayed aggressive behaviours. On 14 January 2014, Child JM was placed with a paternal aunt.[20]

40. On 10 February 2014, Protection Orders (Time Limited) were granted for a period of two years in respect of Child JM. The plan was for Child JM's mother to complete an intensive and supportive program, with a view towards reunification. Child JM initially remained in the placement with his paternal aunt, and was then placed with a maternal aunt in March 2014. An attempt at reunification with his mother in May 2014 was unsuccessful, as were attempts to engage Child JM with education, and psychological and drug counselling. Attempts to engage the mother and child with an Intensive Family Services Program were also unsuccessful. At this stage, Child JM remained primarily in the care of his maternal aunt.[21]

[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.

41. The paternal and maternal aunts' efforts to provide a stable environment for Child JM under challenging circumstances are to be commended, as are those of the grandparents. In May 2015 Child JM again self-selected to reside with his mother, but unfortunately the arrangement was disruptive and short lived, and he was intermittently referred to the At Risk Youth Accommodation. On 23 and 28 October 2015, Child JM's mother contacted the Department of Communities for the purpose of having Child JM removed from her care due to conflict. He was temporarily placed with his paternal aunt, then returned to his mother in December 2015.

42. On 9 February 2016 the Protection Order (Time Limited) ceased. In anticipation of this, the Department of Communities had already prepared a Care Plan for Child JM that addressed his needs in the area of counselling, medical services, education, and independent living if the need arose. On that same date the Department of Communities held a Signs of Safety Meeting with Child JM's mother and her partner, to discuss Child JM's formal transition back into his mother's care.[22]

43. At this point, the Department of Communities did not apply for a further Protection Oder, given that they had been unable to successfully secure and maintain a stable placement for Child JM, their attempts to engage him in medical and counselling services were unsuccessful, and the outcome of their attempts at reengagement with education were no more than his mother was able to achieve. Account was also taken of Child JM's wishes, noting the occasions where he self-selected to live with his mother.[23]

Protection Order (Until 18)

44. Child JM spent the period from 10 February 2016 to 28 June 2016 out of the care of the Department of Communities. Unfortunately, this period was characterised by instability and requests by Child JM for alternative accommodation due to conflict experienced by him in his home.[24]

[22] Ibid.
[23] Ibid.
[24] Ibid.

45. Child JM's mother in turn found his behaviour challenging and conflictual. Between 10 February 2016 and 28 June 2016 the Department of Communities and police attended and/or assisted in defusing numerous incidents at Child JM's home that had escalated into verbal arguments and with household items being broken.[25]

46. On 29 June 2016 Child JM was involved in a serious altercation in his home and he was removed by police and interviewed by the Department of Communities. On that same day he was brought into Provisional Protection and Care under s 37 of the Children and Community Services Act. On 1 July 2016 the Department of Communities completed a Safety and Wellbeing Assessment for Child JM that substantiated physical and emotional abuse and risk of self-harm for Child JM, and on the same day they made an application for a Protection Order (Until 18). This Order was granted on 9 September 2016. [26]

47. In the meantime, Child JM was again placed into the care of his maternal aunt, with the Department of Communities developing a Provisional Care Plan to address his safety, stability, health and educational needs. Child JM remained unsettled and on occasions the Department of Communities referred him to the At Risk Youth Accommodation services.[27]

48. After the Protection Order (Until 18) was granted, long term placements were considered by the Department of Communities but not recommended due to Child JM's behaviours. On occasion Child JM again self-selected to return to his mother's home. As Child JM was older, the Department placed additional weight on his wishes, but they continued to monitor these instances. Unfortunately, Child JM's absconding behaviour and anti-social behaviour continued, and he came to the attention of police and the Youth Justice system on a more frequent and troubling basis.[28]

[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Ibid.

49. On 10 March 2017 the Department of Communities prepared a Care Plan for Child JM in anticipation of his return to live with his mother on a short term basis pending the exploration of alternative youth accommodation options. It was a supportive plan, that included the provision of ongoing therapeutic services to Child JM by the senior clinician from the Specialist Psychologist Outreach Team, and parental engagement with his mother. The plan took account of family contact arrangements, medical needs and the continued support for Child JM's education. It appears Child JM had expressed an interest in carpentry, and support for his training was also included.[29]

50. In March 2017, after many years of support for Child JM, from officers within the Department of Communities and from members of his family, it appears that he was finally turning a corner. It must have been heartening for his mother and for the many people within that department who supported Child JM and maintained their faith in his capacity to develop and engage positively in the community.[30]

51. On 22 March 2017 Child JM's mother assisted with some administrative arrangements for him to commence employment, because Child JM was due to apply for or commence a bricklaying apprenticeship on 23 March 2017. On 27 March 2017, Child JM met with senior clinician from the Specialist Psychologist Outreach Team as arranged, showing his willingness to engage in therapy.[31]

52. Tragically, a few days later on 1 April 2017, Child JM died. His family was left in shock and his potential was not able to be realised.

53. The events leading up to his death are outlined below.

INTERCEPT DRIVING

54. On 31 March 2017, Child JM's friend (the Offender) stole a Holden Commodore Sedan (the Commodore) as part of an aggravated home

[29] Ibid.
[30] Ibid.
[31] Ibid.

burglary offence. On the following day, the Offender drove the Commodore in a dangerous manner with Child JM in the rear passenger seat during a sequence of Intercept Driving incidents, some of them being Evade Police Intercept Driving incidents.[32]

55. These Intercept Driving Incidents started just before 10.00 pm on 1 April 2017 when the Commodore was first sighted by police, and ended tragically shortly afterwards, when the Commodore collided with another vehicle, resulting in fatal injuries to Child JM.[33]

56. Over the relatively short period (approximately ten minutes), there were a number of Intercept Driving incidents, with police in separate vehicles locating and then losing sight of the Commodore as it accelerated away from them.[34]

57. At the inquest I reviewed the evidence concerning the actions of the involved police officers, and as part of that inquiry, I also considered those actions in the light of the Western Australia Police Force Emergency Driving Policy and Guidelines (the Policy).[35]

First Incident

58. On the evening of 1 April 2017 Constable Julian Martin-Robbins and Senior Constable Jeanna Simmons were travelling in the marked police vehicle JB100. Constable Martin-Robbins was a Priority 1 qualified driver and JB100 was a Class 1 vehicle. A Priority 1 driver is not a Priority Pursuit qualified driver, and at the material time, specific conditions needed to be met in order to continue to engage in a pursuit.[36]

59. Constable Martin-Robbins was driving and Senior Constable Simmons was in the passenger seat. At about 9.50 pm they were tasked from

[32] Exhibit 1, tab 7.
[33] Ibid.
[34] Ibid.
[35] Exhibit 2, tab 50.
[36] Exhibit 1, tabs 6 to 10; ts 39 to 42; ts 249.

Belmont Police Station to respond to a disturbance in Redcliffe and they departed to make their way there.[37]

60. As Constable Martin-Robbins and Senior Constable Simmons approached the area in JB100, their priority level was downgraded by the Police Operations Centre because another police unit had arrived there. However, JB100 kept travelling towards that location in case the other police unit needed further assistance. Whilst doing so, JB100 took a wrong turn through the back streets in Redcliffe. They reoriented and found themselves travelling north-east along Epsom Avenue in Redcliffe.[38]

61. At this point, being 9.52 pm, Constable Martin-Robbins and Senior Constable Simmons saw the Commodore driving towards them, and appear to speed up. As it passed them, they realised that it was the vehicle that had been reported as stolen the previous day and involved in a number of alleged burglaries. Due to low lighting conditions they were not able to identify the occupants (or number of occupants). Constable Martin-Robbins had previously been tasked to be on a look out for it, so he executed a U-Turn and activated emergency lights and sirens in order to initiate a Vehicle Intercept of the Commodore and call on it to stop.[39]

62. The Commodore accelerated away from JB100, turning left from Epsom Avenue into Belvidere Street, and then left into Leake Street accelerating hard away from police. JB100 pursued the Commodore and at this stage the matter developed into an Evade Police Intercept Driving incident, requiring police to comply with the Policy requirements for that type of driving.[40]

63. Both police officers in JB100 made their risk assessments, and in accordance with the Policy, Senior Constable Simmons notified the Police Operations Centre over the police radio, with the aim of seeking authorisation. Records reflect that at 9.53 pm, Senior Constable Simmons

[37] Ibid.
[38] ts 40 to 42.
[39] Ibid.
[40] ts 42 to 43; ts 45 to 46.

made contact with Police Operations Centre and provided details of their qualifications, and location. Senior Constable Simmons did not specifically make a request for an authorisation to pursue the Commodore, nor did she specifically receive an authorisation to pursue. Police Operations Centre were going to call upon the Inspector to make a decision, and in the meantime she was to keep providing information.[41]

64. JB100 continued to pursue the Commodore as it turned right from Leake Street into Sydenham Street, then left into Hardy Road (now in Cloverdale), then right into Wright Street. At this stage (9.54 pm) as part of the situation report to the Police Operations Centre, Senior Constable Simmons reported JB100's speed as being 130 kilometers per hour, but they were not catching up to the Commodore.[42]

65. JB100 continued to pursue the Commodore as it turned left from Wright Street into Belgravia Street, and continued to accelerate away heading towards the junction with Kew Street. At this stage the Commodore was about 500 metres away from JB100 and the Police Operations Centre (having ascertained that there were no nearby Pursuit drivers to assist) instructed them to cease their attempt to intercept by communicating "*abort the evade, terminate the evade*". JB100 promptly terminated its pursuit by turning off emergency lights and sirens and momentarily coming to a complete stop.[43]

66. It was 9.55 pm and the Evade Police Intercept Driving Incident had lasted a couple of minutes. JB100 lost sight of the Commodore as it reached the junction with Kew Street, and turned right. When they reached Kew Street they saw a set of tail lights in the distance.[44]

67. Sergeant Michael O'Malley of the Police Operations Centre gave the instructions for JB100 to terminate their engagement with the Commodore. At the inquest he outlined his reasons for that instruction, based upon his independent risk assessment, that took account of

[41] Exhibit 1, tabs 6 to 10; Exhibit 1, tab 19; ts 46 to 50; ts 73 to 83; ts 84 to 88.
[42] Ibid.
[43] Exhibit 1, tabs 6 to 10; Exhibit 1, tab 19; ts 73 to 88; 249.
[44] Ibid.

appropriate factors. This represents the oversight function of the Police Operations Centre.[45]

68. Just after Police Operations Centre instructed JB100 to terminate their engagement with the Commodore, they broadcast a request as follows: "*any pursuit vehicles can start making their way into the area*." As a consequence, a number of appropriately qualified drivers responded.[46]

69. Although Constable Martin-Robbins was a Priority 1 qualified driver, consist with the Policy as it then applied, he was able to commence Evade Police Intercept Driving provided he immediately communicated this to the Police Operations Centre (through Senior Constable Simmons) for the purpose of seeking authorisation (which would be subject to certain conditions needing to be met).[47]

70. Since that time, the Policy has been updated to further restrict the parameters. Under the updated Policy, a driver in the position of Constable Martin-Robbins would require authorisation before commencing the engagement (still with certain conditions needing to be met). This represents an improvement to the safety aspects of the Policy.[48]

Second Incident

71. After Constable Martin-Robbins and Senior Constable Simmons (in JB100) terminated their Evade Police Intercept Driving (i.e. their pursuit), they turned right from Belgravia Street and drove slowly down Kew Street, to see if the Commodore had turned into a side street, or whether it had been abandoned down a side street. Near the intersection of Kew Street and Burns Street, a bystander informed them that the Commodore had gone down to Abernethy Road and it was thought the Commodore was headed towards Leach Highway.[49]

[45] ts 248 to 249.
[46] Exhibit 1, tab 19.
[47] Exhibit 1, tab 23; Exhibit 2, tab 50; ts 316.
[48] Ibid.
[49] ts 50 to 51.

72. Police in JB100 drove down Abernethy Road, towards the intersection with Leach Highway, but did not see the Commodore. Records reflect that they informed the Police Operations Centre of this at 9.58 pm. They continued south-east along Abernethy Road and when they came near the intersection with Aitken Way, they saw the Commodore travelling towards them and passing them at high speed. Constable Martin-Robbins executed a U-Turn and activated emergency lights and sirens to call on the Commodore to stop. This was at approximately 10.00 pm.[50]

73. The Commodore was accelerating heavily travelling north-west along Abernethy Road. Senior Constable Simmons advised the Police Operations Centre of the Commodore's location and direction of travel. Constable Martin-Robbins very quickly lost sight of the Commodore near the intersection of Abernethy Road with Kewdale Road. JB100 continued travelling north-west along Abernethy Road, extinguishing lights and sirens near the intersection with Leach Highway (i.e. self-terminating), and continuing on to the Gabriel Street intersection. This interaction lasted approximately one to one and a half minutes, ending at 10.01 pm.[51]

74. Constable Martin-Robins estimated the Commodore was travelling in excess of 120 or 130 kilometers per hour. The posted speed limit in that area was 70 kilometers per hour. Senior Constable Simmons again called the Police Operations Centre, but by the time she made contact the Commodore had gone over a rise and they lost sight of it.[52]

75. At the inquest Constable Martin-Robins testified that he could not be sure that the Commodore's driver was aware that JB100 had executed a U-Turn and activated its lights and sirens. The Commodore was hundreds of metres ahead of JB100, and Constable Martin-Robbins could not be sure of whether its driver was failing to stop for police, or continuing to drive recklessly. I accept this assessment and in the circumstances am satisfied that the interaction in the Second Incident was an attempted

[50] ts 51 to 52.
[51] Exhibit 1, tabs 6 to 10; ts 52 to 53;
[52] ts 52 to 53; ts 88 to 91.

Vehicle Intercept, and that it did not develop into an Evade Police Intercept Driving Incident.[53]

76. Records reflect that police in JB100 did endeavour to seek authorisation from the Police Operations Centre to essentially reengage with the Commodore. Contact was made at 9.57 pm where JB100 advised of the location of the Commodore, but it was in the context of a significant amount of radio communication to and from other vehicles. At 10.00 pm the Police Operations Centre made it clear that only "*pursuit vehicles*" would receive authorisation to engage.[54]

77. One minute later the Police Operations Centre sought qualifications and driver details from police JB100, but they responded to the effect that they had essentially self-terminated and lost sight of the Commodore. It was known at the Police Operations Centre that police in JB100 were not qualified under the Policy to engage in a pursuit (unless certain conditions were met).[55]

78. At the inquest, Sergeant O'Malley posited that JB100's reengagement with the Commodore (after the initial instruction to terminate as described in the *First Incident*, above) was consistent with the Policy as it applied at the material time. This was also the view posited by Senior Sergeant Nicholas Skinner of the Police Operations Centre.[56]

79. This aspect is not able to be fully assessed in retrospect due to the amount of radio traffic on the police channel available for communications with the Police Operations Centre. It is noted that versions of the Policy before me place conditions upon reengagement, the details of which are subject to my Suppression Order.[57]

80. However, it is unnecessary for me make this assessment, due to the sequence of events that followed. I accept Sergeant O'Malley's evidence and Senior Sergeant Skinner's evidence on this point. It is not my function

[53] ts 52 to 53;
[54] Exhibit 1, tab 19; ts 211 to 213; ts 249 to 250.
[55] Ibid.
[56] Exhibit 2, tab 47; ts 253; ts 258.
[57] Exhibit 1, tab 23; Exhibit 2, tab 50.

to make findings on compliance with the Policy (although hypothetically, a lack of compliance with the Policy would be a factor to take into account on the question of whether a person's death was caused or contributed to by any action of a member of the Police Force).

Third Incident

81. After the Second Incident referred to immediately above, Constable Martin-Robbins and Senior Constable Simmons in JB100 continued travelling north-east along Abernethy Road. When they reached the intersection with Gabriel Street at approximately 10.02 pm, they stopped to talk to the police officers in marked police vehicle JB106. The driver of JB106 was Senior Constable Luke Gobby (a Priority Pursuit qualified driver) and the passenger was First Class Constable Barbara Lyon. Senior Constable Gobby informed police in JB100 that they had not seen the Commodore (and the Police Operations Centre was informed). Both vehicles continued their patrols, with JB106 turning right into Fulham Street.[58]

82. About a minute later (approximately 10.03 pm), police in JB106 observed the Commodore on their right, coming out of a side street into Fulham Street and heading towards Abernethy Road. Senior Constable Gobby activated lights and sirens, executed a U-Turn and proceeded to attempt a Vehicle Intercept of the Commodore. At the time that Senior Constable Gobby executed the U-Turn, the Commodore was at least 100 metres ahead of JB106.[59]

83. At the inquest Constable Gobby testified that he thought the driver of the Commodore had seen the lights of JB106. Constable Gobby followed the Commodore as it turned left from Fulham Street into Abernethy Road, and noted that the Commodore was travelling at considerable speed in a southerly direction along Abernethy Road. Constable Gobby estimated the Commodore's speed to be approximately 120 kilometers per hour, and testified that JB106 did not get close to it.[60]

[58] Exhibit 1, tabs 6 to 13.
[59] Exhibit 1, tabs 6 to 13; ts 113 to 117.
[60] ts 116 to 117.

84. Constable Gobby observed the Commodore being driven dangerously through the intersection of Abernethy Road and Leach Highway. He lost sight of the Commodore as it went through that intersection, because the road dips after the overpass. Constable Gobby performed a risk assessment, and also noted that he was too far away from the Commodore. He therefore deactivated lights and sirens. He did not see any other police vehicles around the Commodore.[61]

85. I am satisfied that the Third Incident was an attempted Vehicle Intercept, of very short duration, and that it is likely that the Commodore's driver saw the lights of JB106 on Fulham Street. However, given the distance between JB106 and the Commodore on Abernethy Road, I am satisfied that this incident did not develop into an Evade Police Intercept Driving Incident.

Fourth Incident

86. At around the same time, police in JB100 had been patrolling some of the back streets and had returned along Gabriel Street to the intersection with Abernethy Road. Constable Martin-Robbins in JB100 saw the Commodore again, coming south-east along Abernethy Road, towards them at high speed. At the inquest he estimated that the Commodore was driving at approximately 130 or 140 kilometers per hour.[62]

87. Constable Martin-Robbins activated lights and sirens, turned left from Gabriel Street into Abernethy Road, and accelerated heavily in order to pursue the Commodore. It was 10.03 pm and he heard Senior Constable Simmons endeavour to contact the Police Operations Centre to advise of their location and actions. On this occasion the radio transmission was unsuccessful due to other transmissions being made in respect of the Commodore.[63]

[61] ts 118 to 119.
[62] ts 54 to 55.
[63] Exhibit 1, tabs 6 to 10;

88. Again the Commodore was a few hundred metres in front of JB100 on Abernethy Road. On this occasion Constable Martin-Robbins and Senior Constable Simmons sighted the Commodore for between 10 and 20 seconds. They last saw the Commodore heading towards the intersection with Leach Highway, and it was being driven dangerously. By the time the Commodore approached that intersection, it was approximately 400 or 500 metres in front of JB100.[64]

89. As the Commodore approached the Leach Highway intersection, police in JB100 saw another police vehicle (JN182) execute a U-Turn in front of them and follow the Commodore. When police in JB100 arrived at the intersection with Leach Highway, the traffic lights were red, they could not see either the Commodore or JN182, and they deactivated lights and sirens.[65]

90. I am satisfied that the Fourth Incident was an attempted Vehicle Intercept of very short duration. It is likely that the Commodore's driver did not apprehend that police in JB100 had activated lights and sirens for the purpose of calling on him to stop, due to his speed and dangerous manner of driving along Abernethy Road, and due to the distance between the Commodore and JB100.

Fifth Incident

91. The marked Class 1 police vehicle JN182 was being driven by Senior Constable Ray Wright, with Constable Daniel Byrne as the passenger. Senior Constable Wright was a Priority Pursuit qualified driver. The vehicle was equipped with a stinger device. When police in JN182 first sighted the Commodore they had stopped in a slip lane near the intersection of Abernethy Road and Leach Highway.[66]

92. Senior Constable Wright already had information about the alleged stolen Commodore. He had previously heard Senior Constable Simmons (in JB100) over the police radio, advising Police Operations Centre that the

[64] ts 54 to 56; ts 91 to 94.
[65] Ibid.
[66] Exhibit 1, tabs 6,7 and 14 to 16; ts 126 to 129.

Commodore was involved in an Evade Police Intercept Driving Incident. Senior Constable Wright was aware Constable Martin-Robbins (JB100) was not a Priority Pursuit qualified driver, and he was aware of a call for qualified drivers to go to the area and assist, and that is what he did. His aim was to consider and assess stinger deployment locations.[67]

93. As police in JN182 headed towards the area, they tried but were unable to make contact with Police Operations Centre over the radio, due to the amount of traffic over the police radio system, so they drove there under normal driving conditions. They had not stopped in the slip lane for long before they sighted the Commodore travelling south-east along Abernethy Road. They were able to see the emergency lights of JB100 further up Abernethy Road, but noted that JB100 was a long way behind the Commodore.[68]

94. Police in JN182 saw the Commodore being driven at speed and dangerously as it travelled through the intersection with Leach Highway. At the inquest Senior Constable Wright estimated the Commodore's speed at this stage as being between 130 and 150 kilometers per hour, with Constable Byrne giving a similar estimate. Senior Constable Wright executed a U-Turn, activated lights and sirens and accelerated along Abernethy Road after the Commodore, endeavouring to assess the risk to other drivers using that traffic light controlled intersection as he proceeded through it.[69]

95. The police's evidence of the estimated speed of the Commodore outlined immediately above is consistent with that given at the inquest by independent civilian eye witnesses. The civilian eye witnesses' evidence also assisted me in establishing that police in JN182, being about three to five seconds behind the Commodore, slowed down and proceeded with caution through the intersection, in pursuit of the Commodore.[70]

[67] Exhibit 1, tabs 14 and 16; ts 131 to 137.
[68] ts 139 to 140; ts 161 to 165.
[69] ts 140 to 144; ts 166 to 168.
[70] ts 15 to 34.

96. As police in JN182 commenced following the Commodore with lights and sirens activated, as outlined above police in JB100, having observed them, ceased their attempted Intercept of the Commodore. Police in JN182 accelerated after they negotiated the intersection, but the Commodore was travelling at great speed and they did not close the gap.[71]

97. At the inquest Senior Constable Wright testified that all he could see ahead of him was some tail lights as the Commodore went around a left-hand bend further up Abernethy Road, and then he lost sight of it. He stated this was several hundred metres east of the intersection. Constable Byrne described the distance as being approximately 500 metres, when they lost sight of the Commodore.[72]

98. I turn now to the standard of communications between the police vehicle JN182, and the Police Operations Centre during this incident. At the inquest Constable Byrne testified that the Police Operations Centre had initially called them to identify that the Commodore was approaching them. Very shortly afterwards, when Constable Byrne saw the Commodore go past them and through the intersection, he attempted to contact the Police Operations Centre, because they were engaging in an Intercept that was likely to become a pursuit. For the initial couple of attempts he was unable to get a response to his transmission over the police radio. This was likely due to the amount of radio traffic.[73]

99. Moments later, on Constable Byrne's third attempt, he achieved access to transmit over the police radio, and he advised the Police Operations Centre of their qualifications and location behind the Commodore. He did not recall receiving a response. At this stage it was 10.04 pm and JN182 was several hundred metres behind the Commodore. Moments after that he was able to hear over the police radio, that another police vehicle was essentially the primary vehicle behind the Commodore.[74]

[71] Exhibit 1, tab 14; ts 145 to 146.
[72] Ibid.
[73] ts 168 to 170.
[74] ts 170 to 171.

100. I have considered the evidence of the police officers in JN182, together with the record of the transmissions with the Police Operations Centre. Records reflect that at 10.03 pm police in JN182 were able to make contact with Police Operations Centre to advise of the sighting of the Commodore and report on its dangerous manner of driving. However, at the inquest Senior Sergeant Skinner testified that neither he, nor the dispatcher heard specific information about the Commodore's dangerous manner of driving. This is understandable in light of the number of transmissions over the police channel, and the ambient sound at the material time.[75]

101. Records reflect that at 10.04 pm police in JN182 advised Police Operations Centre that they were behind the Commodore, and detailed their qualifications. That information appears to have been acknowledged by Police Operations Centre by the words: "*roger*", which may indicate either approval, or it may indicate that the information is received. In any event it does not indicate that JN182 ought to terminate their engagement.[76]

102. However, it would appear that police in JN182 did not hear the words "*roger*" and it is also possible that those words were directed by Police Operations Centre to police in JB100, who were simultaneously, almost, transmitting information to the Police Operations Centre, as well as other police vehicles.[77]

103. At the inquest Senior Sergeant Skinner explained that at the material time, that particular radio transmission channel was covering two Districts (South Metropolitan and South-East Metropolitan). That may account generally for the higher number of voice communications between police using the radio in their vehicles, and the Police Operations Centre, and may also account for the ambient noise at the Police Operations Centre. Senior Sergeant Skinner further explained that communications are now essentially organised around one channel per District.[78]

[75] Exhibit 1, tab 19; ts 209; ts 216.
[76] Exhibit 1, tab 19; ts 217 to 218.
[77] Ibid.
[78] ts 202 to 203.

104. At the inquest, I foreshadowed that I would seek further information about whether any improvements can be made to the configuration at the Police Operations Centre, to lessen the sound levels at the pods during an Evade Police Intercept Driving incident, to address the ambient noise concern that was raised as an issue before me. It is important for the Duty Inspector to be able to hear relevant information in order to continually monitor and assess an incident from a risk management perspective.

105. The State Communications Division subsequently examined the Police Operations Centre's operational floor and spoke with key personnel tasked with responding to the various types of dispatch and response to emergency situations. It is posited by them that the current configuration is optimal for the purpose of allowing oral communication to be conveyed consistently throughout an Evade Police Intercept Driving Incident. Senior officers of the Police Operations Centre advised that this particular event involved periods of louder than usual noise, and on balance it is considered that this is not the usual scenario and that the current configuration of the workspace is not a serious issue requiring attention.[79]

106. I take into account the fact that communications are now organised around one channel per District, and that this matter was not the usual scenario given that it involved numerous communications from police in separate vehicles in respect of the same incident. Balancing that against the need for open communications and continual monitoring, I am satisfied that this is not an aspect that needs to be explored further.

107. At the inquest I heard evidence, followed by submissions, on the question of whether this incident was an attempted Vehicle Intercept, or whether it had escalated into an Evade Police Intercept Driving Incident. In order for it to have so escalated, the police in JN182 would need to have formed the view that the Commodore's driver was aware that they had called on him to stop, and that he chose to evade them.

108. Senior Constable Wright testified that he did not believe the Commodore's driver was aware of his attempt to call upon it to stop.

[79] Exhibit 2, tab 58.

Senior Constable Wright referred to the speed with which the Commodore was driving along Abernethy Road, towards them, and the fact that he did not activate JN182's lights in front of the Commodore.[80]

109. Notwithstanding the initial proximity of the two vehicles when they were facing each other, I am satisfied that on this occasion it is unlikely that the Commodore's driver was aware that police in JN182 had essentially called upon him to stop. The police in JN182 attempted a Vehicle Intercept for a short period of time (a matter of seconds), and they concluded their engagement by 10.04 pm.

110. However, for the purposes of the inquest, the fifth incident is also to be regarded from the perspective of the overall interactions between previous police vehicles and the Commodore, and in this respect I have regard to the evidence of Detective Senior Sergeant Brian Hunter of the Internal Affairs Unit, who raised the issue of the entirety of the interactions by the various police vehicles up to that stage as being an Evade Police Intercept Driving incident, in circumstances where there were multiple attempted Vehicle Intercepts.[81]

111. Whilst at this stage the Commodore's driver may not have been specifically evading the police in JN182, it is clear that he was in the course of generally evading police, who had previously interacted with the Commodore and called upon it to stop. This fact was acknowledged at the inquest by Senior Constable Wright, who understood the Commodore was failing to stop for the police earlier, when it came out onto Abernethy Road.[82]

112. The surrounding (and preceding) circumstances are relevant. The aim of the Policy is to guide police interaction utilising amongst other things, principles of risk management. Whilst it is important to understand each incident, it would be unnecessarily restrictive to compartmentalise each incident and view it in isolation. I am satisfied that JN182 attempted a Vehicle Intercept in circumstances where it was known that the

[80] ts 149 to 150.
[81] ts 274 to 275.
[82] ts 150.

Commodore's driver was in the course of evading police. There is therefore a reasonable basis for also considering the fifth incident to be an Evade Police Intercept Driving incident, and this is how Detective Senior Sergeant Hunter classified it.[83]

113. The point at which an attempted Vehicle Intercept becomes an Evade Police Intercept Driving Incident cannot always be identified with precision, especially because the former may escalate into the latter under very dynamic conditions. Risk assessments are by their very nature ongoing and changeable, usually dependent on matters outside the control of the police. It is known that some drivers who are being pursued will drive dangerously to avoid being caught.

114. The Internal Affairs Unit subsequently conducted an investigation into whether the police officers complied with the Policy. I am relevantly informed, but not bound by the outcome of this investigation. As indicated above, I do not make findings on whether the Policy was complied with; rather, my findings concern the question of whether Child JM's death was caused or contributed to by any action of a member of the Police Force.[84]

115. It is at this juncture relevant to record that the Internal Affairs Unit assessed the involvement of JN182, and whilst matters of Policy compliance were considered and addressed, their conclusion, as explained at the inquest by Detective Senior Sergeant Hunter, was that the Commodore was not responding to the actions of JN182. There was a considerable distance between the two vehicles. I accept the evidence and am satisfied that the Commodore was being driven in the same manner before and after the involvement of JN182.[85]

Sixth Incident

116. Immediately upon JN182 ceasing their engagement, at 10.04 pm police in Class 1 marked vehicle TS215, sighted the Commodore. TS215 was being driven by Senior Constable Ian Bernstein, a Priority Pursuit qualified

[83] ts 272 to 274.
[84] Exhibit 1, tab 6.
[85] ts 270.

driver. His passenger was Senior Constable David Armitage. Their vehicle was equipped with a stinger device. They had heard the earlier radio transmission from police in JB100, and had headed towards the area with the aim of deploying the stinger device.[86]

117. At approximately 10.00 pm police in TS215 had been travelling north-west along Abernethy Road on their way to the last known sighting of the Commodore (as advised through radio communication). They had been monitoring the incident and had just driven through the intersection with Kewdale Road when at 10.04 pm they saw the Commodore travelling south-east along Abernethy Road (i.e. towards them). Police in TS215 could not see police lights behind the Commodore, consistent with the evidence given to the effect that JN182 was a considerable distance behind the Commodore.[87]

118. At the inquest Senior Constable Bernstein testified that he estimated the Commodore's speed to be 150 kilometers per hour as it went past them. Senior Constable Armitage gave an estimate of between 120 and 160 kilometers per hour. Senior Constable Bernstein executed a U-Turn and activated lights and sirens, with the aim of intercepting the Commodore along Abernethy Road. Due to the Commodore's speed and the lighting conditions, they were not able to identify the occupants.[88]

119. As TS215 was preparing to U-Turn, Senior Constable Armitage endeavoured to make radio contact with the Police Operations Centre, with the aim of advising of the location of the Commodore and informing of their intentions. At the inquest Senior Constable Armitage testified that despite attempts, he was unable to make contact with the Police Operations Centre over the police radio. Again this appears to be due to the amount of traffic over the radio transmission system, that in effect blocked his attempted transmission.[89]

[86] Exhibit 1, tabs 17 and 18.
[87] Exhibit 1, tabs 17 and 18; ts 182 to 186; ts 192 to 194.
[88] ts 186 to 187; ts 195 to 196.
[89] Exhibit 1, tab 18; ts 195.

120. Very shortly after TS215 accelerated in the direction of the Commodore along Abernethy Road, the Commodore entered the intersection with Kewdale Road in contravention of the red traffic light, resulting in the collision described under the heading below. At the time of the collision TS215 was approximately 150 metres north of the intersection of Abernethy Road and Kewdale Road. Police in TS215 saw the collision at 10.04 pm and immediately contacted Police Operations Centre to call for an ambulance. That was the first occasion upon which they were able to achieve contact.[90]

121. Given the proximity of the two vehicles, I am satisfied that on this occasion the Commodore's driver was aware that police in TS215 had essentially called upon him to stop, and that he again chose to evade the police. Police in TS215 engaged in Evade Police Intercept Driving for a short period of time (a matter of seconds), and then the collision occurred.

THE COLLISION

122. The Commodore was being driven at dangerous speeds in a south-easterly direction along Abernethy Road with police in TS215 behind it. Abernethy Road is a sealed two-way carriageway for traffic travelling in north-westerly and south-easterly directions. The east and westbound carriageways are separated by paved traffic islands at the intersection of Kewdale Road.[91]

123. Kewdale Road at the location of the collision is also a sealed two-carriageway for traffic travelling in north-easterly and south-westerly directions, and intersects with Abernethy Road as a four-way intersection.[92]

124. On the night of the collision visibility was good at the intersection due to the numerous illuminated street lamps. All carriageways were dry, in good condition and free of loose materials and contaminants. The posted

[90] Exhibit 1, tabs 17 to 19.
[91] Exhibit 1, tabs 6 and 7.
[92] Ibid.

speed limit on Abernethy Road on the approach to that intersection is 70 kilometers per hour.[93]

125. At approximately 10.04 pm the Commodore traveling south-east along Abernethy Road entered the intersection with Kewdale Road in contravention of the red traffic light, and at speed, resulting in the collision. The Commodore's driver swerved violently to the right just before entering the intersection. As it entered the rear passenger side of the Commodore collided heavily with the front driver's side of a Mitsubishi shuttle bus towing a custom trailer, that was traveling south on Kewdale Road, through the same intersection.[94]

126. The bus was proceeding lawfully through the intersection with a green light. The collision caused the bus to yaw counter clock-wise and roll onto its right side, trapping the driver and sliding into the traffic control lights at the intersection. When the bus came to a stop, it was facing north, the direction it had come from, and was in the north-west bound lane on Abernethy Road.[95]

127. The impact caused significant damage to the left rear portion of the Commodore, that took the brunt of the impact. The rear passenger side door had been torn away. This was where Child JM was seated (the back left passenger seat). The Commodore had gone into an uncontrolled spin for approximately 50 metres to where it came to rest on the verge of Abernethy Road to the south east of the intersection. Tyre marks rotational in appearance leading from the centre of the intersection to where the Commodore had come to rest assisted in establishing this.[96]

128. Major Crash Investigation Officers attended the scene on the evening of the collision and commenced their investigations. The Commodore's airbag control module was subsequently downloaded. Analysis of pre-crash data indicated the following, that I accept:

[93] Ibid.
[94] Ibid.
[95] Ibid.
[96] Ibid.

a) From the five seconds marker to the 2.5 seconds marker, pre-crash, the throttle (accelerator pedal) was indicating 99% (consistent with an increase in speed from 133 kilometres per hour to 155 kilometres per hour); and

b) This increase in speed is followed by zero accelerator pedal and application of the service brake bringing the speed down to approximately 108 kilometres per hour, no more than one second prior to impact (possibly 92 kilometres per hour at impact).[97]

129. The Major Crash Investigation made a distance assessment in relation to the recorded data, that I accept, indicating that braking by the Commodore took place between 75 and 109 metres from the point of collision, meaning prior to the Commodore entering the intersection.[98]

130. Subsequent examination of the police vehicles involved (or likely involved) in Evade Police Intercept Driving (JB100, JN182 and TS215) reflected that there was no damage consistent with having come into contact with the Commodore. Subsequent inspection of the Commodore by the Police's Vehicle Inspection Unit established that there were no pre-existing contributory defects. However, the inspection did show that the right and left rear tyre treads were worn below the legal requirement of 1.5 millimeters, with nylon tyre construction material visible on both tyres (and on the left rear tyre, metal construction material visible). Tyres in this condition would have reduced grip capacity on the road, particularly at speed.[99]

131. Tragically and despite the tenacious first aid efforts referred to below, Child JM's injuries proved to be fatal.

[97] Exhibit 2, tab 38.
[98] Ibid.
[99] Exhibit 2, tab 39.

FIRST AID

132. At the time of the collision, TS125 was approximately 200 metres behind the Commodore, JN182 was a further 100 metres behind them, and JB100 was a similar distance behind JN182.[100]

133. Consequently, police in TS215, JN182 and JB100 were the first responders. They were on the scene within seconds, and together they acted promptly to render first aid to Child JM and assist the driver of the bus (who subsequently had to be extricated from his vehicle by emergency services). Police arrested the driver of the Commodore at the scene. Police in JB106 and JN184 also arrived and together with emergency services, they also assisted with the first aid for Child JM.[101]

134. Multiple ambulances attended the scene. For the purposes of this finding I will address the paramedic response in connection with Child JM. Police had initially located Child JM partially ejected from the left rear seat of the Commodore. They cut his seatbelt and commenced CPR. At one stage it appeared a pulse returned, but it was irregular and weak. Child JM's injuries were serious and distressing, and police tried to reassure him. I make special mention of the sustained efforts of Senior Constable Gobby who was assiduous and tenacious in his efforts to render first aid and continue CPR until the paramedics arrived, and Constable Byrne who assisted.[102]

135. Records reflect that at approximately 10.05 pm the St John Ambulance Service received a call, that they departed promptly at 10.06 pm, arriving at the scene at 10.16 pm.[103]

136. Paramedics took over the resuscitation of Child JM, with police officers continuing to assist with CPR throughout. Child JM was unresponsive and is recorded as having a Glasgow Coma Scale of 3. There was no pulse and no respiratory effort. There was extensive bleeding. He was conveyed by ambulance to Royal Perth Hospital with CPR in progress,

[100] Ibid.
[101] Ibid.
[102] Exhibit 1, tabs 11 and 16; ts 120.
[103] Exhibit 1, tabs 6 and 7; Exhibit 2, tab 43.

departing the scene at 10.24 pm and with a handover occurring at 10.38 pm.[104]

137. Despite all efforts within the Emergency Department of Royal Perth Hospital, Child JM was not able to be revived. It was noted that he was in asystole since the time of arrival of the paramedics at the scene. He was tragically pronounced dead at 10.43 pm on 1 April 2017. He was identified on 2 April 2017 by his mother and it must have been traumatising for her. She continues to mourn his loss.[105]

138. The driver of the bus sustained severe and ongoing injuries, with multiple serious fractures, requiring emergency treatment followed by hospitalisation for some weeks. It affected his ability to drive and carry out his work. It was undoubtedly a shocking experience for him, with ongoing health consequences and adverse impacts in his life.[106]

CAUSE AND MANNER OF DEATH

139. On 7 April 2017 the forensic pathologist Dr D. M. Moss (Dr Moss) made a post mortem examination at the State Mortuary on the body of Child JM. Dr Moss' examination revealed severe injuries to the head, along with lesser injuries to the chest and abdomen. There was no evidence of significant pre-existing natural disease.[107]

140. On 7 April 2017 Dr Moss formed the opinion that the cause of death was multiple injuries, and toxicological analysis was ordered.[108]

141. The results of toxicological analysis became available on 10 May 2017. These showed a blood tetrahydrocannabinol level of 1.5 micrograms per litre. Alcohol and other drugs were not detected. The forensic pathologist's opinion on cause of death remained unchanged.[109]

[104] Exhibit 2, tab 43.
[105] Exhibit 1, tab 2; Exhibit 2, tabs 55 and 56.
[106] Exhibit 1, tab 29.
[107] Exhibit 1, tab 3.
[108] Ibid.
[109] Ibid.

142. I accept and adopt Dr Moss' opinion. **I find that the cause of Child JM's death was multiple injuries**.

143. Child JM was a passenger in the Commodore, that was being driven by a male person (the Offender), who was his friend.

144. On 23 April 2018 on his pleas of guilty, the Offender was convicted of a number of criminal offences arising out of this incident, including the unlawful killing of Child JM, and he was sentenced to a number of terms of imprisonment. It was noted that the Offender was affected by cannabis, and that it had impaired his ability to drive to some extent. However, the expert pharmacologist who analysed the Offender's blood results was of the view that the degree of speeding and evasive driving seen in this case was extreme for cannabis intoxication. It was also noted that the Offender's judgment was impaired as a result of the impairment of his cognitive functioning, stemming from Foetal Alcohol Spectrum Disorder (FASD).

145. I have considered the outcome of the above criminal proceedings and had regard to s 53(2) of the Coroners Act, which requires that my finding not be inconsistent with the result of any earlier proceedings where a person has been charged on indictment in which the question whether the accused person caused the death is in issue.

146. **I find that the manner of Child JM's death is unlawful homicide**.

147. In considering whether any member of the Police Force contributed to Child JM's death, I have taken account of all of the evidence before me, and in particular the following:

a) the distance between the police vehicles and the Commodore during the attempted Vehicle Intercepts and/or Evade Police Intercept Driving Incidents;

b) the degree of the involved police officers' compliance with the Policy, and their performance of legitimate policing functions;

c) the deliberate choices and actions of the Offender including his dangerous manner of driving; and

d) the result of the criminal proceedings referred to above,

and, as I indicated at the inquest, I am satisfied that police did not cause or contribute to Child JM's death.[110]

QUALITY OF SUPERVISION, TREATMENT AND CARE

148. Where, as in this case, Child JM was a person held in care immediately before death, s 25(3) of the Coroners Act requires me to comment upon the quality of his supervision, treatment and care while in that care. That essentially requires an assessment of the role of the Department of Communities.

149. Child JM had numerous placements while he was in the care of the CEO of the Department of Communities. On the occasions when he self-selected to return to living with his mother, the arrangements were unsettled and relatively brief.

150. On behalf of the Department of Communities, Mr Glen Mace prepared a report for the coroner. Within that department, Mr Mace is the Acting Assistant Director General, Service Delivery, Metropolitan Communities. He reviewed the records in this case and he gave evidence at the inquest. He explained that their greatest challenge for the teenage cohort is the ability to find a placement that can meet those challenging needs.[111]

151. In the specific case of Child JM, the matter was further complicated by his lack of willingness to work with the Department of Communities to find a placement. Mr Mace described the efforts made by Child JM's case manager and team leader as being quite relentless, but that those efforts were hindered by Child JM's willingness to engage and share what was going on in his life.

[110] ts 294.
[111] Exhibit 2, tab 46; ts 288; ts 302.

152. As outlined previously in this finding, Child JM was taken into the care of the CEO of the Department of Communities on 7 March 2013, and upon application, a Protection Order (Time Limited) was granted on 10 February 2014 for a period of two years. The ultimate aim of a Time Limited Order is to allow for reunification with a child's family, in this case Child JM's mother, which appropriately recognises the importance of this primary relationship.[112]

153. Throughout the period of the Protection Order (Time Limited) the Department of Communities conducted Safety and Wellbeing Assessments for Child JM, and interacted supportively with him and his mother. When Child JM's mother raised her own concerns about his wellbeing, these were followed up promptly.[113]

154. When the Protection Order (Time Limited) expired on 9 February 2016, the Department of Communities did not seek a further protection order. At the inquest Mr Mace explained the reasons for this. He pointed to the difficulty in achieving a placement for Child JM, the judgment they needed to make about harm minimisation in the care environment, Child JM's absconding behaviour, their assessments of his mother's progress and her capacity to provide care, and the fact that Child JM had over time repeatedly elected to return to his mother's care.[114]

155. Ultimately as outlined previously in this finding, the Department of Communities sought and was granted a Protection Order (Until 18) on 9 September 2016 in respect of Child JM. At the inquest Mr Mace explained the reasons for this change of approach. He pointed to their efforts in trying to improve Child JM's situation at home, factors affecting the mother's parenting capacity, and the escalation in Child JM's behaviour (including coming to the attention of the Youth Justice services).[115]

[112] ts 288.
[113] ts 288 to 297.
[114] ts 299.
[115] ts 300.

156. One of the concerns held by Child JM's mother, and shared by the Department of Communities at the material time, was that an older male child (also held in care) was a negative influence on Child JM. There was a concern that this influence may have extended to the manipulation of Child JM, encouraging him be involved in criminal conduct.[116]

157. At the inquest Mr Mace was questioned about efforts made by the Department of Communities to endeavour to negate that negative influence. The court was informed that after 31 October 2013, the Department of Communities did not place Child JM in the same care placement as this older male child. At the material time, reasonable inquiries and efforts were made by the Department of Communities regarding this concern. However, their efforts were hampered unfortunately by Child JM's pattern of absconding behaviour, including absconding with this older male child.[117]

158. As outlined previously in this finding, a number of incidents concerning alleged aggressive and/or harmful behaviours towards Child JM were referred by the Department of Communities to the Western Australia Police Force. In the circumstances it was determined that harm was not substantiated towards Child JM.

159. At the inquest Mr Mace agreed that Child JM's election not to provide information about the alleged incidents essentially limited the investigation outcomes. Mr Mace further explained that running parallel to such investigations however, are the Department of Communities' ongoing assessments of the welfare and safety of Child JM. Those allegations therefore, whilst not formally substantiated, nonetheless informed the Safety and Wellbeing Plans for Child JM. I am satisfied therefore that these incidents (described by Mr Mace as a suspicion) were nonetheless taken into account in pursuance of Child JM's safety and wellbeing.[118]

[116] ts 304.
[117] Exhibit 2, tab 46A; ts 304.
[118] ts 297 to 298; ts 301.

160. It is not known how Child JM came to be in the Commodore that was being driven by his friend. Child JM had come to know the Offender when both were children, the Offender being slightly older. It was posited that Child JM looked up to him, and may have been easily influenced by him.

161. I have had regard to the numerous and consistent endeavours on the part of the Department of Communities to ensure Child JM's safety and wellbeing in the context of the varying care arrangements, whilst also fostering contact and connection with his mother and his family. The department had cogent plans for addressing Child JM's social, medical, psychological and educational needs. His care placements were considered with regard being had to his needs, and the suitability of the placement on each occasion.

162. I am satisfied that quality of Child JM's supervision, treatment and care while in the care of the Department of Communities was appropriate, though of necessity the outcomes were limited by Child JM's reluctance to engage and his pattern of absconding behaviour. The department made reasonable inquiries and efforts to achieve suitable and stable placements for Child JM, and appropriately took into account his safety and welfare, and the desirability of fostering the relationship with his family, in particular with his mother.

IMPROVEMENTS

163. The Department of Communities, as would be expected of governmental departments, is on a pathway of continual improvement. At the inquest Mr Mace was questioned about the department's treatment of the numerous reports of concerns about Child JM's welfare from various sources and whether they were assessed separately, as opposed to being assessed from the perspective of an ongoing problem.[119]

164. Mr Mace explained that in the previous 12 months there have been changes to how the Department of Communities assesses reports of potential harm to children in their care. Their case practice manual has

[119] ts 310

been updated, and the instructions to the case managers are a lot more prescriptive. One of the new matters that needs to be focused upon concerns situations where there is a long history of departmental contact.[120]

165. This is particularly so where there have been previous child safety investigations conducted for a child who is held in care. The changes are designed to ensure that the presenting incident is not looked at in isolation, but in the context of the previous investigation. There is now a greater focus upon the impact of potential cumulative harm. Mr Mace explained that now, in a situation arising in circumstances similar to Child JM, the Department of Communities would require the assessor to look at the history and to consider the cumulative impact of harm. This assessment would consider any history of association with another person who may be seen to be a negative influence upon the child being assessed.[121]

166. Mr Mace explained that since the last 18 months the Department of Communities has had a suite of early intervention and family support strategies. Service providers work intensively with families to try to prevent the need for children to enter the foster care system. The aim is to build the capacity of families to support parents in carrying out their responsibilities in respect of their children.[122]

167. At the inquest Mr Mace drew attention to the Target 120 Program, and after the inquest the Department of Communities provided further information about this program. Target 120 is an early intervention program for a small cohort of very high needs young people at risk of becoming repeat offenders. The objective is to improve outcomes for young people and their families while improving community safety.[123]

168. Target 120 was developed by the Department of Communities in consultation with service partner agencies including the Western Australia Police Force. It is being rolled out state-wide. The Local Interagency

[120] Ibid.
[121] Ibid.
[122] ts 311.
[123] Exhibit 2, tab 46C.

Groups co-ordinate the delivery of services, that include initiatives such as:

a) connecting Target 120 Community Youth Officers with State Government agencies to facilitate service access for program participants; and

b) providing interagency case co-ordination, integration and collaboration to deliver whole of life supports and services for program participants.[124]

169. It is a whole of government commitment and response. It relies upon collaboration across government to prioritise and coordinate services for an identified high needs cohort. It involves liaison with police, schools, community groups, child protection and Youth Justice services, and includes the exchange of relevant information where appropriate.[125]

170. Allied to this are the initiatives that the Western Australia Police Force refers me to, concerning their role in the engagement with young people who are offending, and their families. They have dedicated Youth Policing Officers whose role is to engage with young offenders and young people at risk of offending within districts. They work with agencies (such as the Department of Communities) who refer cases to the Integrated Offender Management Working Group and the intention is to engage young persons in suitable diversionary programs.[126]

171. By reason of the above changes to the Department of Communities' case practice manual to highlight and develop procedures in the area of potential cumulative harm, and the introduction and progressive implementation of the Target 120 Program, there is no need for me to make recommendations in the areas of the broader assessment of cumulative harm by the Department of Communities and/or the appropriate exchange of information between governmental agencies to better protect the welfare of at risk children who are held in care.

[124] Ibid.
[125] Ibid.
[126] Exhibit 2, tab 58.

CONCLUSION

172. Child JM had complex needs, and he displayed challenging behaviours. His pattern of absconding from his care placements and his home was a sad refection of his disengagement from his carers and the community around him. His home environment drew him back repeatedly, but it remained unsettled and on occasion, volatile. He ultimately formed a friendship that was not in his interests, but it needs to be acknowledged that it was a two-way friendship. Tragically he died in the company of his friend. It remains a source of deep sorrow for his family and all those who loved and cared for him.

R V C Fogliani
State Coroner
30 December 2020