Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Barry Paul King, Deputy State Coroner, having investigated the death of ***Amy-Lee Armstrong, Kyrone Terrance Eades and Ashley Scott De Agrela*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 3 April 2019, find that the identities of the deceased persons were* ***Amy-Lee Rose Armstrong, Kyrone Terrance Eades and Ashley Scott De Agrela*** *and that the deaths of Amy-Lee Armstrong and Kyrone Terrance Eades occurred on 2 December 2015 on North Lake Road near the intersection with Hammond Road in South Lake from multiple injuries, and the death of Ashley Scott De Agrela occurrred on 4 December 2015 at Royal Perth Hospital from head injury, in the following circumstances:*

Counsel Appearing:
Ms F Allen assisted the Deputy State Coroner
Ms C Wood (Aboriginal Legal Service of Western Australia) appeared for the families of Ms Armstrong and Mr Eades
Ms J Harman (State Solicitor's Office) appeared for the Western Australia Police Force

TABLE OF CONTENTS

ORDER UNDER S 49(1)(B) *CORONERS ACT 1996*

On the basis that it would be contrary to the public interest, I make an order under section 49(1)(b) of the *Coroners Act 1996* that there 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 2 December 2015, Ms Armstrong, Mr Eades and Mr De Agrela were passengers in a Holden Calais (the Holden) being driven at high speeds by Matthew Conduit when Mr Conduit lost control of the Holden and it crashed into a tree on a central median strip on North Lake Road in South Lake.

2. Ms Armstrong and Mr Eades died at the scene of the crash, and Mr De Agrela died two days later in hospital. Mr Conduit survived.

3. A few minutes before the crash, two WA Police Force (WAPF) Senior Constable Joel Vanson and Senior Constable Darren Cramer, (the officers) who had been patrolling the Cockburn Central Shopping City carpark in a marked police vehicle saw the Holden travelling north on Wentworth Avenue in excess of the posted speed limit. They activated their emergency lights and sirens and began to pursue the Holden, but they aborted the pursuit within a short time.

4. On 7 November 2017, I investigated the deaths without holding an inquest and made findings of how the deaths occurred and the causes of the deaths as required under s 25(1) of the *Coroners Act 1996* (the Act).

5. With my concurrence, on 27 February 2019 the State Coroner set aside my findings on the basis of a requirement under s 22(1)(b) of the Act to

hold an inquest where it appears that the actions of a police officer caused or contributed to the deaths. While it was not clear, it appeared that Mr Conduit may have been attempting to evade the officers at the time of the crash.

6. I held an inquest on 3 April 2019 at the Perth Coroners Court.

7. The documentary evidence adduced at the inquest comprised a detailed report provided to the State Coroner by Detective Sergeant J Giorgi, Crime Manager, Central Metro District Control Centre.[1]

8. Oral evidence was provided by the two police officers who had been involved in the aborted pursuit, two motorists who had witnessed the Holden about the time of the crash, a crash reconstruction officer with the Major Crash Investigation Section who had prepared a forensic collision report about the crash, and a detective sergeant who had investigated the officers' actions leading up to the crash.

9. At the conclusion of the inquest I received oral submissions from counsel.

Amy-Lee Armstrong

10. Ms Armstrong was a 25 year old mother of three who lived in Huntingdale. She had three siblings. She had a bubbly and funny personality, and she was especially caring. For example, when her mother died in a road accident, she took on the responsibility of looking after her maternal grandmother and her younger sister.[2]

11. Ms Armstrong had been in a relationship for a number of years with Mr Eades, who was the father of her children. They had been separated, but at the time of her death they had rekindled their relationship.[3]

[11] Exhibit 1.4
[2] ts 83, Exhibit 1.4A
[3] Exhibit 1.4A

Kyrone Terrance Eades

12. When he was young, Mr Eades was a good bloke with a very kind heart. He always helped other people out and showed his family much love and respect.[4]

13. Mr Eades especially loved his children with Ms Armstrong and, at the time of his death, he was back in a relationship with her after a period of separation. He was 24 years old at the time.[5]

14. Over all, Mr Eades lived a really happy life, and his loss has been tragic for his family.[6]

Ashley Scott De Agrela

15. At the time of his death, Mr De Agrela was 19 years old. He had four siblings, though one brother was deceased. He was very keen on sports and played football and basketball.

16. Mr De Agrela liked to fix motor-bikes and cars, and he had attended a Balga youth program in which he acquired skills in mechanic.

Events leading up to the deaths

17. On the evening of 2 December 2015, Mr De Agrela and his brother Mr Conduit were visiting relatives in Hindmarsh Way in Success.[7] Mr Conduit drank alcohol and used methylamphetamine during the day.

18. At about 9.00 pm, Mr Conduit's girlfriend arrived at his relatives' house in the Holden, which was her car. She met Mr Conduit outside the house and left him the key to the Holden so that he could get something out of it while she went inside with his aunt.[8]

[4] ts 83
[5] Exhibit .14B
[6] ts 83
[7] Exhibit 1.14
[8] Exhibit 1.14

19. While Mr Conduit was out front, Ms Armstrong and Mr Eades walked by on their way to the shops. It turned out that Mr Conduit knew Mr Eades from when they had been in prison together, so they struck up a conversation. Mr Conduit agreed to drive Mr Eades and Ms Armstrong to the shops in the Holden, and Mr De Agrela decided to join them.[9]

20. At 9.40 pm, Mr Conduit was driving Ms Armstrong, Mr Eades and Mr De Agrela north on Wentworth Parade past Cockburn Gateway Shopping City in Cockburn Central. Ms Armstrong and Mr Eades were in the back seat. They were not wearing seatbelts. Mr De Agrela was in the front passenger seat. He was wearing a seatbelt.[10]

21. At the same time, the officers were patrolling the carpark of Cockburn Gateway Shopping City in a police vehicle with the call-sign US105. Senior Constable Vanson was driving. After driving through the carpark, the officers drove to the exit onto Wentworth Parade at the Gate Bar and Bistro and stopped there to wait for traffic to pass.

22. As the officers waited, the Holden passed directly in front of them, heading north towards the traffic lights at the T-intersection with Beeliar Drive.[11] It was clearly travelling at an excessive speed. Assessments carried out by reference to CCTV records at the Gate Bar and Bistro indicate that the Holden was travelling at about 135 km per hour on Wentworth Parade.[12] The speed limit was 60 km per hour.[13]

23. The police officers drove onto Wentworth Parade and followed the Holden in order to intercept it. US105 was appropriate for vehicle intercepts and Senior Constable Vanson was qualified to engage in pursuit driving.

24. When the Holden reached the intersection with Beeliar Drive, Mr Conduit drove it through a red light and turned right onto Beeliar Drive to head

[9] Exhibit 1.14
[10] Exhibit 1.14
[11] Exhibit 1.16
[12] Exhibit 1.42 17
[13] Exhibit 1.15

east. The officers activated the sirens and emergency lights on US105[14] and contacted the Police Operations Centre (POC) to advise that they were attempting to intercept a vehicle that had failed to stop. As they were speaking, the Holden turned left onto Midgegooroo Avenue.[15]

25. The officers turned right at the lights on Beeliar Drive and followed the Holden onto Midgegooroo Avenue. Senior Constable Vanson thought that they had recorded the registration number of the Holden at about that stage and that Senior Constable Cramer had relayed it to the POC,[16] but Senior Constable Cramer stated that they had never got close enough to the Holden to obtain it.[17] It is clear from the transcript of the radio communication with the POC that they did not advise the POC of the registration number,[18] so I infer that they did not obtain it.

26. The speed of the Holden increased on Midgegooroo Avenue, and it then turned left onto North Lake Road where it began to head northwest. The officers in US105 were about 150 metres behind it at that stage.[19] After that, the officers could see the tail-lights of the Holden in the distance on North Lake Road as they attempted to keep it in sight. Senior Constable Vanson accelerated up to the speed cap in the WAPF Emergency Driving Policy and Guidelines (the Policy), but the Holden slowly increased its distance.[20]

27. As the officers approached the intersection of North Lake Road and Semple Court, Mr Conduit turned off the Holden's headlights and began travelling on the wrong side of the road.[21] The officers then aborted the pursuit and advised the POC accordingly. They decreased the speed of US105 and turned off the emergency lights and sirens.[22] That occurred within 25 seconds of the officers in US105 initially notifying the POC of the pursuit.[23]

---

[14] Exhibit 1.16
[15] Exhibit 1.48
[16] ts 9
[17] Exhibit 1.17
[18] Exhibit 1.48
[19] Exhibit 1.17
[20] Exhibit 1.16
[21] Exhibit 1.16
[22] Exhibits 1.16, 1.48
[23] Exhibit 1.48

28. The officers travelled a short distance further and saw a large amount of smoke across North Lake Road near the intersection with Thomas Street. They slowed down and saw a white van parked on the eastern verge on the south-bound lanes and a man standing near the van. Beside a tree in the median strip was what appeared to be wreckage from the Holden, and there was further wreckage across the south-bound lanes.[24]

29. Marcus Downs was one of the two witnesses who had been travelling on North Lake Road at the time of the crash. He was travelling south in his panel van and had just driven through the intersection with Berrigan Drive when he heard the noise of a car approaching his position from the south at high speeds. He was looking south to try to determine what was making the noise when the Holden hit the tree on the median strip about 30 metres to the front of him, made a loud crashing noise and sent a large wave of woodchips and debris towards him.[25]

30. Mr Downs swerved onto the left verge, regained control of his van and parked it on the footpath.[26] He could see the rear half of the Holden next to a tree on the median. About 30 seconds later, the police officers arrived at the scene and saw him standing near his van.[27]

31. The other witness who had been travelling on North Lake Road was Maria Pakston, an enrolled nurse who had just finished her shift at Fiona Stanley Hospital. She was travelling south and was slowing down to turn right onto Hammond Road when the Holden came towards her at a high speed with no headlights on. She braked hard and stalled her car, and the Holden flew past her. She looked over her right shoulder and heard a bang.[28]

32. When Nurse Pakston looked back, she saw a cloud of smoke covering a central median strip, so she did a U-turn and went slowly back to the median strip where she saw that the Holden had split in two pieces. She did another U-turn, parked beside the road and got out of her car. By this

[24] Exhibit 1.16
[25] Exhibit 1.18A
[26] ts 48
[27] Exhibit 1.18A
[28] Exhibit 1.18B

time, the police officers had arrived. She spoke to Senior Constable Vanson, who asked her to assist with a person trapped in the Holden.[29]

33. Nurse Pakston went to the front section of the Holden and saw Mr De Agrela in the passenger seat with his seatbelt tight across his chest. Another member of the public, who was also a nurse, came up and together they moved Mr De Agrela out of the seat and provided first aid until ambulance paramedics attended and took over.[30]

34. Meanwhile, Senior Constable Cramer was alerted by a member of the public of a deceased person lying on the northern verge of North Lake Road. He went to the person, who was Mr Eades, and checked for signs of life but could not feel a pulse. On his way back to US105 to inform Senior Constable Vanson about Mr Eades, he found Ms Armstrong lying on the road. She had sustained severe injuries and was obviously dead.

35. It is a credit to the officers and their training that they were able to act as effective first responders to the crash.

36. Sergeant John Smith from the Major Crash Investigation Section certified the deaths of Mr Eades[31] and Ms Armstrong[32] at the scene.

37. Ambulance paramedics conveyed Mr De Agrela to the emergency department at Fiona Stanley Hospital where he was stabilised before being transferred to Royal Perth Hospital and admitted into the intensive care unit with severe head injuries.[33] On 4 December 2015, he was intubated following discussion with his next of kin, and he died at 5.10 pm that afternoon.[34]

38. A police officer attending the scene breath-tested Mr Conduit and found that he had a blood alcohol reading of 0.072%. Mr Conduit told a

[29] Exhibits 1.18B and 1.16
[30] Exhibit 1.18B
[31] Exhibit 1.6
[32] Exhibit 1.5
[33] Exhibit 1.10
[34] Exhibit 1.7

paramedic who was attending to him that the speed at which he was driving was 'off the clock'.[35]

Cause of the crash

39. Investigation by officers in the Major Crash Investigation Section led to the conclusion that the Holden had been travelling in the northwest-bound carriageway of North Lake Road when Mr Conduit lost control and it began to yaw clockwise. It skidded sideways for about 111 metres before travelling over the kerbing of the median trip and crashing into a tree. The rear portion of the Holden stayed near the tree, but the front portion travelled about 91 metres further northwest.

40. Police vehicle examiners found that the Holden's rear tyres had significant wear, but there were no lockup/skid marks.[36] The tyre wear was not identified as a cause of the crash.[37]

41. An investigation by a Main Roads Department team found no road environmental issues related to the cause of the crash. Human factors identified in the attending police officers report included excess speed and reckless driving. The Main Roads Department team had no information about blood-alcohol level.[38]

42. Senior Constable Peter Price, a crash reconstruction officer with the Major Crash Investigation Section, explained that the cause of the Holden yawing was excessive steering input for the speed at which it was travelling.[39]

43. The available information leaves the precise cause of the crash somewhat unclear. However, on balance it appears that, while affected by methylamphetamine and alcohol, Mr Conduit drove the Holden at excessive speeds and lost control of it when he tried to steer sharply, causing it to skid sideways and collide with a tree.

---

[35] Exhibit 1.27
[36] Exhibit 1.43
[37] Exhibit 1.42
[38] Exhibit 1.44
[39] ts 59

Cause of Ms Armstrong's death

44. Forensic pathologist Dr J McCreath performed a post mortem examination of Ms Armstrong and found extensive non-survivable injuries, including fractures of the skull, limbs, pelvis ribs and spine, and lacerations of the head and internal organs. Toxicological analysis detected alcohol and methylamphetamine.

45. Dr McCreath formed the opinion, which I adopt as my finding, that the cause of Ms Armstrong's death was multiple injuries.

Cause of Mr Eades' death

46. Dr McCreath performed a post mortem examination of Mr Eades and found extensive non-survivable injuries, with fractures of the ribs, sternum, pelvis and spine, as well as lacerations of the internal organs and internal bleeding. Toxicological analysis detected alcohol, methylamphetamine and tetrahydrocannabinol.

47. Dr McCreath formed the opinion, which I adopt as my finding, that the cause of Mr Eades' death was multiple injuries.

Cause of Mr De Agrela's death

48. Dr McCreath performed a post mortem examination of Mr De Agrela and found bleeding over the surface of the brain and over the superior aspect of the neck and pneumonia. Neuropathological examination showed recent brain trauma and some haemorrhage surrounding the spinal cord.

49. Dr McCreath formed the opinion, which I adopt as my finding, that the cause of Mr De Agrela's death was complications of head injury.

How the deaths occurred

50. Mr Conduit sustained only minor injuries in the crash. On 3 December 2015, he participated in an interview with police investigators and

admitted his role in the crash. He was charged with three counts of dangerous driving occasioning the deaths of each of Ms Armstrong, Mr Eades and Mr De Agrela in circumstances of aggravation and with failing to comply with a direction to stop the Holden. The circumstances of aggravation were that he had exceeded the speed limit by 45 km per hour or more and that he was driving to escape pursuit by police.

51. On 14 August 2017 Mr Conduit pleaded guilty to the charges. In sentencing Mr Conduit on 15 September 2017, District Court Judge McCann took into account that Mr Conduit had consumed methylamphetamine and alcohol and was incapable of safely driving a vehicle under any conditions, that he was needlessly speeding when first seen by the officers and then drove at speeds of up to 70 km per hour over the speed limit, thereby creating a great danger to the members of the public. His Honour found that Mr Conduit's driving was the direct and only cause of the fatal collision.[40]

52. I find that each of the deaths occurred by way of unlawful homicide.

Investigation of the police officers and review of the Policy

53. The actions of the officers in US105 were investigated by Detective Sergeant Derek Sainsbury of the Internal Affairs Unit. At the time of the inquest, he was a senior trainer at the detective training school at the Police Academy. He found that the officers in US105 complied with the Policy and that there was no managerial action required in relation to them.[41]

54. It is clear that the officers in US105 acted appropriately and that they did not cause the crash. However, it also seems clear that Mr Conduit was aware at some stage that the officers were pursuing him, so it is open to argue that, by engaging in the pursuit, the officers may have contributed in some way to the crash occurring.

[40] transcript, ***The State of Western Australia v Matthew John Conduit***, District Court of Western Australia, 15 September 2017, 2
[41] Exhibit 1.45

55. In another inquest, I addressed the issues relevant to that argument and to the police policy that governs how officers are to decide whether to continue to pursue a vehicle when the driver is attempting to evade a police intercept. In simple terms, I do not accept that police officers who commence a pursuit can be said to cause or contribute to a subsequent crash.[42]

56. At the same time, it is clear that high-speed pursuits are associated with significant dangers for the participants and for the public at large, so the continuation of such a pursuit can increase the likelihood of tragic consequences.

57. It is also clear that officers who are engaged in high-speed pursuits that end in tragedy can be psychologically traumatised due to a misplaced, though understandable, feeling of being involved in the crash. To paraphrase Senior Constable Vanson's evidence after he was asked how the incident affected him personally, part of the role of police officers is to deal with death; for example, in car crashes and suicides, but being directly involved in an incident like this one changes things, and it had an impact on him.[43]

58. In hindsight, it appears that it would have been reasonable for the officers to have aborted the pursuit when the Holden went through the red light and turned onto Midgegooroo Avenue. The officers were attempting to intercept the Holden because it was being driven dangerously by speeding and going through a red light, but, as Senior Constable Cramer said in his statement, it was apparent at that stage that the Holden was not going to stop.[44]

59. It seems to me that, while aborting the pursuit then would not likely have led to a different outcome, it would have left the officers without any basis for feeling involved or responsible.

---

[42] ***Inquest into the death of G J Forbes and J H Forbes*** [2019] CORC 27
[43] ts 19
[44] Exhibit 1.17

60. It therefore appears that there are good grounds for the existence in the Policy for a clear guideline that, in the absence of an overriding reason, a pursuit should be aborted in circumstances where the vehicle being pursued is being driven dangerously and shows no sign of stopping.

61. I have previously recommended that the WAPF consider amending the Policy to make it clearer and more prescriptive in order to provide more guidance for officers caught up in the stressful, adrenalized situations necessarily associated with high-speed pursuits. I reached the view that such guidance is particularly needed in the first minute or so before the Police Operations Centre Communication Controller (POCCC) is able to direct the officers to abort a pursuit. I still have that view, and it is strengthened by the facts of this case.

62. The previous recommendation I made about the Policy was not accepted by the WAPF.[45] Rather, citing concerns about restrictive policies leading to the use of those restrictions by offenders to evade police, the WAPF indicated the Policy already provides clear instructions and that the WAPF intends to monitor trends and issues through its emergency driving review committee.[46]

63. I want to make clear that I do not discount the difficulties associated with this area of policing. There are important but conflicting issues underlying any policy in this area, and reasonable minds may differ in relation to the best approach. However, I must point out that the concerns cited by the WAPF would be more persuasive if offenders were not already aware that officers will abort pursuits in certain circumstances, as Senior Constable Vanson noted in relation to Mr Conduit turning off the headlights and driving onto the wrong side of the road.[47]

Submissions

64. In final submissions, Ms Wood identified a number of recommendations which the families of Ms Armstrong and Mr Eades asked me to make.

[45] Letter 27 May 2020 from Minister of Police to State Coroner
[46] http://www.coronerscourt.wa.gov.au/_files/inquest-2020/forbes%20recommend.pdf
[47] ts 13

Those recommendations, based on the emergency driving policy adopted in Queensland, were for the WAPF to adopt a restrictive approach to pursuits by prohibiting pursuits for traffic and driving offences, by including more guidance on alternative resolution strategies, and by requiring officers who terminate a pursuit to pull over their vehicles to make clear that they are no longer in pursuit.[48]

65. Ms Wood also submitted that the WAPF should introduce follow-up or periodic practical emergency driving training and a regular review of pursuit returns, the latter being reports now provided by officers involved in any evade police intercept driving and from the relevant POCCC.[49]

66. Ms Harman submitted that the WAPF did not agree that the Policy needed wholesale changes because changes are being continually considered.

67. I am generally sympathetic to Ms Wood's submissions, but there is insufficient evidence available in this inquest for me to make the recommendations she seeks and, in any event, the WAPF has already determined not to accept my earlier recommendations for a more prescriptive and restrictive policy. Nonetheless, I suggest that the WAPF Emergency Driving Review Committee seriously consider Ms Wood's submissions when conducting its ongoing review of the Policy.

Suggested improvements of the use of the Policy

68. Senior Constable Vanson said that, in his experience, most police officers who are qualified to engage in emergency driving are across the Policy, and Detective Sergeant Sainsbury said in oral evidence that, in his opinion, the Policy is fairly clear and easy to understand.[50]

69. However, Detective Sergeant Sainsbury agreed that officers in pursuits are affected by adrenaline and that makes them more likely to make poor decisions, which is why the POCCC supervises them. He also agreed that officers make a case-by-case assessment of each pursuit, which puts a

[48] ts 90
[49] ts 91
[50] ts 76

huge burden on them, with potentially highly traumatic consequences for them and every other person involved in the case of a catastrophe.[51]

70. Despite there being significant difficulties for officers to make objective decisions during pursuits, it appears that the WAPF does not carry out debriefing assessments of pursuits in order to analyse the decision-making process of the officers involved.[52]

71. Instead, appraisals of significant incidents are solely related to the question of whether the officers adhered to the Policy's rather open-ended requirements. Detective Sergeant Sainsbury said that appraisal of the decision-making processes only occurs when it ends up in an environment like the Coroners Court.[53]

72. In accordance with the WAPF usual practice, the officers' decision-making processes in this case were not reviewed.

73. In my view, a post-incident analysis of each evade police intercept incident to evaluate the reasons for the decisions to commence, continue, and abort the pursuit would likely provide useful insight into the practical application of the Policy.

74. A similar process is carried out in emergency management as part of the incident review component, and post-incident analyses known as 'root-cause' analyses are used by hospitals when a serious clinical incident has occurred. The purpose of such analyses is to attempt to foster continuous improvement and to attempt to ensure that similar incidents do not happen again in the same way.

75. In addition, Senior Constable Vanson said that, after the training in which officers become qualified to engage in pursuit driving, there is not a lot of practical training with a physical component to it.[54]

[51] ts 81
[52] ts 81
[53] ts 81
[54] ts 20

76. It appears to me that the WAPF would likely benefit from carrying out analyses of the decision-making processes of officers engaged in pursuit driving incidents, especially those which ended in crashes. If appropriate, the results of the analyses might be applied in training or re-training officers for emergency driving, or it may lead to improvements to the Policy.

77. I therefore suggest that, when reviewing police intercept incidents, the WAPF consider implementing a practice of analysing the decision-making processes of officers involved.

78. I also suggest that WAPF consider a regular practical refresher of its emergency driving qualifications and that any refresher contain a decision-making component.

Conclusion

79. In oral submissions, Ms Wood cited[55] the following comments of Deputy State Coroner H C B Dillon in the Inquest into the death of HAMISH RAJ:[56]

> The fundamental rationale for police pursuits world-wide is law enforcement. But the rationale for enforcement of traffic law is public safety. The apprehension of persons who have jeopardised or are jeopardising the welfare of other members of the community, and the deterrence of others who would do so but for the risk of being caught by police, is means to that end, not an end in itself.
>
> By definition, a police pursuit that results in a fatal motor vehicle accident is a failure: it has not only failed to prevent dangerous driving or deter the commission of a serious offence, it has resulted in the very thing it is intended to avert – death and injury on the roads.

80. In my view, Deputy State Coroner Dillon's comments are compelling in relation to the ongoing debate over police pursuits.

---

[55] ts 83 - 84

[56] *Inquest into the death of Hamish Raj*, State Coroner's Court of New South Wales, 7 April 2014, File number 2011/00389491 [77] [78]

81. However, in the present case, it is clear that the crash was not the result of the pursuit. When Mr Conduit drove the Holden at more than twice the speed limit on a suburban street, there was already a strong likelihood that the trip would end in tragedy.

82. Ms Armstrong, Mr Eades and Mr De Agrela were young people who left behind devastated families and orphaned children due to Mr Conduit's disregard for their safety and the safety of the public. It did not excuse him that his deliberate recklessness was fuelled by his use of methylamphetamine, as is seen too often by police officers, ambulance paramedics, emergency doctors, intensivists, forensic pathologists and coroners.

83. Senior Constable Vanson and Senior Constable Cramer also bear the effects of their involvement in the brief pursuit and from the grim scene they encountered in its aftermath. The circumstances of this case suggest that the Policy does not provide police officers with the guidance they deserve. That should change.

B P King
Deputy State Coroner
7 August 2020