
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : PHILIP JOHN URQUHART, CORONER
HEARD : 21 FEBRUARY 2022
DELIVERED : 13 APRIL 2022
FILE NO/S : CORC 684 of 2019
DECEASED : MS B

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Tyler assisted the coroner

Mr J Berson and Ms S Smith (State Solicitor's Office) appeared on behalf of the Western Australia Police Force

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of a woman referred to as **Ms B** with an inquest held at Perth Coroner’s Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 21 February 2022, find that the death of **Ms B** occurred on 25 May 2019 near the intersection of Vincent Street and Charles Street, North Perth, from the effects of fire (including smoke inhalation, thermal injuries and incineration) in the following circumstances:*

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SUPPRESSION ORDERS

1. Suppression of the deceased's name from publication and any evidence likely to lead to her identification. The deceased is to be referred to as Ms B.
2. That there be no reporting or publication of the details of any of the versions of the WAPF's "*Police Emergency Driving Policy and Guidelines*", including, but not limited to, any cap on the speed in which police officers are authorised to drive.

INTRODUCTION

- 1 The deceased (Ms B) died on 25 May 2019 a short distance from the intersection of Vincent Street and Charles Street, North Perth after the stolen car she was a passenger in collided with a steel barrier and caught fire. She was 40 years old. At the time of her death, the driver of the stolen car (the offender) was evading two police officers from the Western Australian Police Force (WAPF) who were travelling in a marked police car.
- 2 Ms B's death was a reportable death within the meaning of section 3 of the *Coroners Act 1996* (WA) (the Act), because it resulted from injury. By reason of section 19(1) of the Act, I have jurisdiction to investigate Ms B's death.
- 3 Ms B's death occurred during what police describe as an Evade Police Intercept Driving incident. Therefore, pursuant to section 22(1)(b) of the Act, an inquest into Ms B's death was mandatory as it "*appears that the death was caused, or contributed to, by any action of a member of the Police Force*".

- 4 Section 22(1)(b) of the Act is enlivened when the issue of causation or contribution in relation to the death arises as a question of fact, irrespective of whether there was fault or error on the part of the police officers involved.
- 5 On the basis that it would be contrary to the public interest, I made a suppression order in respect to any reporting or publication of the details of any versions of the WAPF document titled “*TR-07.04 Police Emergency Driving Policy and Guidelines*” (the Policy). I also suppressed Ms B’s name from publication and any evidence likely to lead to her identification.¹ The terms of these orders are set out on page three of these findings.
- 6 I held an inquest into the death of Ms B at Perth on 21 February 2022. The following seven witnesses gave oral evidence:²
- i. Senior Constable Ross Lavers, the driver of the marked police vehicle with the call sign GD107;
 - ii. Senior Constable Samantha Alborn, the passenger of the marked police vehicle with the call sign GD107;
 - iii. Senior Constable Richard Russell, driver of the unmarked police vehicle with the call sign GI303;
 - iv. Senior Constable Stuart McCallum, passenger of the unmarked police vehicle with the call sign GI303;
 - v. Detective Sergeant Kevin Wisbey, the investigating officer from the WAPF Major Crash Investigation Section;
 - vi. Detective Sergeant Nesib Uzonovic, author of the WAPF Internal Affairs Unit (IAU) report;
 - vii. Senior Sergeant Steve Dawson, Officer in Charge, Operations Skills Safety Coordination Unit – Professional Development Portfolio.
- 7 The documentary evidence at the inquest comprised of one volume of the brief that was tendered as exhibit 1 at the commencement of the inquest. An aerial photograph of the location of the crash was tendered during the inquest (exhibit 2).

¹ The identification of Ms B had previously been suppressed by the Supreme Court of Western Australia in the criminal proceedings relating to the offender.

² I have used the ranks of the police officers as of May 2019.

- 8 At the inquest, Mr Berson, counsel for the WAPF, stated that he would provide a photograph of the Emergency Warning Devices control panel that was located in the console of the two police vehicles involved in this incident. That photograph was attached to an email from Mr Berson to Counsel Assisting dated 22 February 2022. The photograph also had an accompanying key that described the function of each button. I have made this photograph and its key exhibit 3.
- 9 My primary function has been to investigate the death of Ms B. It is a fact-finding function. Pursuant to section 25(1)(b) and (c) of the Act, I must find, if possible, how the death of Ms B occurred, and the cause of her death. Given the known circumstances in this matter, those findings can be made without difficulty.
- 10 Pursuant to section 25(2) of the Act, I may comment on any matter connected to the death of Ms B, including public health and safety or the administration of justice. This is an ancillary function of a coroner.
- 11 Section 24(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any civil liability or suggest a 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 During the course of an inquest, and within the related finding, a coroner is permitted to make findings or comments that are adverse to the interests of an “*interested person*”, which includes a person who, by act or omission, may have caused or contributed to the death: section 44 of the Act. Pursuant to section 44(2) of the Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

13 At the conclusion of the inquest,³ I advised Mr Berson that I would not be making any findings against a police officer over and above the conclusions drawn by Senior Sergeant Steve Dawson (Officer Dawson) in his report dated 11 February 2022⁴ and the conclusions made in the second IAU report dated 17 February 2022.⁵ These reports found that there had been breaches of the WAPF *TR-07.04 Emergency Driving Policy and Guidelines* by two police officers. In those circumstances, Mr Berson elected not to make any closing submissions regarding those matters.⁶

14 In making my findings, I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 361-362 (Dixon J), 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 (the *Briginshaw* principle).

15 I am also mindful not to insert hindsight bias into my assessment of the actions taken by police who were involved in this incident.⁷ The need to adhere to that principle is particularly relevant in this matter as police officers were required to make quick decisions in an adrenalised environment.

MS B⁸

16 Ms B was born on 16 July 1978 in Sydney, New South Wales. She was the eldest of four daughters. Ms B lived with her mother in Hamersley.

³ ts 21.2.22, p.127

⁴ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022

⁵ Exhibit 1, Volume 1, Tab 56.2, Supplementary Report by Detective Sergeant Uzonovic dated 17 February 2022

⁶ ts 21.2.22, p.127

⁷ Hindsight bias is the tendency, after the events, to assume the events are more predictable or foreseeable than they really were: Dillon, H and Hadley, M, *The Australasian Coroner's Manual* (2015) 10

⁸ Exhibit 1, Volume 1, Tab 8, WA Police Victimology Report; Exhibit 1, Volume 1, Tab 8B, Victim Impact Statement of Ms B's mother dated 26 June 2020; Exhibit 1, Volume 1, Tab 10, Statement of Ms B's mother dated 26 August 2020; Exhibit 1, Volume 1, Tab 55.2, Transcript of the offender's sentencing proceedings in the Supreme Court of Western Australia dated 14 July 2020

- 17 Due to Ms B's mental health issues, her mother had become her fulltime carer. These mental health issues were managed with medications and admissions to hospital.
- 18 Sadly, Ms B had a lonely life, with limited friendships. Her quiet and gentle disposition often made it difficult for her to fit in with other people. Although Ms B was sensitive and willing to help others, she lacked confidence and was vulnerable and naive. She had developed a very close relationship with her mother.
- 19 Ms B had met the offender at a boarding house a number of years ago. The offender befriended Ms B and, initially, Ms B was very happy to have met someone with whom she could engage in a friendship. However, the relationship was marred by the offender's violence towards Ms B, as he had assaulted her on a number of occasions. By 2019, Ms B rarely saw the offender.

THE OFFENDER⁹

- 20 The offender was 38 years old at the time of Ms B's death. He was diagnosed with schizoaffective disorder in 1998 and had been admitted to Graylands Hospital on a number of occasions. The offender had not worked for many years and he received a disability pension. He was a regular user of illicit drugs, commencing with cannabis when he was 14 years old. He began using methylamphetamine and heroin from when he was 24 years old. Although he had ceased using heroin, he was still using methylamphetamine in May 2019.
- 21 The offender had convictions for assault occasioning bodily harm, stealing (including stealing cars), possessing a prohibited drug, possessing a prohibited weapon, assault, criminal damage, possessing an article with an intent to cause fear, possession of drug paraphernalia, threats to injure, endanger or harm, breach of a

⁹ Exhibit 1, Volume 1, Tabs 55.1 and 55.2, Transcript of the offender's sentencing proceedings in the Supreme Court of Western Australia dated 30 June 2020 and 14 July 2020

Violence Restraining Order, breach of protective bail conditions and various traffic offences. As at May 2019, the offender had previously been sentenced to terms of imprisonment; however, they had all been suspended.

- 22 The offender admitted he had had a history of personal violence towards Ms B over the many years they had known each other. This personal violence included assaults.

THE EVENTS OF 25 MAY 2019

*The offender's theft of the Ferrari*¹⁰

- 23 On the morning of 25 May 2019, the owner of a red 2004 Ferrari 360 was driving his car on Hay Street in West Perth when he parked it on the street in order to buy a coffee at a café. For some inexplicable reason, he not only left the Ferrari unlocked, but also left the key in the ignition.

- 24 At about 10.15 am, the offender was walking past the Ferrari when he noticed the key was in the ignition. He then made an impulsive decision to steal the car. After accessing a YouTube video on his mobile phone to figure out how to operate the Ferrari's gears, the offender drove the Ferrari away. When the owner discovered his car had been stolen, he reported it to police.

*The offender's visit to Ms B*¹¹

- 25 The offender drove the Ferrari to the house in Hamersley where Ms B lived with her mother. He had earlier called Ms B on her mobile phone. It is clear that Ms B was not involved in the theft of the Ferrari. I am also prepared to accept that due to

¹⁰ Exhibit 1, Volume 1, Tab 16.1, 16.2, Statements of the Ferrari's owner dated 25 May 2019 and 29 October 2019; Exhibit 1, Volume 1, Tab 55.1, Transcript of the offender's sentencing proceedings in the Supreme Court of Western Australia dated 30 June 2020

¹¹ Exhibit 1, Volume 1, Tab 55.1, Transcript of the offender's sentencing proceedings in the Supreme Court of Western Australia dated 30 June 2020

her naivety and trusting nature, Ms B was not aware the offender had stolen the Ferrari when he offered her a ride in it.

26 After picking Ms B up, the offender drove the Ferrari to North Perth. At about 11.35 am, the offender was stationary in a line of east-bound traffic on Vincent Street at the approach to the intersection of Charles Street. This was a four-way intersection controlled by traffic lights (the intersection).

27 East-bound and west-bound traffic on Vincent Street had two lanes on either side of the intersection, with east-bound traffic having a third “right hand turn only” lane onto Charles Street that commenced about 85 metres from the intersection. There was a raised central median strip on Vincent Street west of the intersection that was about 100 metres in length (the median strip).¹² There was also a longer median strip on Vincent Street east of the intersection.

Police presence at the intersection of Vincent Street and Charles Street¹³

28 Senior Constable Ross Lavers (Officer Lavers) and Senior Constable Samantha Alborn (Officer Alborn), from the Wembley Police Station, were on duty on the morning of 25 May 2019. Just before 11.30 am, they had been tasked to attend the location of an unrelated stolen car located on Morriston Street, North Perth.¹⁴ They were in a marked police sedan with the call sign GD107 (car GD107). Officer Lavers was driving. The route Officer Lavers drove was north on Charles Street and then left onto Vincent Street, heading west towards the Beatty Park Leisure Centre (Beatty Park).

¹² Exhibit 1, Volume 1, Tab 11.3, Main Roads Crash Investigation Form, Photographs 3 and 4; Exhibit 2, Aerial photograph of the location of the crash; Dash-Cam Video DICHIERA Eastbound Vincent Street.AVI – VLC media player

¹³ Exhibit 1, Volume 1, Tabs 42-45, Statements and Transcript of IAU Interviews of Senior Constables Lavers, Alborn, Russell and McCallum

¹⁴ Morriston Street is adjacent to the western side of Beatty Park Leisure Centre.

- 29 Senior Constable Richard Russell (Officer Russell) and Senior Constable Stuart McCallum (Officer McCallum) were Forensic Investigations Officers attached to the Central Metropolitan District Forensic Investigations Office. They had been tasked to carry out a forensic examination of a stolen car that had been abandoned in the Beatty Park carpark. They were in an unmarked Toyota Prado police car with the call sign GI303 (car GI303). Car GI303 was fitted with lights and sirens. Officer Russell was the driver. Car GI303 was travelling west along Vincent Street towards the intersection of Charles Street. Officer McCallum intended to turn right from Vincent Street into Charles Street and attend Beatty Park from the rear. At the relevant time, car GI303 was stopped at a red traffic light in the west-bound right inside lane of Vincent Street. There were several cars in front of car GI303.
- 30 By this stage, the police officers in cars GD107 and GI303 were already aware, from earlier police radio communications, that a red Ferrari had been stolen in West Perth that morning.

Police interaction with the Ferrari¹⁵

- 31 As car GD107 was travelling west on Vincent Street towards Beatty Park, Officers Lavers and Alborn noticed the red Ferrari that was being driven by the offender stationary in the east-bound right inside lane of Vincent Street. It was one of a number of cars in the east-bound lanes on Vincent Street that had banked up for some distance due to a red traffic light.
- 32 As Officer Lavers drove past the Ferrari, Officer Alborn conducted a TADIS check of the Ferrari's registration number.¹⁶ That check confirmed the Ferrari was the one that had been stolen earlier that morning.

¹⁵ Exhibit 1, Volume 1, Tabs 42-45, Statements and Transcript of IAU Interviews of Senior Constables Lavers, Alborn, Russell and McCallum; Exhibit 1, Volume 1, Tab 55.2, Transcript of the offender's sentencing proceedings in the Supreme Court of Western Australia dated 14 July 2020

¹⁶ At the time, TADIS was the WAPF's police vehicle on-board computer system. It has since been replaced by the OneForce Core mobile phone application

33 Officer Lavers then made a U-turn on Vincent Street. As the build-up of east-bound traffic made the Ferrari inaccessible from the correct side of Vincent Street, he drove car GD107 east along Vincent Street on the incorrect side of the road. He pulled up slightly behind the Ferrari, which was still stationary in the right inside lane. The median strip west of the intersection that I have already referred to was between the Ferrari and car GD107.¹⁷

34 As the two officers began to get out of car GD107, the offender drove forwards, making slight contact with the rear of the car in front of the Ferrari. He then drove over the median strip and onto the incorrect side of Vincent Street. The Ferrari then accelerated east towards the intersection. Officer Lavers followed the Ferrari and remained on the incorrect side of Vincent Street as he did so. The distance which the Ferrari and car GD107 travelled on the incorrect side of Vincent Street before reaching the intersection was about 85 metres.¹⁸

35 A short time earlier, as car GI303 was stopped at the intersection, Officers Russell and McCallum had seen car GD107 turn left onto Vincent Street and drive west towards Beatty Park. Moments later, the two officers heard Officer Alborn over the police radio communications advising she and Officer Lavers had seen the Ferrari that had been stolen earlier that day. From their position, Officer Russell and McCallum could see that car GD107 had turned around and was now driving back towards the intersection on the incorrect side of Vincent Street. They correctly assumed that the stolen Ferrari was somewhere in the stationary line of east-bound traffic on Vincent Street.

36 As west-bound cars on Vincent Street were still stationary at the red light, Officer Russell decided to drive car GI303 over the median strip east of the intersection and

¹⁷ See Exhibit 1, Volume 1, Tab 11.3, Main Roads Crash Investigation Form, Photographs 3 and 13

¹⁸ I have made this calculation using Photographs 3 in Exhibit 1, Volume 1, Tab 11.3 (which shows that the Ferrari mounted the median strip just in front of the light pole on the median strip) and using the scale in Exhibit 2 to estimate the distance between the light pole and the commencement of the intersection.

into the lane closest to this median strip on the incorrect side of Vincent Street. Officer McCallum activated the emergency lights of car GI303 as Officer Russell made this manoeuvre. The intention of these two officers was to drive through the intersection and assist with the arrest of the driver of the stolen Ferrari.

37 As Officer Russell slowly drove car GI303 towards the intersection on the incorrect side of Vincent Street, he heard the distinct noise of the Ferrari's engine. He and Officer McCallum then saw the Ferrari driving east towards the intersection on the incorrect side of Vincent Street. Officer Russell applied the brakes of car GI303 and it stopped just before it entered the intersection.¹⁹ At the same time, the Ferrari had entered the intersection at an estimated speed of 69 km per hour whilst still accelerating, and contrary to the red light that was still facing east-bound traffic on Vincent Street.²⁰ As the Ferrari drove through the intersection, the offender veered to the left so that the Ferrari was back onto the correct (east-bound) side of Vincent Street. It then passed car GI303 on the outside left lane.²¹ As it did that, the offender lost control of the Ferrari, which struck the curbing of the footpath alongside Vincent Street. It then slid out of control along the footpath before striking a steel barrier positioned on the side of the footpath closest to the road. The passenger side door of the Ferrari impacted with the steel barrier. The Ferrari then careered back onto the east-bound lanes of Vincent Street and caught fire.

38 The offender was able to get out of the Ferrari and he was quickly placed under arrest by police. Ms B remained trapped inside the Ferrari. Officer Lavers and Officer Russell each got the fire extinguisher from their respective police vehicles. However, they could not do anything to put out the fire, which was later extinguished by Department of Fire and Emergency Services personnel.

¹⁹ Exhibit 1, Volume 1 , Tab 33, Statement of Joshua Middleton dated 4 June 2019; Dash-Cam Video MIDDLETON Northbound Charles Street. Mp4-VLC media player

²⁰ Exhibit 1, Volume 1, Tab 55.2, Transcript of the offender's sentencing proceedings in the Supreme Court of Western Australia dated 14 July 2020, p.63

²¹ Exhibit 1, Volume 1 , Tab 33, Statement of Joshua Middleton dated 4 June 2019; Dash-Cam Video MIDDLETON Northbound Charles Street. Mp4-VLC media player

39 A toxicological analysis of blood samples taken from the offender found an intoxicating level of methylamphetamine in his system at the time of the crash.

40 Readings from the digital clock on dash-cam footage of the incident demonstrates how quickly this incident developed. From the time car GD107 turned onto Vincent Street from Charles Street to when the crash occurred was only about 45 seconds.²²

CAUSE AND MANNER OF DEATH

*Cause of Death*²³

41 Dr Jodi White, a forensic pathologist, conducted a post mortem examination of Ms B's body on 29 May 2019.

42 The post mortem examination showed severe generalised incineration changes to Ms B's body. A subsequent toxicological analysis detected carbon monoxide in Ms B's blood at a level considered to be within the toxic to fatal range.

43 Upon receiving the results of the toxicological analysis, Dr White expressed the opinion that the cause of Ms B's death was the effects of fire (including smoke inhalation, thermal injuries and incineration).

44 I accept and adopt the conclusion expressed by Dr White as to the cause of Ms B's death.

*Manner of death*²⁴

45 The offender was charged with a number of offences arising from the events of 25 May 2019.²⁵ The most serious offences were the manslaughter of Ms B and the

²² Dash-Cam Video DICHIERA Eastbound Vincent Street.AVI – VLC media player

²³ Exhibit 1, Volume 1, Tabs 5.1-5.4, Supplementary Post Mortem Report dated 29 May 2019, Post Mortem Report dated 29 May 2019, Interim Post Mortem Report dated 29 May 2019 and Statement of Dr Jodi White dated 11 September 2019

²⁴ Exhibit 1, Volume 1, Tab 55.2, Transcript of the offender's sentencing proceedings in the Supreme Court of Western Australia dated 14 July 2020

²⁵ Exhibit 1, Volume 1, Tab 2.1, Major Crash Investigation Report to the State Coroner by Detective Sergeant Wisbey dated 1 August 2020, p.2

stealing of the Ferrari in circumstances of aggravation, namely that he drove the Ferrari in a manner that was dangerous to the public.

46 The offender pleaded guilty to both these charges in the Supreme Court of Western Australia. On 14 July 2020, he was sentenced to imprisonment for 2 years for the aggravated stealing offence and 8 years 6 months for the manslaughter of Ms B. The sentencing judge ordered that the two offences be served cumulatively, which meant that the offender's total term of imprisonment was 10 years 6 months. He was made eligible for parole. In addition, the offender was made ineligible from obtaining a motor driver's license for four years following his release from prison.

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

48 Accordingly, I find that the manner of Ms B's death was unlawful homicide.

ISSUES RAISED BY THE EVIDENCE

Introduction

49 Whenever police engage in Emergency Driving, they are required to comply with the Policy.²⁶ [REDACTED] two categories of Police Emergency Driving: Response Driving (Priorities 1 and 2) and Intercept Driving.²⁷ Intercept Driving also includes Evade Police Intercept Driving. The category, Response Driving – Priority 2, applied to the actions of car GI303 and the category, Intercept Driving (together with Evade Police Intercept Driving), applied to the interactions between car

²⁶ See Exhibit 1, Volume 1, Tab 61, TR-07.04 Emergency Driving Policy and Guidelines

²⁷ Exhibit 1, Volume 1, Tab 61, TR-07.04 Emergency Driving Policy and Guidelines, p.165

GD107 and the Ferrari. I will address the driving of car GD107 by Officer Lavers first.

Failure by Officer Lavers to activate car GD107's emergency lights and siren

50 For the reasons outlined below, I have found that once Officers Lavers and Alborn made the decision to stop the driver of the Ferrari, car GD107 was engaged in Intercept Driving [REDACTED]. The action of Officer Lavers in performing the U-turn on Vincent Street and driving on the incorrect side of the road was the commencement of the Intercept Driving.²⁸

51 The Policy requires [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]²⁹

52 In his statement to investigators from the WAPF Major Crash Investigation Section, Officer Lavers said that he had activated the emergency lights of car GD107 when he did his U-turn on Vincent Street as he “*was about to drive on the wrong side of the road.*”³⁰

53 However, dash-cam footage from a car that was stationary on an east-bound lane of Vincent Street showed that the emergency lights of car GD107 were in fact not activated when it followed the Ferrari towards the intersection on the incorrect side of Vincent Street.³¹

²⁸ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.9
²⁹ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.10
³⁰ Exhibit 1, Volume 1, Tab 42.1, Statement of Senior Constable Lavers dated 25 May 2019, p.2
³¹ Exhibit 1, Volume 1, Tab 36, Police request for Dash-Cam footage belonging to Domenic Dichiera dated 28 May 2019; Dash-Cam Footage Video DICHIERA East-bound Vincent Street AVI-VLC media player

54 After viewing the dash-cam footage, Officer Lavers conceded, at a compulsory interview with IAU detectives on 13 January 2022, that he did not activate his emergency lights: *“I thought I activated my emergency lights by reaching down and pushing the button, but now watching the vision, I mustn’t have done ‘cos they weren’t on...”*.³²

55 In his evidence at the inquest, Officer Lavers stated that he did not activate the siren as he did not want to panic other motorists into making manoeuvres that did not need to be done.³³

56 The Policy expressly states [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED].³⁴

57 Notwithstanding the plausible reason why Officer Lavers made the decision not to activate his siren, [REDACTED]
[REDACTED]. At the very least, he should have instructed Officer Alborn to request permission from the POCCC and then conduct a thorough risk assessment if it was necessary to action his intentions to intercept the Ferrari before the POCCC responded.³⁵

58 I accept Officer Laver’s explanation that he honestly believed he had activated his car’s emergency lights on and that he must not have pushed the button hard enough.³⁶

59 Nevertheless, as car GD107 was engaged in Intercept Driving [REDACTED]
[REDACTED]

³² Exhibit 1, Volume 1, Tab 42.2, Transcript of IAU Interview of Senior Constable Lavers dated 13 January 2022, p.5
³³ ts 21. 2.22 (Lavers), p.21
³⁴ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.10
³⁵ ts 21.2.22 (Dawson), p.115
³⁶ Exhibit 1, Volume 1, Tab 42.2, IAU Interview with Senior Constable Lavers on 13 January 2022, p.7

[REDACTED], Officer Lavers drove car GD107 contrary to the Policy.

60 I therefore agree with the conclusion made by Senior Sergeant Dawson, Officer-in-Charge, Operations Skills Safety Coordination Unit – Professional Development Portfolio (Officer Dawson) that there was a breach of the Policy.³⁷

61 At the inquest, I asked Officer Lavers these questions:³⁸

Once you did your U-turn on Vincent Street and started driving on the incorrect side of the road, did you regard yourself as being involved in intercept driving? --- At the time, sir, no. Because the vehicle was stationary – I don't know.

Okay. What about now with the benefit of hindsight? --- With the benefit of hindsight and – and my attention being drawn to policy, yes, it would be considered an intercept.

62 That concession was properly made by Officer Lavers.

63 As noted above, Intercept Driving also includes Evade Police Intercept Driving.

The Policy defines this category of Intercept Driving as being undertaken [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

40

64 For the reasons outlined below, I find that the interaction between car GD107 and the Ferrari meant that car GD107 progressed from an Intercept Driving incident to an Evade Police Intercept Driving incident. I also find that the action taken by

³⁷ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, pp.10-11

³⁸ ts 21.2.22 (Lavers), pp.28-29

³⁹ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.6

⁴⁰ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.6

Officer Lavers in following the Ferrari after it had driven over the median strip constituted Evade Police Intercept Driving, [REDACTED]

65 When asked in his interview with IAU detectives whether he considered it was an Evade Police Intercept Driving incident after the Ferrari drove over the median strip, Officer Lavers answered: “*I was in the process of doing that so yeah... [T]hings were happening so fast as soon as he took off...*”⁴¹

66 As to this part of the incident, I asked Officer Lavers these questions at the inquest:⁴²

...once [the offender] drove over the median strip and started to drive on the incorrect side of Vincent Road heading east – again, if it was the benefit of hindsight, by all means, say that – did it become an evade police intercept? --- If I – if I engaged in a pursuit, yes, it would be an evade police.

Right. But you’re saying you didn’t engage in a pursuit. Your reason for following him was simply to provide relevant information to the Police Operations Centre as to which way he was driving and matters of that nature? --- And get to the correct side of the road because I’m on the wrong side of the road. So I would either follow him or take the same path he took at normal pace, at normal – under normal road conditions or I pulled off the road and parked up.

Well, if you need to get off the incorrect side of the road, you could have just pulled into the nearest driveway? --- Yes. I could have done that. Yes.

Yes. But the purpose of following him was to provide that further information? --- Yes. Yes. Update the POC as much as I could.

But it didn’t become an evade police intercept as far as your vehicle was concerned? --- No. I was not – not engaging in him – into an evade – a pursuit. Yes.

67 I accept Officer Lavers’ evidence that he was not engaging in a “*pursuit*” with the Ferrari given the low speed GI307 was travelling, as depicted on the relevant dash-cam footage.⁴³ However, I am of the view that car GD107 had commenced Evade Police Intercept Driving [REDACTED]
[REDACTED]

⁴¹ Exhibit 1, Volume 1, Tab 42.2, IAU Interview with Senior Constable Lavers on 13 January 2022, p.18

⁴² ts 21.2.22 (Lavers), p.29

⁴³ Dash-Cam Video DICHIERA East-bound Vincent Street. AVI-VLC media player

⁴⁴ Exhibit 1, Volume 1, Tab 61, TR-07.04 Emergency Driving Policy and Guidelines, TR-07.04.2.4

[REDACTED] As the Ferrari had evaded his earlier attempt to intercept it, he was engaging in Evade Police Intercept Driving once he began following it. I note that this same assessment was made by Officer Dawson in his report.⁴⁵

68 As Officer Lavers was driving a Class 1 vehicle and was a qualified Priority Pursuit driver, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

69 I therefore accept the conclusion made by Officer Dawson regarding this aspect of Officer Lavers' driving.⁴⁶

Failures by Officer Russell to obtain permission to engage in Response Driving – Priority 2 and to ensure car GI303's siren was activated

70 The action by Officer Russell to drive car GI303 over the median strip and drive west-bound on the incorrect side of Vincent Street constituted Emergency Driving as the circumstances that he believed existed meant he was engaging in Response Driving – Priority 2.⁴⁷ It was the intention of Officers Russell and McCallum to assist the police officers from car GD107 in the arrest of the driver of the stolen Ferrari.⁴⁸

71 I accept Officer Russell's account that he had no intention of intercepting or pursuing the Ferrari. As Officer McCallum said at the inquest: "*I was under the*

⁴⁵ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.12
⁴⁶ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.12
⁴⁷ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.13
⁴⁸ Exhibit 1, Volume 1, Tab 44.1, Statement of Senior Constable Russell dated 7 June 2019, p.2

police radio.⁵⁴ It is the responsibility of the passenger in police vehicles to conduct radio communications.

77

It was Officer McCallum who turned the emergency lights on as car GI303 went up onto the median strip.⁵⁵ When asked at the inquest why he did not turn the siren on, Officer McCallum answered that he hit the button and then grabbed the radio, and that he did not register the siren was not on.⁵⁶ He said that he did not make a conscious decision to only activate the emergency lights.⁵⁷

78 The photograph provided by Mr Berson of the control panel for the Emergency Warning Devices shows that there is one button marked "*Primary*" for emergency lights and a larger red button next to it marked "*Alert*" that activates both the emergency lights and siren.⁵⁸ I accept that Officer McCallum made an honest mistake in pressing the "*Primary*" button instead of the "*Alert*" button.

79 I accept the conclusion drawn by Officer Dawson with respect to the breach of the Policy by Officer Russell [REDACTED]. I also agree with Officer Dawson's conclusion that by only activating the lights component of the Emergency Warning Devices during the Response Driving – Priority 2, car GI303 acted [REDACTED].⁵⁹

80 I also agree with Officer Dawson's evidence at the inquest that although Officer McCallum made the mistake of not pressing the correct button, the activation of the

⁵⁴ ts 21.2.22 (Russell), p.59

⁵⁵ Exhibit 1, Volume 1, Tab 45.3, IAU Interview with Senior Constable McCallum dated 20 January 2022, p.15

⁵⁶ ts 21.2.22 (McCallum), pp.70-71

⁵⁷ ts 21.2.22 (McCallum), p.71

⁵⁸ Exhibit 3

⁵⁹ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022, p.14

correct Emergency Warning Devices remains the responsibility of the driver of the police vehicle.⁶⁰

81 At the inquest, Officer Russell was asked if there was an explanation as to why a request was not made to the POC for him to commence Response Driving – Priority 2. He answered:⁶¹

No, I think just everything happened so, so quickly at the time, and I knew those two officers were just so close to us, and I couldn't see them and so I didn't know if they were being assaulted, so I just wanted to get across there. And like I said, I made sure it was safe before I crossed over onto Vincent Street. There was [sic] no vehicles travelling down that side, and then I went – I went – and as soon as I crossed over, I went, like I said, one car length – one and a half car lengths, and then I saw the Ferrari travelling down on the other side of the road and I stopped.

82 At the inquest, Officer Dawson agreed with my observation there was “*somewhat of an over emphasis*” by the officers in car GI303 on Officer Alborn’s comment “*urgent*”.⁶² However, I would be inserting hindsight bias if I was to now be critical of the mistaken belief held by Officers Russell and McCallum that their colleagues, who were a short distance away, might be in danger. At the inquest, Officer Russell was asked:⁶³

With the benefit of hindsight and that learning experience, are there actions that you would undertake differently if you were faced with this situation again? --- I'd definitely call up on the radio and to get permission to – to go and assist, and maybe find out what was actually happening, if they were first of all okay. That's probably – yes. Just like I said, I couldn't see what was going on, unfortunately. But I would definitely call up in future and say do they require assistance, that they – yes, that's what I would probably do.

83 Officer Russell accepted that he breached the Policy [REDACTED]
[REDACTED].⁶⁴ He also accepted that it was his

⁶⁰ ts 21.2.22 (Dawson), p.123

⁶¹ ts 21.2.22 (Russell), p.57

⁶² ts 21.2.22 (Dawson), p.118

⁶³ ts 21.2.22 (Russell), p.59

⁶⁴ ts 21.2.22 (Russell), p.59

responsibility as the driver of car GI303 to ensure the emergency lights and sirens were activated before he drove over the median strip.⁶⁵

84 Those concessions were properly made by Officer Russell.

The IAU investigation

85 By letter dated 8 April 2020 to the Principal Registrar of the Coroner’s Court, Acting Detective Superintendent Craig Collins attached the initial IAU report dated 3 April 2020 for this matter (the first report). That letter stated: *“I have reviewed the investigation conducted by Detective Sergeant Uzonovic and agree with his findings. Accordingly, IAU will be conducting no further investigations into this death.”*⁶⁶ The IAU did, however, conduct further investigations and provided a supplementary report dated 17 February 2022, shortly before the commencement of the inquest (the second report).⁶⁷ This was a sensible course of action to take by the IAU, as there were obvious errors made in the findings of its first report.

86 Although the first report correctly concluded that there was *“no criminal culpability attributed to police actions”*,⁶⁸ it failed to identify all breaches of the Policy. [REDACTED]

[REDACTED]⁶⁹

87 The second report identified the two breaches of the Policy by Officer Lavers and the additional Policy breach of Officer Russell with respect to [REDACTED]

⁶⁵ ts 21.2.22 (Russell), p.50

⁶⁶ Exhibit 1, Volume 1, Tab 56.1, Letter from Acting Detective Superintendent Collins to the Principal Registrar of the Coroners Court dated 8 April 2020

⁶⁷ Exhibit 1, Volume 1, Tab 56.2, Supplementary IAU Report dated 17 February 2022

⁶⁸ Exhibit 1, Volume 1, Tab 56.1, Letter from Acting Detective Superintendent Collins to the Principal Registrar of the Coroners Court dated 8 April 2020

⁶⁹ Exhibit 1, Volume 1, Tab 56.1, IAU Investigation Report by Detective Sergeant Uzonovic dated 3 April 2020, p.34

- 88 The IAU had recognised the need for the second report after it received Officer Dawson's report, which had identified these additional breaches of the Policy.⁷⁰
- 89 Of the four police officers from cars GD107 and GI303, only Officer Russell was compulsorily interviewed by the IAU before the completion of its first report.⁷¹ The other three officers were not compulsorily interviewed by IAU until January 2022. The explanation given by Detective Uzonovic at the inquest was that this was to assist Officer Dawson in the preparation of his report.⁷²
- 90 The initial IAU investigation starkly illustrates the importance of obtaining a policy expert's opinion as part of an IAU investigation into a death that may become the subject of an inquest under section 22(1)(b) of the Act. The first report incorrectly concluded that car GD107 had not engaged in an Evade Police Intercept Driving incident.⁷³ This led to the conclusion that no policy related breaches had been identified for Officer Lavers as the driver of car GD107. That was not correct and a report from a policy expert such as Officer Dawson would have ensured that this error was not made.
- 91 The initial IAU investigation was also deficient in its failure to note that dash-cam footage (which had audio) clearly demonstrated that as car GD107 followed the Ferrari on the incorrect side of Vincent Street, it did not have its emergency lights or siren activated.⁷⁴ This evidence from the footage should have led to a conclusion by the IAU in its initial investigation that, at the very least, Officer Lavers had contravened the Policy with respect to [REDACTED]. Instead, the initial IAU investigation placed undue weight upon the mistaken accounts from

⁷⁰ Exhibit 1, Volume 1, Tab 62, Report of Senior Sergeant Dawson dated 11 February 2022

⁷¹ Exhibit 1, Volume 1, Tab 43.3, Transcript of IAU Interview with Senior Constable Russell dated 26 July 2019

⁷² ts 21.2.22 (Uzonovic), pp.97-98

⁷³ Exhibit 1, Volume 1, Tab 56.1, IAU Investigation Report by Detective Sergeant Uzonovic dated 3 April 2020, p.33

⁷⁴ Dash-cam video DICHERIA East-bound Vincent Street AVI – VLC media player

Officers Lavers and McCallum that car GD107 had its emergency lights on at this point.⁷⁵

92 I note that Officers Lavers and Russell received verbal guidance relating to their breaches of the Policy.⁷⁶ I am of the view this was an appropriate course of action, given the relatively minor nature of these police officers' breaches.⁷⁷

CONCLUSION

93 I have found that two police officers were in breach of the relevant WAPF Policy regarding Emergency Driving with respect to their driving in the moments before the crash that killed Ms B. However, those breaches did not cause or contribute to the crash. The person solely responsible for Ms B's death was the offender. When intoxicated by methylamphetamine, he dangerously drove a very powerful car that he had stolen and was not accustomed to driving. With a total disregard for Ms B's life and the lives of other road users, his grossly irresponsible driving led to the catastrophic crash of the stolen Ferrari that resulted in Ms B's death.

94 Although the initial IAU investigation into this matter failed to identify all breaches of the Policy, those deficiencies were later corrected when the IAU completed compulsory interviews of all the subject police officers and obtained an opinion from a policy expert. By taking those steps, the IAU was able to prepare a second report which made amends for the oversights in the first report.

95 There has been no need for me to make recommendations to the WAPF so that the deficiencies in the first report by the IAU are not repeated. This is because I have already made the necessary recommendations in another inquest completed last year that involved the death of the target vehicle's driver during an Evade Police

⁷⁵ Exhibit 1, Volume 1, Tab 42.1, Statement of Senior Constable Lavers dated 25 May 2019, p.2; Exhibit 1, Volume 1, Tab 45.1, Statement of Senior Constable McCallum dated 6 June 2019, p.2

⁷⁶ Exhibit 1, Volume 1, Tab 56.2, Supplementary IAU Report dated 17 February 2022, p.13

⁷⁷ Senior Sergeant Dawson was also of the view that the breaches of the Policy were minor: ts 21.2.22 (Dawson), p.124

Intercept Driving incident.⁷⁸ By taking the action that it did in this matter by conducting a further investigation that included compulsory interviews and seeking a policy expert's report, I anticipate the IAU will adopt my earlier recommendations in any future investigations regarding mandatory inquests pursuant to section 22(1)(b) of the Act

96 Notwithstanding the minor breaches of the Policy by two of them, I commend the actions of all four police officers in cars GD107 and GI303. Although the impact of Ms B's death on that day will never be as profound for these police officers as it was for Ms B's loved ones, it is clear to me that this incident had a considerable impact on them. I have no doubt that none of them expected the reckless response from the offender as car GD107 pulled up alongside the Ferrari. As Officer Lavers said at the inquest: "*[A]t the time, I was trying to prevent a high speed incident, and I thought that there was an opportunity to do that, and I took it. And unfortunately it didn't work out.*"⁷⁹

97 I also note the following evidence from Officer McCallum at the inquest:⁸⁰

I want to give my condolences to the family of Ms B. We made the decisions, the best decisions we thought at the time, and it's something that you never want to see as a police officer ... So [I] just want to say how sorry I am and I hope it never ever happens again.

98 Ms B's sudden and tragic death on 25 May 2019 left members of her family, particularly her mother, devastated. As stated by Ms B's mother:⁸¹

We miss her presence at the dinner table and on special occasions. Our family life has been shattered and it will never be the same. It has been a struggle to keep the

⁷⁸ Inquest into the death of *Child JP* [2021] WACOR 42 delivered 21 December 2021. The two recommendations were that for IAU investigations involving a fatality that may be the subject of a mandatory inquest under section 22(1)(b) of the *Coroners Act 1996* (WA), the IAU (i) always obtains a report or opinion from a relevant policy expert, unless there are exceptional reasons not to do so and (ii) ensures all subject officers are compulsorily interviewed (whether or not they have already provided statements to another section of the WA Police Force), unless there are exceptional reasons not to do so.

⁷⁹ ts 21.2.22 (Lavers), p.28

⁸⁰ ts 21.2.22 (McCallum), p.75

⁸¹ Exhibit 1, Volume 1, Tab 9, Victim Impact Statement of Ms B's mother dated 26 June 2020

family and our lives moving forward. I rarely communicate with family and others as I am so consumed by the cruel and tragic death of my beautiful, loving daughter.

99 I offer Ms. B's mother and other family members my sincere and heartfelt condolences.

PJ Urquhart
Coroner
13 April 2022