IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 5767

FINDING INTO DEATH WITH INQUEST

Amended pursuant to section 76 of the Coroners Act 2008

Form 37 Rule 60(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: JASON SHAUN KUMAR

Delivered On:	14 July 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	9, 10 and 11 August 2013
Findings of:	JOHN OLLE, CORONER
Representation:	MR RON GIPP instructed by Victorian Government Solicitors for the Chief Commissioner of Police
Counsel Assisting the Coroner	MR PAUL LAWRIE instructed by Coroners Court In-House Solicitors Service

I, JOHN OLLE, Coroner having investigated the death of JASON SHAUN KUMAR

AND having held an inquest in relation to this death on 9, 10 and 11 August 2013
at CORONERS COURT MELBOURNE
find that the identity of the deceased was JASON SHAUN KUMAR
born on 30 May 1994
and the death occurred on 13 December 2009
at the intersection of Canterbury Road and Bayswater Road, Bayswater 3153
from:

1 (a) INJURIES SUSTAINED IN A MOTOR COLLISION

in the following circumstances:

1. Jason Shaun Kumar, born 30 May 1994, was 15 years of age at the time of his death. He was the fourth child of Ms Wendy McCorkell and Mr Prem Kumar with older brothers Nathan, Brent and Clinton.

2. At approximately 2.37 am on Sunday, 13 December 2009, Jason was killed when the car he was driving (a white 93 Ford Laser, FHG 507) collided with a cyclone fence and the base of a sign located near the intersections of Canterbury and Bayswater Roads, Bayswater. The accident occurred shortly following a police pursuit, which had been terminated prior to the accident. His young friend, Paul Deaks, a passenger in the vehicle, received serious injuries as a result of the accident.

3. Debris from the Laser struck a Holden Rodeo utility that was stopped at the intersection, facing east on Canterbury Road.

4. Ms Nicole Higgs was driving a black Mitsubishi Lancer west along Canterbury Road and was struck by the Laser. She suffered bruising to her abdomen and chest, swelling to her right foot and left calf. She remained in the Dandenong Hospital for two nights but subsequently recovered from her injuries.

5. I was assisted with my investigation into Jason's death by the Major Collision Investigation Unit (MCIU) with oversight by Professional Standards Command (ESD at the time).

Medical Examination

6. Dr Matthew Lynch, Forensic Pathologist of the Victorian Institute of Forensic Medicine (VIFM), conducted an autopsy and determined the cause of death as 'Injuries sustained in motor vehicle collision'.[1] He noted that there was no evidence of seat-belt impressions on Jason's body.

7. The toxicology analysis of body fluids disclosed Δ9-tetrahydrocannabinol (THC) detected at 6 ng/ml, with no other drugs or alcohol detected.

8. Dr Morris Odell, Forensic Physician of VIFM did however note that as the blood tested was collected 4 days after death, it is impossible to estimate the degree to which any change in the THC level may have occurred. At most he could say that a THC level in whole blood of 6 ng/ml would ordinarily be associated with psychomotor impairment which may have a detrimental effect on driving ability.

Purposes of the Coronial Investigation

9. The primary purpose of the coronial investigation of a reportable death[2] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[3] An investigation is conducted pursuant to the *Coroners Act 2008* (the Act).

10. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[4] This is referred to as the prevention role of the coroner.

11. Contemporaneous with my investigation into Jason's death, I conducted a broad investigation into Victoria police pursuit policy as part of an investigation into the death of a

---

[1] An earlier reference to Jason being the 'driver' was deleted by a Supplementary Report of Dr Lynch dated 1 March 2010, which I have adopted.

[2] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdiction nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury. Clearly, Jason's death falls within this definition.

[3] Section 67 of the Act.

[4] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

young girl who was the passenger in a vehicle being pursued by police. All matters regarding public health and safety arising from my investigation into Jason's death have been incorporated into that finding.[5]

THE EVIDENCE

12. This finding is based on the entirety of the investigation material comprising of the coronial Brief of Evidence[6] compiled by Senior Sergeant Jeffrey Smith[7] including material obtained after the provision of the brief, the statements and evidence of those witnesses who appeared at the inquest, and any documents tendered through them, or either counsel and written submissions of both Counsel Assisting and counsel representing the Chief Commissioner of Police (CCP).

13. The following witnesses gave evidence at the inquest:

- Ms Chantelle Penfold
- Mr Troy Langeveld
- Ms Bernadette Coster
- Mr Robert Polderman
- Senior Constable (S/C) Rebecca Watkins
- Leading Senior Constable (L/S/C) Christopher Jeffrey[8]
- Senior Constable (S/C) Jacqueline Stubbins (nee Browne)
- Senior Constable (S/C) Andrew Scanlon
- Sergeant (Sgt) David Stephenson[9]
- Sergeant (Sgt) Daniel Keane
- Senior Sergeant (S/Sgt) Jeffery Haines

14. I received written submissions from Counsel Assisting and the CCP. I have been assisted by both the submissions and have adopted relevant parts, where appropriate.

---

[5] Sarah Booth, COR 2006 4974 Stage Two

[6] Which also included photos, audio material and maps.

[7] I was also later assisted by Detective Leading Senior Constable Shane Miles, MCIU.

[8] He was a Senior Constable at the time of the incident. I will refer to him as his current rank for throughout the finding.

[9] He was a Senior Constable at the time of the incident. I will refer to him as his current rank for throughout the finding.

Issues for the Inquest

15. Before the commencement of the inquest, it was clear that most of the facts about Jason's death are known including his identity, the medical cause of his death and aspects of the circumstances, including the place and time of his death, as noted at the commencement of my finding.

16. The primary focus of the inquest related to the circumstances in which Jason's death occurred and matters related to the conduct of the police pursuit in the context of Victoria Police policy and guidelines.

17. I note the CCP articulated some of the issues as follows: [10]

    (a) *whether a preliminary risk assessment should have been done by police in the period (From 2.24am on 13 December 2009 when the D24 operator communicated to Knox 251 that the white Ford Laser was driving erratically and appeared to have a young driver on board, to 2.36am when Knox 311 observed the vehicle travelling north along Scoresby Road, near Orange Grove) prior to the sighting of the stolen vehicle by Knox 311 and Whitehorse 630;*

    (b) *whether a pursuit should have been initiated at all; and*

    (c) *whether, due to the very short time involved in this pursuit, police were able to conduct an adequate risk assessment.*

Circumstances of Jason's death

18. At 6.10pm on Saturday, 12 December 2009, Jason Kumar and his friend Paul Deaks were spoken to by a police officer and the contact was recorded. The officer said that the boys were cooperative (Paul emptied a stubby on request and was given a verbal warning rather than a penalty notice), polite and she had no concerns for Jason's welfare. It was only later she discovered the outstanding warrant and returned to the area, but found they had gone.

19. Later that evening and into the early hours of Sunday, 13 December 2009, Jason and Paul were driving in a stolen white 1993 Ford Laser with registration FHG507 (the Laser)[11]. The car had been reported stolen from Wollohra Place in Heathmont some time between 10pm to

[10] As articulated in the Submission of the CCP

[11] Jason's mother maintains that Jason did not steal the motor vehicle.

midnight on Saturday, 12 December and half past midnight on Sunday, 13 December 2009. Wollahra Place is about 1.6 kilometres northwest of the accident scene.

20. The events of the collision were preceded by a number of witness sightings and one, concerned about her observations (and that of her passenger), reported what they observed to police.

21. Ms Rachel Taylor, a friend of Jason and Paul, said that some time between midnight and 2am, she saw Jason and Paul standing beside the Laser parked near her home in Ringwood East, about 800 metres north of the accident scene.

22. Rachel said that she briefly spoke with Paul who told her that the car was stolen. Sometime later she saw the Laser travelling on Mount Dandenong Road 'pretty fast', and saw it go through a red light at the intersection of Mount Dandenong Road and Hawthory Road, which is about five kilometres northeast of the accident scene.

23. At about 2.14am, the Laser was seen in Geoffrey Drive in Kilsyth, by Ms Chantelle Penfold, who gave evidence at the inquest. She was driving home with Mr Troy Langeveld, and said that she saw the Laser drive off abruptly as they approached. They followed the Laser as it went through some side streets before turning west onto Mount Dandenong Road. She described the car as all over the place and erratic as the driver tried to get away, but said that once the Laser was on Mount Dandenong Road, it was fairly controlled.

24. Ms Penfold also described the car as travelling very fast before it got out onto Mount Dandenong Road and going away faster than the speed limit once on Mount Dandenong Road. She recorded the registration number[12] and called 000 at 2.14am.

25. Ms Penfold described the driver as young, around 15 or 16 (*'it looks like a young boy driving it...he looks very young to be driving'*).

26. Mr Langeveld, who also gave evidence at the inquest, thought that the driver of the Laser looked very young, about 16 or 17 years old. He said that the driver of the Laser floored it and was giving it all he could when he turned onto Mount Dandenong Road.

27. At about 2.24am, police radio D24 broadcast a 'keep a look out for' (KALOF) based on the 000 call received from Ms Penfold. This included a description of the vehicle as a white

[12] She inverted one number which was later corrected.

Ford Laser being driven erratically, the observation that the driver looked '*too young to be driving*' and was travelling fast.

28. At about 2.28am there were a number of broadcasts which confirmed that the car was stolen and that the registration number of the vehicle was in fact FHG507.

29. At 2.36am, approximately 12 minutes after the first KALOF broadcast, the Laser was sighted by two police units (Whitehorse 630 and Knox 311), as it was travelling north in Scoresby Road. These two units were both travelling south and each turned their vehicles around between Nielson Street and Farnham Road, which is approximately 650 metres south of Mountain Highway.

30. Whitehorse 630 was an unmarked traffic management unit with driver, S/C Andrew Scanlon[13] and observer, S/C Jacqueline Brown[14]. Both driver and observer held a gold class licence. Knox 311 was a marked divisional van with driver, S/C Christopher Jeffery and observer, S/C Rebecca Watkins.

31. Whitehorse 630 did a U-turn turn first and became the primary pursuit vehicle. Knox 311 did a three point turn and became the secondary pursuit vehicle.

32. Other units on duty at the time include the pursuit controller[15] (Knox 251), who was Sgt Daniel Keane and the Divisional Patrol Manager[16] (Mooroolbark 265), who was S/Sgt Jeffrey Haines. Both gave evidence at the inquest.

---

[13] With responsibilities to: Continually assess the risks and reasons. If at any time the risks outweigh the result to be achieved, terminate the pursuit.

[14] With responsibilities to: Immediately notify PCC on an open channel and remain on that channel unless directed otherwise; Maintain constant police radio communications, relaying reasons for the pursuit, speed, direction, environmental conditions, vehicle description and any other relevant information. Note that this role may pass to the secondary unit. Where the primary unit has a driver only, this role must pass to the secondary unit as soon as possible. If at any time effective police radio communications can not be safely relayed, terminate the pursuit.; Assist the police driver by providing feedback on the environment, traffic conditions, etc.; Continually assess the risks and reasons, including perceptions of the competence of the primary unit driver. If at any time the risks outweigh the result to be achieved, direct the driver to terminate the pursuit.

[15] The Pursuit Controller's responsibilities mean that the pursuit controller is in control of the pursuit. They must:

- Take charge of the pursuit;
- Request the reasons for the pursuit and whether it is imperative or elective;
- Request Police Airwing assistance;
- Develop a resolution strategy.
- Coordinate and direct all police vehicles involved.
- Continually monitor and assess the risks and reasons. If at any time the risks outweigh the result to be achieved, direct that the pursuit be terminated.
- Ensure all police involved comply with the Instruction.
- Is accountable for the operational tactics and deployment of police resources in the pursuit.

33. Whitehorse 630 and Knox 311 were fitted with an Mobile Data Terminal (MDT) with a global positioning system (GPS) which allows for the capture of GPS data at a number of particular points. Each poll point contains details of the time at which it was recorded, the latitude and longitude to a usual accuracy of plus or minus six metres, the direction of travel of the vehicle in terms of degrees and the vehicle's speed in kilometres per hour.

34. The rate at which that data is recorded is the poll rate which varies depending on whether the MDT and GPS is in one of two modes; patrol mode or pursuit (urgent) mode. This mode is switched by the operator in the police communication centre (PCC). It cannot be switched from mode to mode within the police vehicle. Patrol mode means that there is a poll point recorded for every 500 metres travelled or every 15 minutes, whichever is the sooner. Pursuit (or urgent mode) means that a poll point is recorded every 100 metres or 15 seconds, whichever is sooner, but up to a maximum frequency of once every three seconds.

35. GPS information was available to me as part of my investigation and proved a revelation to some police officers during the inquest.

36. It appears that the U-turn of Whitehorse 630 took place around 58 Scoresby Road which is approximately **1.8 kilometres** from the collision scene. The time elapsed between the U-turn of Whitehorse 630 and the collision was not more than **55 seconds**. The time elapsed between Whitehorse 630 notifying PCC that they were in pursuit and the collision is not more than **17 seconds** (S/Sgt Haines calculated it as 13 seconds).

37. At 2:27:30, the Airwing comes up on the radio indicating its availability.

38. When the Laser was first observed it was not reported to be speeding. '[T]*he car did not appear to be speeding'* said S/C Scanlon and according to S/C Browne, *'it wasn't doing anything silly and appeared to be travelling at the speed limit*'. S/C Watkins said the Laser was travelling 60 km/h but it increased once they changed direction. L/S/C Jeffery said the Laser was travelling between 60 - 70 km/h.

---

[16] With responsibilities to: Continually monitor and assess the risks and reasons for any pursuit that is in your Division, regardless of where it started. If at any time the risks outweigh the result to be achieved, direct that the pursuit be terminated.: Nominate to take over the role of Divisional Patrol or Response Manager of pursuits starting in a different Division but have now entered your Division. (The Divisional Patrol or Response Manager no longer has responsibility of the pursuit once it has left their Division and another employee has nominated to take over this role.); Ensure all police involved comply with this Instruction.; May direct a police employee to withdraw from the pursuit for any reason including their conduct, demeanour or competence.; May provide advice to the pursuit controller regarding strategies that are proposed or adopted.

39. The GPS data indicates that once facing the same direction as the Laser, Whitehorse 630 reached a maximum speed of 171 km/h, 90 metres north of the railway crossing, after having travelled approximately 560m from the point of its U-turn.

40. By the time it had travelled a further 1160m (approx.), 36 seconds (approx.) after the U-turn, the vehicle was travelling at 159 km/h (about 120m north of Mountain Highway).

41. At a third point, 90 metres south of Canterbury Road, about 51 seconds after the U-turn, Whitehorse 630 travelled about 1.7 kms and its speed was approximately 85 km/h.

42. The police say that they positioned themselves behind the Laser in order to intercept the vehicle and a pursuit was called at 2.37am by Whitehorse 630, when they were about 100 metres north of Mountain Highway. S/C Scanlon said that he activated the lights and sirens in the vicinity of Mountain Highway.

43. S/C Scanlon said '*we came to the crest of a hill or small rise in the road when I noticed that the lights at the intersection of Bayswater Road and Canterbury Road were red. I saw now that the other car was travelling very fast at this stage and I was instantly worried about the vehicle crashing the red lights at such a big intersection. I immediately switched the lights and sirens off and braked quite heavily.*' S/C Scanlon says that he decelerated and switched off his lights and sirens which is reflected in the poll point showing 85 km/h approximately 90ms south of Canterbury Road (as noted above).

44. The course of the police units as they travelled north along Scoresby Road and then Bayswater Road was seen by a number of witnesses. Mr Jonathan Hall was stationary at a red light at the intersection of Mountain Highway and Bayswater Road facing east. He saw the Laser travel north through the intersection at an estimated speed of at least 120 kilometres an hour, approximately three to four seconds later he saw a silver unmarked police vehicle with its lights flashing follow through at about the same speed, and about five to six seconds later he saw a divisional van, again with its lights flashing, follow through at a lower speed.

45. Mr Sandep Babugiri was working inside the service station situated along the west side of Bayswater Road, which is about 300 metres south of Canterbury Road and saw the Laser go past at a speed he estimated to be in excess of 120 kilometres an hour. About four to five seconds later he saw two police cars come from the same direction.

46. Ms Bernadette Coster, who gave evidence at the inquest, was driving east through the intersection and saw the Laser approaching from her right at an extremely fast speed. She

estimated it to be between 100 and 120 kilometres an hour. She saw the impact and her vehicle was struck by debris as it went through the intersection. Her partner at that time, Mr Gregory Clark, provided first aid to Jason. Ms Coster said that from the point of impact, approximately 10-15 seconds expired before she saw a vehicle with flashing lights (in her rear view mirror) and a further 10 seconds before she noted another vehicle with flashing lights. She couldn't recall hearing any sirens.

47. Mr Polderman, who gave evidence at the inquest, was facing east in Canterbury Road waiting to turn right to travel south in Bayswater Road, in a car with his daughter. He thought he heard a siren and then saw the Laser approaching the intersection from the south against a red light. He then saw the impact with the west bound Mitsubishi Lancer. After calming his daughter, he helped extinguish the fire which started under the bonnet of the Laser shortly after the impact.

48. The time of the accident was approximately 2.37am. The force of the impact ejected Jason from the vehicle and he was located on the ground immediately outside the driver's door. He died at the scene.

49. Sergeant Peter Bellion, MCIU, attended the scene and later determined an estimated pre-impact speed of Jason's vehicle at the point of impact was 143-158 km/h and the other vehicle at 51-57 km/h.

50. Police investigators believe that Jason was the driver of the Laser on the basis of DNA analysis of a shoe found in the car. In addition, there is compelling evidence based on the position of the occupants following the accident. As noted above, Jason was ejected from the vehicle and was located on the ground immediately outside the driver's door. Paul was located inside the vehicle, straddling the centre console, his torso leaning up against the driver's side door. The windscreen was intact and there appears to be no other way for Jason to have been ejected from the car except through the driver side window. I am satisfied that Jason was the driver of the Laser at the time of the accident.

Police Pursuits in Victoria

51. At the time of Jason's death, the relevant Victoria Police policy governing pursuits was contained in the Victoria Police Manual (VPM) Instruction 102-3 titled *Urgent duty driving*

and pursuits.[17] (the policy has been substantial amended since Jason's death). This Policy also governed urgent duty driving but provides that a pursuit is always considered to be urgent duty driving. The Policy established two types of pursuits - an *elective* pursuit and an *imperative* pursuit. I note that this distinction **no longer exists** in Victoria Police policy.

52. The Policy provides that an *elective* pursuit:

> *is the pursuit of a vehicle that has failed to stop after being signalled to stop for a lawful purpose. The reason for the pursuit is to intercept an offending driver.*

53. The Policy provides that an *imperative* pursuit:

> *is the pursuit of a vehicle:*
>
> - *That is creating a danger to the public by its presence on the road; or*
> - *Where there are reasonable grounds to believe that immediate apprehension of the driver or occupant/s is essential to prevent danger to prevent danger to any persons.*
>
> *The reason for the pursuit is to minimise or remove a danger.*

54. The Policy made the following overarching statement with respect to police pursuits:

> *There are **inherent risks** with urgent duty driving. These risks increase significantly when high speeds are involved, and in areas of high vehicular or pedestrian traffic.*
>
> *Given the risks involved the circumstances under which police are justified in driving in an urgent duty manner are prescribed in policy. Victoria Police will support any employee who acts in good faith an in the course of their duty, however you are reminded that legislation and policy and procedures will not protect you from the consequences of negligence or disregard for safety.*
>
> *A **police member's duty to protect life and property** will always have primacy over the need to arrest offender, especially when the offence involved is **relatively minor**, or where there are **safer options** other than immediate arrest.*

---

[17] Issued 11/07/03 and last updated 5/08/08. The pre-requisites for police pursuits are also set out in the Policy (VPM – Policy Rules Police Vehicles). Victoria Police personnel are required to hold an Approved Driving Authority in order to drive police vehicles. This is an internal licensing system which has a colour coded system. The Victoria police fleet also have classification that are colour coded. The licence codes and vehicle codes are linked together. The highest is a Gold Class licence which enables the driver to drive a Gold Class vehicle at unrestricted speeds. The rules regarding the authority to drive police vehicles and police vehicles are also set out in the Police Vehicle Rules. There were no issues regarding this aspect of VP policy as part of this investigation.

57. The Policy goes onto provide in relation to the requirement to assess risks at the commencement and throughout a pursuit:

> ***Before*** *you consider urgent duty driving* ***assess*** *the risks and* ***continue*** *to assess the risks during your driving. In all situations the priority is* ***safety first.*** *This includes not only our own safety but also the safety of other* ***occupants*** *in the police vehicle and other road users, including the occupant/s of a pursued vehicle. Regardless of the reasons for urgent duty driving, no* ***incident is urgent enough to risk your life or that of others****. You must constantly assess risks. If the risks outweigh the* ***result to be achieved****, moderate your driving* ***even if this means terminating a pursuit****.*

58. The Risk Assessment is set out in the Policy as follows:

> *Anything can influence an urgent duty driving risk assessment; however, consider the following before and at all times during the driving. Any action should escalate or de-escalate depending on the risks.*
>
> *a. What is the outcome you are trying to achieve?*
>
> *b. What is likely to happen if you don't stop a pursued driver, or if you arrive at an incident slower than anticipated?*
>
> *c. How safe do you feel driving in the manner you are?*
>
> *d. What class of police vehicle are you driving?*
>
> *e. What types of warning devices are fitted your police vehicle?*
>
> *f. What are the road, weather and traffic conditions like and how familiar are you with driving in those conditions or locations?*
>
> *g. Do you know the identity of the person you are pursuing?*
>
> *h. How competent or experienced a driver do you believe the person you are pursuing to be?*
>
> *i. If responding to incident, what type of incident is it and what other police are responding?*

59. In addition there is a table which provides a scale for 'elective pursuits' (e.g. driver fails to stop for a breach of the Road Rules), Lawful reason to intercept vehicle ('*I have a lawful right to stop this driver.*") →Reasonably belief that pursuit does not endanger the public or police ('*My pursuit is not endangering the public or police*') →But pursuit must be

terminated when the urgent duty driving poses serious danger (*'I will terminate pursuit because there is a serious danger'*).

60. The policy provides for termination conditions which include:

- risks outweigh benefit;
- the identity of driver established and no immediate threat to public or police safety;
- an officer calls the pursuit off;
- police communications lost or ineffective;
- lights or alarm fails and
- any police vehicle or employee fails to comply with or does not meet any of the restrictions of the Policy Rules.

61. The Policy provides that the observer (or the driver if there is not observer) must notify PCC that a pursuit has been initiated and maintain constant radio communications. All communications by the PCC operator is recorded. The PCC operator is to acknowledge the pursuit and notify an operational police supervisor to perform the role of Pursuit Controller.

62. The termination of a pursuit results in an audible sound, all persons have to acknowledge termination, and pull over, report location.

Analysis of the police response

63. Although some time had elapsed since the Laser was last spotted and police thought the chances of finding the vehicle were *'relatively low'*, the police were nevertheless patrolling to see if they could locate it and decided to patrol the McDonalds in Bayswater to maximise their chances. Appropriate thought and resources appear to have been devoted to this task.

64. Whilst all police members thought that the pursuit commenced as an *elective* pursuit, S/C Watkins described the pursuit changing from an *elective* pursuit to an *imperative* pursuit because of the speed of the Laser.

What the police knew prior to locating the Laser?

65. After the original KALOF was broadcast and prior to the sighting of the Laser there was a period of approximately 12 minutes in which the police had some information available to them in advance of the Laser being sighted (in the event that it was). This included: that the

vehicle was a 1993 Ford Laser, that it was stolen, that the driver appeared very young or too young to be driving and that the vehicle had been seen to be driving at least at one stage erratically and at high speeds. Although S/C Scanlon did not recall a reference to the driver being young and this detail was not part of his statement made shortly after the event.

66. Each police officer approached the information that the driver may be too young to drive with a degree of scepticism (given there was only one report and it was based on the perception of the complainant). However, when pressed (at inquest) police members generally agreed that there was no *downside* in adopting a conservative approach for the purpose of a risk assessment. Police members agreed that the driver of a stolen car might actively avoid interception by police and, that young drivers had less driving skills and were more likely to take more risks when driving which could increase the risks of engaging in a pursuit.

67. Whilst it was sometimes referred to as pre-planning at the inquest, a term which may imply a concluded or inflexible approach, in my view, accepting information conveyed to PCC as the best available information (which may be proved incorrect later) is consistent with the approach police members generally adopt when approaching tasks (*every piece of information you get is valuable, whether truthful or otherwise, definitely*, Sgt Stephenson).[18] An anticipatory plan does not have to mean a pre-determined response.[19]

Risk Assessment

68. As a rule it was agreed that a risk assessment will always be based on incomplete information and a police officer will only ever have a complete picture when the person has been intercepted.

69. With respect to police estimating the speed of their own vehicle or that of a target vehicle, the evidence suggests that police struggle with these tasks. This has further implications because often police are assessing the speed of the target vehicle by comparison with the speed of their own vehicle.

---

[18] *So you will make observations of the vehicle when you see it and you will then make a risk assessment on what you see, you'll couple it with the information you've received in advance and then you will make the decision about whether you will one, try to intercept the vehicle, and if it refuses to be intercepted whether you will conduct a pursuit and that's certainly the mindset at that time but you agree if the information is available in advance of the sighting of the vehicle that preplanning, using His Honour's example, about what you would do if you saw a person acting erratically with a knife at the oval, you'd engage in the same process?---That's correct.* (S/C Scanlon at T240)

[19] *What I'm talking about is the potential of essentially pre-loading your thought processes. What happens if you come across this vehicle, you try and access it and it accelerates away heavily and achieves a high speed, okay? Is that a reasonable scenario for you to think about in advance?---Reasonable, yes.* S/C Stubbins at T174.

70. S/C Watkins said it was very difficult to estimate the speed of the police vehicle and estimated the highest speed her vehicle was travelling was 120-125 km/h. The GPS indicated the speed was 135 km/h.

71. L/S/C Jeffery thought his vehicle was travelling at about 100 km/h but as noted above it was travelling at 135 km/h, which surprised him.

72. S/C Stubbins found the distance she travelled was too short to even look at the speedometer (which was fitted with both an analogue and digital instrument) as she said that she was keeping observations on the driver, even though the period over which she had opportunity to make observations was over 51 seconds. Although not surprised by her own vehicle's speeds, as shown on the GPS, she didn't think the Laser was speeding and was surprised with the estimate of 143 -158 km/h by Sgt Bellion of the Laser at impact.

73. S/C Stubbins agreed that it was hard to estimate a target vehicle, even though this is one of the biggest risks in a pursuit and the first thing a police officer would want to ascertain. .

74. S/C Scanlon agreed that it was difficult to assess the speed of a target vehicle at night, even if the road is well lit, because there is little to reference it to and, also agreed that the speed of the target vehicle was the *number one* risk in a pursuit. S/C Scanlon said:

> *"In the catch-up phase, I couldn't estimate the speed. Once it started to take the bend and I realised it uses the whole road for the bend as I said that's when the penny dropped and I said, that's a high speed, that's just where we de-escalated everything and turned the lights and sirens off."*

75. This realisation was a terminating event in the course of the pursuit and demonstrates in practice how the task of risk assessment is hampered by an inability to estimate target vehicle speed.

76. In general, the police officer engaged in the pursuit considered the same risks as part of their risk assessment. These factors included the weather (on this occasion not wet), that the traffic was light (related to the time of day), road conditions and visibility. These risks were usually articulated first and as positive considerations, although when pressed (at inquest), members generally agreed that they were in fact neutral risk factors. The risks considered negative were traffic at cross roads, speed of the Laser, age of the driver and that it was a stolen vehicle.

77. However, given that the report of the driver's age was treated with some scepticism, the question required to be considered as part of the risk assessment: *How competent or experienced a driver do you believe the person you are pursuing to be?* would appear not to have been adequately addressed. Or indeed the question: *What is likely to happen if you don't stop a pursued driver, or if you arrive at an incident slower than anticipated?* was not articulated.

78. In any event, if members did indeed address all the questions, there is no guidance as to how they should be weighted.

79. It appears that no one presumed that the driver of the target vehicle may be drug affected for the risk assessment, although one officer presumed he wasn't.

80. It was agreed that conducting a risk assessment was an intellectually challenging task (*extremely difficult*), which was further hampered by the high pressure conditions of a pursuit. This was even so for those police officers specifically trained and holding gold licences.

81. Given this, there was some agreement that it might be more appropriate to concentrate on any negative aspects in the risk assessment.

82. It was also clear that the major factor which couldn't be controlled is the target driver, although the idea of abandoning a pursuit (or stopping at a failed intercept) is that the target vehicle might return to a safer form of driving.

83. It was also clear that the other major factor which is largely out of police control is other road users. I make the comment that low traffic, does not mean no traffic as was demonstrated by the facts of this case.

The pursuit

84. The pursuit was started and stopped in a matter of seconds – approximately 17 seconds. It is not clear that Jason would have moderated his driving if the pursuit hadn't commenced beyond the failed intercept, as it appears that he was already travelling at high speeds and may have thought he was still in danger of being intercepted.

85. Following a receipt of a report of a young erratic driver (regardless of the car being stolen or not) it would be reasonable for the police to try and intercept the vehicle (for everyone's safety), although an alternative could have been to use the Airwing (as suggested at inquest) and not even intercept the vehicle.

86. Both A/C Watkins and L/S/C Jeffery agreed in hindsight that they wouldn't have engaged in a pursuit if certain facts were accepted at the time, as it was too dangerous.

> *Do you share your partner's view that if you had've known that in fact he was 15, he had cannabis in him, that he had been driving in excess of speed and erratically only minutes earlier, would you share her view that a pursuit should not have taken place here?---In hindsight, yes.*

87. Sgt Keane said that following an unsuccessful intercept and the target vehicle bolting he would not engage in a pursuit *(I would stop it).*

88. Sgt Haines when put the proposition:

> *You've got a 15 year old - - - - in a stolen car bolting on you?---Based on what I already know from this, and he's - he's now taken off, I'd - I'd - I'd terminate. I would. You'd stop?---Yeah, definitely.*

Conclusions with respect to police pursuit

89. I note that the overarching statements contained in the guiding policy (paragraph 57 and 58), acknowledge the obvious dangers involved in the conduct of a pursuit and the need to put the protection of life above the need to arrest, especially where the offence is minor. In addition, it requires that the risk assessment process must be applied to, firstly decide if a pursuit is appropriate, and if commenced, reapplied as circumstances change (including simply the passage of time). Again, this statement of principle places risks at the highest level with **safety first** at the heart of decision making regarding police pursuits.

90. However, to support these principles in practice (paragraph 59), the Policy does not explain **how** a member is to apply the various risk assessment criteria (posed as a series of questions), what order (if any) and what weight should be given to an individual criteria (positive, negative or neutral).

91. The inadequacy of this risk assessment model has been demonstrated by the evidence given by police officers in this case. In saying this, I make no criticism of the police members

personally who are only as effective as the training, tools and guidance they are provided with.

92. As noted above, the members nominated risk factors, such as time of day, weather and road condition as if they were positive factors, when they were at best neutral. In this context, I agree with Counsel Assisting: *'This approach may lead to a situation where appropriate weight has not been given to factors which do increase the risk....such as the risk of cross traffic from side streets.'* It is clear from the facts of this case that minimal traffic does not mean there are no traffic risks, it ends up being a matter of probably.

93. As noted above, there was no downside to adopting a conservative approach with respect to the suspected youth of the driver for the purpose of a risk assessment. This resulted in there being an *'insufficient emphasis on commencing the process of risk assessment at the earliest opportunity.....although none off it had been validated it was the best available at the time and it was proper to use it to commence the risk assessment process.'*[20]

94. Estimations of speeds by police were difficult (if not impossible) and these estimates were critical to accurate risk assessments being undertaken.

95. There is no doubt that the task loading when engaged in a pursuit is overwhelming: *'the identification and weighing of multiple factors on a moment basis when the members are fully engaged with the multiple of other tasks that are an inherent part of a high speed pursuit.'* Victoria Police acknowledge that the task is *difficult.*

96. If, as the evidence suggests, the task of risk assessment becomes more difficult when a pursuit commences, then clearly there needs to be an emphasis on the risk assessment before it commences – that is, the initial decision.

97. I further note the variation of views expressed by police members in relation to whether they would commence a pursuit or not, had they assumed or known different facts. Whilst noting that they are hindsight observations, Sgts Keane and Haines, would not have engaged in a pursuit once the Laser bolted. In my view, a risk assessment model should be capable of the same (or similar outcomes) based on the same factual scenario.

98. There was evidence at inquest that there was scope for senior officers on duty to provide guidance, where possible, to members around police pursuits. In my view, this could include, reminding members of both the safety principles and the need to justify a pursuit in

[20] Counsel Assisting Submission

accordance with the policy over the airways or say to broadcast an *intercept only* in appropriate circumstances.

99. Having considered all the evidence and in particular the matters discussed above, I do not propose to be critical of the manner in which the police members who participated in the pursuit carried out their functions.

Was Jason a person in care or custody at the time of his death?

100. As noted above, at the time of Jason's death, he was subject to a Long Term Guardianship Order under section 290 of the CYFA which was issued on 8 August 2009 and which was due to expire on 30 May 2012.[21]

101. Section 3(a) of the Act provides that a *'person placed in custody or care* includes: *a person who is in the custody or under the guardianship of the Secretary to the Department of Human Services under the* [CYFA]' which means that Jason was a person in *care* at the time of his death for the purpose of coronial legislation.

102. In addition 3(j) of the Act provides that a '*person placed in custody or care* includes: *person who a member of the police force was attempting to take into custody.*' I note that what is meant by *'attempting to take into custody'* is not defined in the Act.

103. Whilst the police pursuit has been terminated at the time of the accident, this had only occurred a short time before the accident and it appears that Jason had not changed his behaviour, although possibly impaired by the substance he had consumed, and that he continued to try and evade police.

104. On the basis of all these matters therefore, I find that Jason was also '*in custody*' at the time of his death.

Background

105. Jason first came to the attention of Child Protection in 1994, when he was three months old and eventually custody to Secretary Order was made on 30 April 2004.

106. Jason began residing with Mr Mark and Mrs Colleen Sweet on 7 July 2005. There were ups and downs with the placement eventuating with Mr and Mrs Sweet struggling to manage the placement prior to Christmas in 2008.

---

[21] The effect of a Long Term Guardianship Order is to grant custody and guardianship of the child to the Secretary of the Department of Human Services to the exclusion of all other persons. The Secretary delegated her decision making in respect of long term Guardianship Orders to the Manager, Child Protection

107. At a DHS best interests planning meeting on 23 July 2009, Mrs Sweet observed that *Jason had represented Victoria in weightlifting and that coaching staff had informed her that Jason shows great potential in this sport. ... Jason is well known and liked in the community.* Jason said *that he was happy to stay at school and felt that he was receiving good support from school. Jason further stated that things were 'going well' for him, and that he enjoyed playing basketball, going to the farm, and riding the motorbike. Jason also said that he liked socialising with his friends."*

108. On 26 August 2009, Jason's placement with Mr and Mrs Sweet ended. Mrs Sweet further observed *"...that Jason's departure was the culmination of a number of events stretching back over the past two months. She described his poor peer associations leading to his marijuana use, his alcohol consumption and his refusal to abide by the limits placed on him, as factors influencing his current attitude."*

109. DHS noted *that between May 2009 and August 2009, Jason's behaviour deteriorated, and he began to disengage from his school and home. Jason would not attend school to be with his friends and was increasingly using marijuana. There was an abandoned house in Lilydale that he would frequent when he was not attending school.*

110. Following the placement ending, Child Protection obtained a section 598 warrant under the CYFA to have Jason returned to safe placement. Jason was found foster care placements but absconded on 21 October 2009 and his whereabouts was unknown until 24 November 2009. He was located on 24 November 2009 (charged with motor vehicle theft) and arrangements were made for him to reside in emergency foster care.

111. On 26 November 2009, a meeting took place between Jason and Child Protection. He appeared to have lost weight but overall appearance was good. He disclosed that he had been staying in squats and using marijuana and wanted to speak to his mother. This was facilitated by phone.

112. In relation to the breakdown in the placement: *"...Jason said that he was causing the family too much trouble and wanted to leave.....Jason's friends contacted Child Protection and advised that Jason had told him that he did not deserve to be with his long term foster carers because of his family background."*

113. Jason absconded on 30 November 2009, and a further section 598 warrant was issued on 1 December 2009. A missing persons report was filed with the police on 2 December 2009. Jason was recorded as missing at the time of his death.

114. Jason's mother, reported that Jason began living with her in Croydon in late November 2009.

FINDING

115. Having considered all the evidence, I find that Jason Shaun Kumar born on 30 May 1994 died on 13 December 2009 from injuries sustained in a motor collision in the circumstances described above.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this finding be published on the internet.

I direct that a copy of this finding be provided to the following:

- Ms Wendy McCorkell
- Mr Mark and Mrs Colleen Sweet
- Secretary, Department of Human Services
- Victorian Government Solicitors on behalf of the Chief Commissioner of Police
- Jeffrey Smith, Investigating Member

Signature:

JOHN OLLE
CORONER
Date: 14 July 2014

Amended 4 February 2015