IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 003012

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the death of: Raymond Noel Lindsay THOMAS

Delivered on:	20 September 2021
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	June 21 – 24, 28 – 30, July 2 2021
Findings of:	Coroner John Olle
Representation:	Mr Michael Rivette of Counsel, Counsel Assisting Mr A. Trood, with Mr J. Tito for the family Mr R. Gipp for Chief Commissioner of Police (CCOP)

I, John Olle, Coroner, having investigated the death of Raymond Noel Lindsay Thomas, and having held an inquest in relation to his death at Melbourne:

find that the identity of the deceased was Raymond Noel Lindsay Thomas

born on 15 August 1986

and that the death occurred on 25 June 2017

at the corner of Victoria Road and Kellett Street, Northcote, Victoria 3070

from: 1(a) Injuries sustained in a motor vehicle collision (driver)

SUMMARY[1]

1. Raymond Noel Lindsay Thomas (**Raymond Noel**)[2] was the 30-year old son of Uncle Ray and Auntie Debbie Thomas, a proud Gunnai, Gunditjmara and Wiradjuri man. He lived with his parents and partner, Melissa Terrick, in Thornbury.

2. Raymond Noel died of injuries sustained in a motor vehicle collision (driver) at approximately 11pm on 25 June 2017 when the 2000 Holden Commodore VX station wagon he was driving south on Victoria Road collided with vehicles and a fence near the intersection with Kellett Street, Northcote.

3. Just prior to the collision, Sergeant (**Sgt**) John Sybenga, with observer Leading Senior Constable (**LSC**) Debra McFarlane, was driving in pursuit of the Commodore in a marked Victoria Police 2016 Holden Commodore SS sedan.

JURISDICTION

4. Raymond Noel's passing was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act* 2008 (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.[3]

[1] This section is a summary of facts that were uncontentious and provide a context for those circumstances that were contentious and will be discussed in some detail below.

[2] At his parents' request I will refer to Raymond Noel by these two names throughout this document.

[3] The Act, section 4(2)(a).

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *reportable death*[4] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, and is confined to those circumstances sufficiently proximate and causally relevant to the death, not merely all circumstances which might form part of a narrative culminating in death.[6]

6. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[7] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8] These are effectively the vehicles by which the prevention role may be advanced.[9]

7. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited

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[4] Defined exhaustively in section 4 of the Act to include relevantly *"the death of a person who immediately before death was a person placed in custody or care;"* For the purposes of the Act, a *person placed in custody or care* is defined in section 3 of the Act and includes relevantly *"(e) a person in the legal custody of the Secretary to the Department of Justice…"* See also footnote 37.

[5] Section 67(1) of the Act.

[6] This is the effect of the authorities – see for example ***Harmsworth*** *v* ***The State Coroner*** [1989] VR 989; ***Clancy*** v ***West*** (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[7] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

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

[9] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[10]

8. I was assisted in my investigation by Detective Sergeant (**D/Sgt**) Christian von Tunk, Major Collision Investigation Unit (**Coroner's Investigator**). His investigation was oversighted by Professional Standards Command (**PSC**) in accordance with the Victoria Police Oversight principles.

EVIDENCE AND STANDARD OF PROOF

9. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence compiled by D/Sgt Von Tunk including material obtained after provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, together with other documents tendered through the course of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprise my investigation into the passing of Raymond Noel.

10. In addition, I have been greatly assisted by the respective submissions of members of Counsel, including Counsel Assisting. I also acknowledge and thank Ms Samantha Brown, Principle In-House Solicitor and Ms Raagini Vijaykumar, Coroners Solicitor who have provided me with invaluable assistance in this investigation.

11. Whilst I have thoroughly reviewed and carefully considered all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

12. In the coronial jurisdiction, facts must be established on the balance of probabilities.[11]

BACKGROUND AND PERSONAL CIRCUMSTANCES

13. Uncle Ray addressed me on the final day of the inquest:

[10] Section 69(1) of the Act.

[11] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

> Thank you for this opportunity. Just a little bit about Ray and who he was. Raymond Noel was a proud Gunnai Gunditjmara man, connected to communities right across the State of Victoria from the east to the west and into central New South Wales. He had a beautiful nature and a very caring person and he just was very protective of family and his friends, and particularly girls and his cousins. At school he was teachers – you know, they recognised that in him and said he was just this beautiful person, young man. He had compassion, very deep compassion for those around him. And that was our Raymond Noel.[12]

14. Uncle Ray spoke of their special relationship, and how much he has missed their talks.[13]

15. In a display of remarkable courage and dignity, Auntie Debbie also spoke to me:

> This is the statement that I wrote, I'm not very good at penning this kind of stuff. Please let everyone know how much we loved Raymond Noel Thomas, Hubba Bubba. The loss of our son, there are no real words to say how heartbreaking, devastated and how heavy we carry grief. Raymond's brothers will never be the same, and how the power of love is with the Thomas brothers is one very rare love. The four brothers were inseparable, absolutely in sync with each other. Every day, I mean every day, I could hear his laughter and non-stop talking about everything. Always Raymond at the toaster, tea, coffee, breakfast. Was the happiest time in our lives. Raymond was born a warrior, and a keeper of all his siblings, especially his sisters Amy, Natea (deceased) and Meeka. It only goes to prove that we lost Natea, Raymond said that he must go look after her and little did we know that. Raymond Noel Thomas, he was made from pure love and tell everybody, and his family and friends, that he died for all of us. Can't say much more about him leaving. That's all I can say. Thank you.[14]

16. I provided my assurance their words would be incorporated in my finding. Further, I acknowledged their dignity, and respect for the proceeding. The empathy they displayed to all witnesses at inquest, was humbling and inspirational. I learnt a great deal from Uncle Ray and Aunty Debbie.

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[12] Transcript (**T**) page 906.

[13] T 907.

[14] T 911.

17. Respecting the families wishes, Raymond Noel's sad demise will be referred to as his passing.

FINDINGS AS TO UNCONTENTIOUS MATTERS

Identity

18. Raymond Noel, born 15 August 1986, was formally identified by comparison of ante- and post-mortem dental x-rays.[15]

19. Identity was never in dispute and required no further investigation.

Medical Cause of Death

20. Dr Victoria Francis, forensic pathologist of the Victorian Institute of Forensic Medicine, conducted a preliminary examination of the body and formulated a reasonable cause of Raymond Noel's passing as 'Multiple Injuries Sustained in a Motor Vehicle Incident (Driver)'.[16]

21. Toxicological analysis revealed delta-9-tetrahydrocannabinol or THC (the active form of cannabis) in the amount ~29 ng/L, methamphetamine ~0.04 mg/L and amphetamine ~0.02 mg/L.[17]

22. Dr Sanjeev Gaya, Forensic Physician reported the amphetamines were below levels found in large numbers of people driving under the influence of drugs. And indeed, due to post-mortem redistribution, were possibly at lower levels at the time of driving. In a similar vein, it was noted that THC is subject to enormous changes post-mortem.[18]

23. Dr Gaya opined that it is not possible to interpret the nature of any driver impairment related to these drugs.[19]

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[15] Report of Dr Lyndall Smythe (undated).

[16] Medical Investigation Report of Dr Francis dated 3 July 2017.

[17] Toxicology Report dated 14 July 2017.

[18] Report of Dr Sanjeev Gaya dated 28 August 2017.

[19] Report of Dr Sanjeev Gaya dated 28 August 2017.

THE INQUEST AND FINDINGS AS TO CIRCUMSTANCES

24. For the purposes of my Finding, the marked police pursuit vehicle with call sign Greensborough 655, will be referred to as 'GB 655'. The dark coloured Commodore station wagon Raymond Noel was driving will be referred to as the 'Commodore'.

25. Significantly, GB 655 was fitted with a Mobile Data Terminal (**MDT**), which sends and receives messages over Motorola Australia's Mobile Data Network (**MDN**). In addition to functions associated with policing, the MDT operates as an Automatic Vehicle Locator because regular global positioning system (**GPS**) information is recorded on the MDN.[20]

26. Although the broad parameters of the interaction between GB 655 and the Commodore, from the point of police involvement until the tragic outcome, were not in dispute, I cannot overstate the extent to which Mr Somers, Principal Engineer at Motorola Australia, has assisted my investigation. His expert analysis of the raw data uplifted from GB 655's MDT provided precision in respect to speeds, times and locations of the pursuit vehicle throughout its engagement with the Commodore. His reports will be referred to as the 'Motorola Report'.

27. The Motorola Report is particularly helpful in this investigation, as neither police member knew the speed of GBB 655 at any stage of their involvement with the Commodore.

28. Given that prior to the inquest it was apparent that most of the facts about Raymond Noel's passing were known and were not in dispute, my scope of inquest was as follows:

    a) The factual circumstances and appropriateness of the decision by Victoria Police to initially follow the vehicle driven by Raymond Noel.

    b) The factual circumstances and appropriateness of the decision by Victoria Police to instigate a pursuit of the vehicle driven by Raymond Noel (Police Pursuit), and whether the making of the decision to initiate the Police Pursuit complied with the Victoria Police policy and procedures at the time of the incident (Pursuit Policy).

    c) Having made the decision to instigate the Police Pursuit, whether that pursuit:

        i. Was conducted in compliance with the Pursuit Policy;

[20] Report of Andrew Somers dated 23 March 2020.

ii. Was terminated in compliance with the Pursuit Policy; or

iii. If not terminated, whether the pursuit should have been terminated in compliance with the Pursuit Policy.

d) The adequacy of the methods employed by Victoria Police to ensure that the police officers involved in the Police Pursuit were trained in, and equipped to comply with, the Pursuit Policy.

The Witnesses

29. The Following witnesses gave evidence at the inquest:
    a) Sergeant John Sybenga.
    b) Leading Senior Constable Deborah McFarlane.
    c) Detective Sergeant Darren Hinchcliffe.
    d) Bettina Monello.
    e) Simon O'Connell.
    f) Marisa Mella.
    g) Senior Sergeant Shane O'Loughlin.
    h) Detective Sergeant Christian Von Tunk.
    i) Assistant Commissioner Elizabeth Murphy.

Road Policing, Urgent Duty Driving, and Pursuits

30. The evolution of Victoria Police policy, guidance and training in relation to the use of police vehicles, including 'urgent duty driving' and 'pursuits' from 2002 to the present is helpfully canvassed in the statement provided by Assistant Commissioner (**AC**) Murphy.[21]

31. Victoria Police policy and rules are contained in the Victoria Police Manual (**VPM**). Of relevance are the policies in relation to Urgent Duty Driving (**UDD**) and Pursuits (**2016 Pursuit Policy**) current on the night of Raymond Noel's passing.[22]

Urgent Duty Driving

[21] Dated 11 June 2021.

[22] VPM – Policy Rules – Urgent Duty Driving (first issued 5/8/2013; last updated 13/7/2015) and VPM – Pursuits (revised policy issued 27/7/2016; last updated 16/1/2017).

32. UDD occurs when a police member drives a police vehicle in a manner that requires breach of one or more of the *Road Safety Road Rules* 2009 (**Road Rules**) in order to respond to an incident or carry out duties.[23] Compliance with UDD policy rules is mandatory and the policy highlights the 'inherent risks' of UDD, especially when high speeds are involved.[24]

33. The policy prioritises safety, requires the driver to assess the risks of UDD before commencing, continually assess risks throughout the UDD situation, and moderate or cease UDD 'if the risks outweigh the result to be achieved'.[25] The Road Rules do not apply to the driver of a police vehicle if the driver is taking reasonable care and the vehicle's blue and red flashing lights or siren is activated while engaging in UDD.[26]

34. The UDD policy states that 'as soon as' a driver fails to comply with a direction to stop, or deliberately avoids being stopped, 'this is a pursuit', and a pursuit is 'always considered' UDD.[27]

Interception of a vehicle

35. Before outlining the Victoria Police pursuits policy framework, it is worthwhile to clarify how police issue a direction to stop a vehicle and so, by implication, what constitutes a driver's failure to comply with that direction.

36. LSC McFarlane explained that when police members intend to stop a vehicle that direction is communicated in several ways.[28] First, the police vehicle is positioned 'up behind' the vehicle so that the driver is aware his/hers is the one being pulled over.[29] Second, the flashing lights on the police vehicle will be activated to indicate to the driver s/he should stop and, third, the siren may be turned on to alert the driver if the lights alone have not induced the desired response.[30] The intercepted vehicle is given an opportunity to stop within a 'reasonable time,

[23] VPM – Policy Rules – Urgent Duty Driving (first issued 5/8/2013; last updated 13/7/2015).

[24] UDD Policy.

[25] UDD Policy.

[26] UDD Policy. Police may omit use of flashing lights or siren if it is 'reasonable' to do so pursuant to Rule 305 of *Road Safety Road Rules* 2009.

[27] UDD Policy.

[28] I note additional information about interception and directions to stop is contained in the 2016 Pursuits Policy.

[29] T 263.

[30] T 263, 269.

distance and/or appropriate location'.[31] When the driver indicates s/he will pull to the side of the road, the police vehicle will pull over as well, turning off the siren but leaving on the flashing lights for safety.[32] The 'intercept' occurs when the target vehicle has stopped.[33]

Pursuits

37. The 2016 Pursuits Policy makes the following overarching statement:

> There are inherent risks with conducting pursuits; risks to the community and other road users, the occupants of pursued vehicles and to police members. Therefore, pursuits are not the primary means for effecting the apprehension and arrest of fleeing drivers and may only be conducted when specific criteria are met. The intent of this policy is to minimise the death and serious injury associated with pursuits, while maintaining the ability to pursue vehicles where there is a serious risk to the health or safety of any person.

38. The 2016 Pursuit Policy defines a pursuit – whether or not lights or sirens are activated or a pursuit formally declared – as occurring when a police vehicle continues to follow a vehicle that:

a) has failed to comply with the member's direction to stop, or

b) is taking deliberate action to avoid being stopped.[34]

39. Section 3.1 of the 2016 Pursuits Policy provides a list of mandatory requirements that need to apply before a pursuit is conducted. The mandatory requirements refer to specifications on the type of police vehicle, the Approved Driving Authority (**ADA**) of the driver and the occupants of a vehicle.

40. To conduct a pursuit, the pursuit justification criteria must be met. The criteria are outlined in section 3.2 of the 2016 Pursuits Policy:

> Members may only conduct a pursuit when they reasonably believe a serious risk to the health or safety of a person existed before attempting interception and there is a need to prevent or respond to that risk; and
>
> - Other means for apprehending the vehicle occupant/s are not practicable; and

[31] 2016 Pursuits Policy.

[32] T 263.

[33] T261.

[34] 2016 Pursuit Policy, Definitions.

- The serious risk they are seeking to prevent or respond to is greater than the risks involved in conducting the pursuit at that time.

When assessing whether alternative responses to immediate apprehension are practicable, considerations include whether:

- The driver needs to be apprehended immediately, given the nature of the offence or behaviour

- A planned approach is possible and likely to be safer and more effective; for example where the offenders are known or can be located, or additional resources are required

- All members involved in the pursuit most apply the Risk assessment and decision making guide at section 3.4 when conducting a pursuit. Any member involved can terminate the pursuit.

41. The 'Risk assessment and decision making guide', Section 3.4 of the 2016 Pursuits Policy, contains examples of hazards during a pursuit and the level of risk they carry. The hazards are associated with conditions/environment, driver behaviour/capability and condition/safety features of the pursued vehicle. The risks and likely consequences of conducting the pursuit are to be continually assessed throughout the pursuit.[35]

42. The 2016 Pursuits Policy mandates certain actions upon the initiation of a pursuit and delineates the roles and responsibilities of primary (and any secondary) police unit, police communications, Patrol Supervisor and Pursuit Controller.

43. Any member involved in a pursuit may direct the pursuit be terminated. Pursuits must be terminated (among other reasons) when the criteria for conducting a pursuit are no longer met. Termination of a pursuit involves notification of others involved through police communications (including the details of the pursued vehicle, its location and direction of travel), and the following police vehicle(s) must 'immediately stop' when safe to do so, turning off any flashing lights and siren.[36]

Evening of 25 June 2017

44. Raymond Noel's partner stated that at about 10.50pm on Sunday, 25 June 2017, Raymond Noel left home in the Commodore to purchase chocolate at a local supermarket. The

[35] 2016 Pursuit Policy.

[36] 2016 Pursuit Policy, Section 6.

Commodore was owned by her father but loaned to her six weeks earlier. She explained though Raymond Noel was unlicensed, he drove locally to go to shops or visit family or friends.[37]

45. On the evening of 25 June 2017, Sgt John Sybenga was performing night shift divisional duties with LSC Deborah McFarlane (**the members**). Experienced members, they each held gold class licences.[38] In addition, Sgt Sybenga had an advanced diploma in police safety and other management diplomas. Sgt Sybenga was the driver of GB 655.

46. The members performed patrols, including issuing infringement notices, the last of which was issued at 10.42pm, and thereafter they patrolled along High Street and Bell Street, St Georges Road, Plenty Road, and past Bell City Hotel and eventually ended up in Dundas Street.

Dundas Street

47. Dundas Street is a 50 kilometre per hour (**kph**) zone, which runs east/west, with one lane in each direction. GB 655 was travelling along Dundas Street in a westerly direction. The road was damp.

48. Approximately 800 metres west of the Victoria Road intersection, GB 655 travelled through an area described by Sgt Sybenga as a 'criminal hotspot'.[39] As GB 655 passed a side street feeding on to Dundas Street to the right, police involvement with the Commodore commenced. They observed a dark-coloured Commodore about to turn left to travel east in Dundas Street.

49. Neither member could identify the driver, however Sgt Sybenga called out the New South Wales (**NSW**) registration number of the Commodore.[40]

50. There was nothing untoward about the way the Commodore was being driven, however considering the NSW plates, the time of night and location, Sgt Sybenga decided the Commodore looked 'dodgy' and worth intercepting.[41]

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[37] Statement of Melissa Terrick dated 23 August 2017.

[38] A Gold class licence is the highest level of approved driving authority within Victoria Police which permit the holder to drive gold class vehicles at unrestricted speeds.

[39] T 89.

[40] Statements of Sgt Sybenga and LSC McFarlane each dated 26 June 2017.

[41] T 94.

51. GB 655 continued a short distance in a westerly direction, before pulling over to the south side of Dundas Street to enable LSC McFarlane to key the registration number into the MDT. Sgt Sybenga performed a U-turn and parked on the north side of Dundas Street facing east, the same direction in which the Commodore was travelling. Upon the MDT indicating the Commodore was unregistered, Sgt Sybenga accelerated hard to intercept the Commodore. The Motorola Report reveals 18 seconds had elapsed since the first sighting of the Commodore.

52. From a standing start, GB 655 ascended a gentle rise, reaching a speed of 103kph within five seconds. At the crest of the rise, the Commodore was sighted in the distance and there were no other vehicles on the road. GB 655 reached speeds of 134kph as it closed on the Commodore, reducing its speed to about 80kph through two roundabouts. There remained nothing untoward about the driving of the Commodore. Sgt Sybenga chose not to activate emergency lights or siren, explaining he did not want to alert the driver to pull over, until sufficiently close, lest the driver attempt to avoid interception.[42] The members considered they were undertaking UDD[43] and that no direction to stop was given in Dundas Street.[44]

53. As GB 655 gained ground, the only suggestion of untoward driving was that LSC McFarlane thought it possible the Commodore was slightly over the speed limit.[45] However, at the traffic lights of Victoria Road, the Commodore's brake lights illuminated, and without indication, it made a right-hand turn into Victoria Road too quickly. Sgt Sybenga described the turn as 'cut[ting] the corner'.[46]

54. Although Sgt Sybenga believed the driver had seen the marked police vehicle at the outset[47] it is significant that he did not believe the Commodore avoiding interception along Dundas Street – or in the terms of the 2016 Pursuit Policy, 'taking deliberate action to avoid being stopped'.[48] The evidence was unequivocal that the Commodore was a long way ahead of GB 655 after it performed the U-turn and stopped, and as Sgt Sybenga stated, had the Commodore

[42] T 62.

[43] T 73-74.

[44] T 62.

[45] Statement of LSC McFarlane dated 26 June 2017.

[46] T 119.

[47] Statement of Sgt Sybenga dated 26 June 2017.

[48] 2016 Pursuit Policy.

sought to avoid interception, there were side streets in Dundas Street and the driver could have 'turned down one of those'.[49]

55. I note in passing that due to the high speed at which he was travelling along Dundas Street, Sgt Sybenga was unable to check his speed at any stage.[50] LSC McFarlane was unable to sight the speedometer from the passenger seat, due to the layout of the dashboard.[51]

Victoria Road

56. Victoria Road is classified residential and has a posted speed limit of 50kph. There is a single lane each for north and southbound vehicular traffic, adjacent to which are designated lanes for cyclists and parallel parking on each side of the road. There are numerous side streets feeding into Victoria Road.

57. Upon turning into Victoria Road, the members observed fresh debris on the roadway, and a damaged parked car on the east side of Victoria Road, about 30 meters from Dundas Street. The members deduced the Commodore had impacted the parked vehicle and slowed to ascertain no persons were injured.[52]

58. The Commodore was now travelling south in Victoria Road, though it appeared closer than Sgt Sybenga expected, likely due to the collision.

59. Sgt Sybenga assessed the Commodore was now a danger to the public and had failed to stop at the scene of a collision.[53] He accelerated and when sufficiently close to the Commodore, activated lights and siren to communicate a direction to stop.

60. The response of the Commodore to the lights and siren was immediate and dramatic. Sgt Sybenga explained the Commodore 'booted it'.[54] The Commodore had – in the terms of the 2016 Pursuit Policy – 'failed to comply with the member's direction to stop' and GB 655 'continue[d] to follow' it.[55]

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[49] T37.

[50] T 123, 126.

[51] T 124.

[52] Statements of Sgt Sybenga and LSC McFarlane each dated 26 June 2017.

[53] Statement of Sgt Sybenga dated 26 June 2017.

[54] T 56.

[55] 2016 Pursuit Policy.

The Calling of the Pursuit

61. At Sgt Sybenga's direction, a pursuit was radioed in by LSC McFarlane, and the high-speed pursuit commenced.[56]

62. For the duration of the pursuit, the vehicles travelled at approximately 150kph, with a top speed of 156 kph. In the witness box, Sgt Sybenga saw for the first time CCTV footage of the pursuit, which revealed GB 655 was 1.6 seconds behind the Commodore as the vehicles passed Zak's Surfboards.[57] His response was genuine surprise at how close GB 655 was travelling behind the Commodore.

63. As the vehicles approached the traffic lights at Darebin Road, they passed within one or two meters of a driver who was stepping from her recently parked vehicle to their left. She had parked her car a short distance from the Darebin Road intersection, having undertaken a U-turn across Victoria Road. She provided a graphic description of how quickly vehicles cover ground in a high-speed pursuit. Having parked, she first became aware of approaching vehicles as she placed her right leg out of her car. She had not seen or heard the lights or siren, which I am satisfied were operating at the time. The vehicles sped past her and through the green lights of the intersection at 150kph. She bluntly described her unbridled shock and horror.

64. Immediately south of the Darebin Road intersection, Victoria Road gently rises for 200 metres. As the Commodore crested the rise, it moved into the on-coming lane. Sgt Sybenga immediately decreased his speed and called for the pursuit to be terminated. As GB 655 topped the crest, the horrific collision scene unfolded. A distressed LSC McFarlane radioed 'He's come to grief, he's come to grief'.[58]

65. Sgt Sybenga did not immediately pull over upon terminating the pursuit (as required by the 2016 Pursuits Policy) because he wanted to be able to relay the last location and direction of travel of the Commodore.[59]

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[56] Statements of Sgt Sybenga and LSC McFarlane each dated 26 June 2017.

[57] Statement of Glen Urquhart dated 9 September 2019.

[58] Statement of LSC McFarlane dated 26 June 2017.

[59] T 157.

66. The pursuit from the point it was called to the radio transmission lasted a mere 21 seconds. There was no opportunity for a Pursuit Controller to perform any role.

Specific finding in relation to the Commodore changing lanes

67. Notwithstanding the terrifying speeds the vehicles travelled during the pursuit, the Commodore at no earlier stage attempted to move out of its correct, south bound, lane. Yet, having travelled through the traffic lights at Darebin Road at 150 kph, the Commodore moved into the incorrect lane as it reached the crest a few hundred meters south of the Victoria-Darebin Road intersection.

68. At these speeds, the lane change at the crest of a rise would have been horrifying development – leading to the immediate decision to terminate the pursuit with a significant reduction in speed. Attempting to make sense of the manoeuvre, Sgt Sybenga questioned whether the manoeuvre was designed to terminate the pursuit.

69. At inquest, the more likely explanation of Raymond Noel's actions was revealed by CCTV footage.

70. The CCTV footage shows a taxi travelling slowly, south, ahead of and so in the path of the speeding Commodore. Raymond Noel appears to have attempted to avoid impact with the taxi by changing lanes to overtake it. It would appear likely he undertook the manoeuvre without knowledge of several on-coming vehicles travelling north on Victoria Road. The taxi did not stop after the collision and so until review of the CCTV footage its presence was not known.

71. Had Raymond Noel remained in the correct, southbound, lane at the crest of the rise, the Commodore would have impacted the rear of a slow-moving taxi at a speed of 150kph.

72. The collision re-construction performed by Dr Jenelle Mehegan of the Major Collision Investigation Unit revealed that whilst travelling in the northbound lane, Raymond Noel forcefully attempted to turn the wheel, but in so doing has overcorrected causing the Commodore to yaw and a loss of control.[60] It is possible the overcorrection occurred when Raymond Noel attempted to avoid head-on impact with northbound vehicles he likely first saw at the crest. Whilst out of control, the Commodore sideswiped an on-coming vehicle and

[60] Statement of Dr Jenelle Mehegan (undated).

impacted a parked car and a fence. Raymond Noel was ejected from his vehicle and passed immediately. No other person was physically injured.

UDD, intent to intercept but no pursuit in Dundas Street

73. In evidence, Sgt Sybenga expressed surprise that he had reached a top speed of 134 kph in Dundas Street. Neither lights nor siren were activated at any point in Dundas Street despite the expectation in the UDD policy that this will occur.

74. Sgt Sybenga agreed the signal to pull over is to alert not alarm the driver. That is, to ensure the driver pulls over – not frighten the driver. Yet neither member in GB 655, nor AC Murphy expressed any concern about a police vehicle undertaking UDD, without emergency lights, bearing down upon a vehicle at significant speed, to intercept the driver of an unregistered vehicle.

75. Frankly, I consider this practice should cease. Firstly, a police vehicle travelling at high speed without lights or siren activated, poses an unacceptably high risk to other road users, be they drivers, cyclists, or pedestrians. In addition, in an attempted intercept, there is real potential to instil fear in the subject driver. Drivers in panic can make poor decisions.

76. The members had no knowledge who was driving the Commodore, or indeed whether the driver was aware it was unregistered. I consider an intercept which requires UDD should never be undertaken without members considering the potential to alarm as opposed to alert the driver to pull over. And certainly, I consider there must be compelling reasons not to activate lights or siren. Especially for a minor traffic infringement.

77. I accept neither officer realised how fast they were travelling in Dundas Street. I further accept that although Sgt Sybenga believed the driver of the Commodore had seen the marked police vehicle at the very outset, neither member considered the likelihood that the Commodore cut the corner in its right turn into Victoria Road to avoid interception. Had the members formed that view, the definition of a pursuit would have been met at that time; a pursuit occurs when a police vehicle continues to follow a vehicle that is taking deliberate action to avoid being stopped.

78. Although I hold significant concerns about the way GB 655 undertook UDD, I do not find the pursuit commenced in Dundas Street particularly given that it was only in hindsight that Sgt Sybenga considered the likelihood the Commodore was attempting to avoid intercept when cutting the corner at Victoria Road intersection.

WHETHER PURSUIT WAS CONDUCTED IN COMPLIANCE WITH PURSUIT POLICY

79. The members observed fresh debris on the roadway and a damaged parked car on the east side of Victoria Road about 30 meters from Dundas Street. In light of the collision and failure to stop, Sgt Sybenga formed the belief the Commodore was:

> a clear danger to the public as he had collided with a parked car and kept going – my fear was that he was going to keep driving and present an ongoing danger to the public.[61]

80. Upon justifying the reason for pursuit, the members were required to conduct a risk assessment in line with section 3.4 of the 2016 Pursuit Policy to continually assess whether the pursuit should be continued. This requires continually assessing the hazards during a pursuit as they relate to the environment, driver, and pursued vehicle, and the risks and consequences of conducting the pursuit.

81. As Sgt Sybenga closed upon the Commodore, he was unsure how the Commodore would respond once the lights and sirens were activated. There is no evidence that either officer considered what they would do if the Commodore did not pull over, or worse, took flight.

82. Once the Commodore "booted it", Sgt Sybenga's question was answered.

83. I have heard evidence from the members in this inquest and other pursuit fatality inquests, the minute the vehicle takes flight, it is explosive. In that moment, I cannot imagine a more challenging setting in which to conduct a risk assessment, in respect to any event which history records, can have catastrophic consequences.

84. The speed at which the event transforms will rarely provide members an opportunity to conduct an appropriate risk assessment. In a heartbeat, both vehicles are travelling at such speed, the driver is unable to look at the speedometer or appreciate how closely he is travelling behind the vehicle. And further, the members had no knowledge whether the driver was for example - underage, psychotic, inebriated, drug affected, unlicensed or simply in panic.

85. To the credit of Sgt Sybenga, he acknowledged in hindsight: in booting it, the Commodore increased risk to public;[62] the manner in which he himself was driving during the pursuit may

[61] Statement of Sgt Sybenga dated 26 June 2017.

[62] T 377.

have affected behaviour of car in front;[63] wouldn't have started pursuit if knew traffic was ahead;[64] and did not know taxis and other vehicles were beyond crest.[65]

86. In the highly charged atmosphere, neither member considered the damp road, the dull lighting, the traffic lights at a major intersection up ahead, the potential the Commodore was damaged, the possibility the driver was injured, or whether a serious risk existed before police involvement with the Commodore. They did not consider whether their attempt to intercept had elevated an initial poor decision not to stop, into a scenario of extreme danger. Nor did either member consider how a high-speed pursuit could de-escalate the danger. Finally, neither member considered how this high-speed pursuit would end.

SHOULD THE PURSUIT HAVE COMMENCED?

87. Counsel for CCOP submits that Sgt Sybenga's assessment that the Commodore was a clear and ongoing danger to the public was the primary justification for the pursuit and met the justification criteria, namely:

> Is there a need to apprehend the vehicle occupants to prevent or respond to a serious risk to the health or safety of any person?

88. CCOP's Counsel submits the following three facts led Sgt Sybenga to conclude the Commodore posed a serious risk to public health and safety:

a) That the Commodore had dangerously collided with the parked car

b) The possibility that the driveability of the Commodore had therefore been compromised

c) That the Commodore had "booted it" and was travelling at an excessive speed.

89. However, the justification criteria states that the serious risk must exist before attempting intercept. It follows that the Commodore booting it as a result of an attempt to intercept was not a factor ought to be considered when deciding whether to conduct a pursuit.

[63] T 516 – T 517.

[64] T 174, T 409.

[65] T412.

90. Counsel for the CCOP further submits that because the Commodore had NSW registration plates and Victorian law would not have enabled police to ascertain who the driver of the vehicle was, the second justification criteria was met:

> "Are there any other practicable means for apprehending the vehicle occupant/s".

91. In addition, CCOP's Counsel submits that factors such as the Commodore being unregistered or appearing suspicious were "background information" for Sgt Sybenga and did not actually form part of Sgt Sybenga's decision and justification for the pursuit. The actual justification for pursuit was the dangerous driving of the Commodore once it collided into the parked car.

92. The serious risk to public health and safety that the members considered when determining whether a pursuit was justified was the risk that occurred directly prior to the pursuit being called, not the risk that existed before police involvement when the Commodore was in Dundas Street.

93. The 2016 Pursuit Policy justification criteria clearly states that the members are to turn their minds to whether a serious risk to public health or safety *existed before attempting interception* and there is a need to respond to that risk (emphasis added).

94. AC Murphy's statement provides further context on the meaning of the policy:

> "The justification for a pursuit is primarily based upon a need to address a serious risk posed by the offender to the health or safety of anyone – and the serious risk must exist before police involvement"

95. In this case, it would require the members to ask if a serious risk existed before the decision to attempt to intercept the Commodore in Dundas Street.

96. However, Counsel for CCOP submits the correct interpretation of "before police involvement" is to understand it as "before police conduct a pursuit". He acknowledges the policy could be more clearly written to reflect this distinction.

97. Frankly, I struggle to accept this submission. In my view the policy as written leaves no room for interpretation – that the serious risk must exist before the decision to intercept, that is, as AC Murphy states, before police involvement. For reasons I am unable to comprehend, I have heard and accept that there is a divergence of interpretation which supports the submission of Counsel for CCOP. This divergence of interpretation must end.

What is the significance of a vehicle attempting to avoid intercept?

98. In his November 2015 email to all sworn police members, Assistant Commissioner Fryer spoke of the 99.9% of drivers who comply with police and pull over. He spoke of a small but determined cohort who do not.

99. He asked – "How will it end if we pursue them? The answer is often badly – either for you, for them or an innocent member of the community could be injured or worse." He criticised drivers who failed to pull over, but stated: 'whether underage, drug or alcohol affected or whatever, they pose a significant risk on the roads, but in pursuit they will continue to flee and increase speed, with a heightened increase in risk to police, themselves and members of the community.'

100. Once a vehicle takes flight, the serious risk is created and rapidly escalates. Pursuit related fatalities catalogue a litany of serious driving offences which are committed in the course of a pursuit. They include, but are not limited to, vehicles running red lights, crossing double lines, cutting corners, and endangering the lives of themselves and other road users. The common thread in all pursuit fatalities is that dangerous driving is a consequence of the attempt to intercept. In other words, were it not for police involvement, the danger would not exist.

101. This is where the 2016 Pursuit Policy failed due to misinterpretation. The response to activating lights and sirens, namely, the Commodore booting it is the very danger the policy seeks to avoid being created. Acknowledging the inherent danger of pursuits, the policy seeks to avoid a pursuit being undertaken as a result of police involvement.

102. Prior to the members forming the belief that the Commodore had hit the parked car without stopping, no serious risk existed.

103. When the members observed the Commodore cut the corner at Victoria Road, they did not consider if the Commodore was avoiding intercept. When Sgt Sybenga observed the damaged parked car, he then formed the belief the Commodore was avoiding intercept. Rather than consider whether a serious risk existed before police involvement, the members formed the view the Commodore was now a risk to the public and continued with the attempt to intercept. In the process, lights and sirens were activated and the Commodore booted it and the pursuit was called.

104. Neither officer:

a) Identified a serious risk to public health or safety before the initial attempt to intercept, before police involvement with the Commodore

b) Considered whether their attempt to intercept had caused a deterioration in the driving of the Commodore

c) Considered whether the driver was injured as a result of the collision

105. Whether the pursuit commenced upon the activation of lights and siren or 200 meters earlier when Sgt Sybenga formed the view the Commodore cut the corner to avoid intercept, does not the alter the requirement to identify whether the serious risk existed before decision to intercept.

106. Sgt O'Loughlin is a vastly experienced pursuit controller and would have performed the role of pursuit controller on the night of question. However, due to the short duration of the pursuit, he had no opportunity to perform his role. He agreed however, he would routinely enquire 'what was the original reason that you followed this vehicle'. He would need to understand if the members were dealing with a serious criminal matter, for example an abduction as opposed to a minor traffic offence.

107. Prior to inquest, Sgt O'Loughlin's knowledge of the pursuit was limited to information he obtained and briefly noted upon attending the scene. Namely, during an attempted intercept, the vehicle had a collision at the corner of Victoria Road and Dundas Street and the pursuit was commenced. At Inquest, Sgt O'Loughlin was fully appraised of the circumstances, in particular the collision with a parked car, and the speed subsequently reached in the 50 kph residential setting. He concluded he would have terminated the pursuit.

108. If training of members in the 2016 Pursuit Policy, reflected the policy as written, namely that a pursuit of a vehicle which is attempting to avoid intercept, is never justified unless a serious risk to public health or safety exists before police involvement. The members did not comply with the written policy, and therefore the conclusion of Sgt O'Loughlin is correct. The pursuit was not justified.

109. However, in assessing the decision of the members to pursue, I must not ignore the evidence of witnesses, including AC Murphy, and submissions of Counsel for CCOP that the interpretation of the policy is at odds with the written word.

110. I will address this alarming contradiction in the exercise of my prevention role.

MEMBERS NEED PRESCRIPTION, NOT SUBJECTIVE ANALYSIS

111. The members did not consider, analyse, and assess the totality of hazards, known and unknown, prior to commencing the pursuit. However, to criticise the members would ignore the evidence of senior members before me who held vastly differently opinions, even in hindsight.

112. Counsel for CCOP submits the controversy in this inquest is that there are differing minds to risk. As was put to both members by Counsel Assisting in this inquest, and with which they agreed, different members will have different subjective views about what is safe and what is not safe, or whether it is safe for a police vehicle to continue at the speeds or in the manner in which it is proceeding.

113. Sgt O'Loughlin was of the view he would have terminated the pursuit whilst AC Murphy considered that the pursuit was initially justified.

114. Sgt Sybenga agreed that as an operational member he is asked to make subjective decisions without any prescription other than it has to be safe.[66]

115. In my view, Counsel for CCOP correctly identified the controversy: members will always hold different views. However, in respect to an event as inherently dangerous as pursuits, this reality is unacceptable.

116. The members agreed any assistance they could receive to assist members make the best, most consistent decisions should be sought. Air Wing option and enhanced capacity for a passenger to check speed are examples of excellent enhancements. However, Sgt Sybenga expressed both members view, that anything to assist this daunting task, including a more prescriptive approach before commencing a pursuit, would be welcome.

<u>2015 policy</u>

117. The 2015 pursuits policy was introduced in July 2015, and stipulated the criteria for engaging in pursuits, provided additional requirements to assess and mitigate any risk to community

[66] T137.

safety and police members, and prohibited members from pursuing drivers for any property or minor traffic offences ("the prohibition").

118. As AC Murphy summarises in her statement:

> "The 2015 pursuit policy was a restricted policy; it was intended to alleviate the responsibility of allowing individual officers to conduct a risk assessment and to have Victoria Police as an organisation take responsibility for choosing whether and when to pursue".

119. The introduction of the 2015 Pursuit Policy saw the almost immediate reduction in overall pursuits – from 171 per month in July 2014 to seven pursuits per month in November 2015. Nevertheless, there was widespread negativity from Victoria Police members and the public towards what became broadly seen as a 'no pursuit' policy. Several negative public media articles were published relating to the policy change. It was blamed and reported for increasing car thefts, drink driving and petrol theft offences.

120. In this inquest, I have learnt that following implementation of 2015 Pursuit Policy, there was no evidence of an increase in stolen vehicles. However, in my view the most extraordinary and positive outcome of the 2015 Pursuit Policy was that pursuit related trauma was trending towards zero. I consider that outcome a remarkable achievement, which illustrated the absolute determination of CCOP to reduce pursuit related trauma. It must not be overlooked, that beyond the tragic loss of life, pursuit fatalities impact a wide range of survivors, and no less so, serving members involved in pursuits.

121. Following the negative feedback to the 2015 Pursuit Policy, a revised 2016 Policy was created. The most significant change was the removal of the prohibition to pursuing drivers for any property or minor traffic offences.

122. I have heard since the introduction of the 2016 Pursuit Policy pursuits have increased ten-fold. A significant increase but significantly fewer than prior to the introduction of the 2015 policy.

<u>Need for prescription</u>

123. I commend CCOP for the significant work devoted to enshrining primacy of life the bedrock of the 2016 Pursuit Policy. However, in hindsight, I consider the removal of the prohibition inadvertently undermined this message. To the extent there is misunderstanding as to the

requirement that a serious risk exist before the initial decision to intercept, that is before police involvement.

124. I cannot fathom how members, new and old, can comply with a policy which on the one hand, removes the prohibition of pursing a vehicle for minor traffic or property offences, yet stipulates that a serious risk must exist before the decision to intercept.

125. In my view, it is not possible to reconcile these inconsistent propositions.

126. I refer to my Findings in Sarah BOOTH Stage two – Comments and Recommendations and specifically Paragraphs 59 – 62 under Risk Assessment Models.

> "In my view, a risk assessment model must, on application, produce the same or similar outcome by those who apply it to the same factual scenario (regardless of seniority)
>
> The necessity for this outcome finds support in the Police Pursuit Review 2002 conducted by members of Victoria Police and in my view, still resonates:
>
> …. If a policy is worded in such a way to allow for discretion, it gives the police officer the opportunity to interpret the policy guidelines to suit his or her needs for the purpose of justification …. An appropriate starting point in pursuit research may be to examine officers opinions and behaviours relative to an existing policy. Police members sought prescriptive policy and risk assessment being an important component. There was a general belief that emphasis needed to be focused on the application of risk assessment during pursuits …
>
> There needs to be a determination process whereby the driver, observer and pursuit controller can make assessments, which are based on similar perceptions. The process of assessing the information needs to be in a prescriptive form that allows all parties to draw the same conclusion."

127. In evidence, the members joined the chorus of operational members referred to above in the 2002 review, in seeking prescriptive policy. Prescription will assist members make the best decisions and enhance consistent decision making in the pursuit scenario where incorrect decisions can have devastating consequences.

128. Acknowledging the extreme danger of a pursuit, a policy which unequivocally enshrines the primacy of life as the paramount consideration, must demand that pursuits are never conducted

unless there exists a serious risk to public health or safety before the decision to intercept, that is, before police involvement. However, I consider the removal of the prohibition in the 2015 policy, diluted the primacy of life foundation of the 2016 Pursuit Policy. It unintentionally minimised the extreme danger of pursuits.

129. The retention of subjectivity invites differing decisions made in a highly charged and rapidly evolving setting. Operational members who are not subject to prescriptive policy are placed in an invidious position and will face intellectual challenges which can lead to tragedy.

130. For things to change there needs to be some prescription within the Pursuit Policy, that is used to prompt the thought process of the members, and to remove some of the burden they have in making spilt second decisions purely on their own subjective analysis. In my view, a Pursuit Policy should offer operational police the clearest opportunity to make sound decisions in these highly charged scenarios.

131. CCOP must ensure that a pursuit must never be undertaken unless there is a clear and absolute risk to public health or safety, which exists prior to the decision to intercept, and not a consequence of the intercept attempt. In so doing, the common thread identified in police pursuit fatalities will be reduced. Namely, no longer will an attempt to intercept be the catalyst for the inherent danger created by the pursuit.

132. My focus, arising from this inquest is to provide members with absolute, unequivocal clarity that a pursuit will never be justified and must never be commenced unless a serious risk to public health and safety exists before the decision to intercept, namely before police involvement. I will subsequently recommend that this requirement be enshrined in Pursuit Policy.

TRAINING

133. Counsel Assisting advocates the need for Pursuit Policy training to include both practical and theoretical elements. The members agreed with this proposition, as is found in their following evidence:

    a) 2016 e-learning module had no objective criteria or examples, but this would be of assistance;[67]

[67] T 69.

b) more concrete objective criteria in training would assist members;[68]

c) Sgt Sybenga accepted that it would be of assistance to him if answers had been provided to the questions posed - but only to promote thinking about different scenarios;[69]

d) practical training on the Pursuit Policy could be incorporated into the Gold Class ADA training;[70]

e) more real time training videos would be advantageous;[71]

f) it would be beneficial for trainees to first see pursuits in a controlled environment and shown when to start and terminate – and to provide more objective criteria.[72]

134. Counsel Assisting submits aviation is a safety-first industry. It uses simulators. The aviation industry does not leave it to a pilot of cockpit crew to first encounter (and attempt to solve) life threatening issues for the first time when flying a plane. To do so would be not only inadequately train pilots as to real risks that may be encountered – such as weather, mechanical malfunction – and risk to the lives of passengers and the public below, should a plane be crashed.

135. By contrast there is no simulator or practical training of members in the important Pursuit Policy. Evidence was given of some limited training at Attwood, which is a controlled setting and not on public streets. This cannot adequately train members on the inherent risks posed by public streets, when considering whether to commence or terminate a pursuit.

136. Video footage from actual pursuits, taken from fitted In Car Video (ICV) should be used in simulators and as part of practical training. Good example, bad examples, should be replayed and assessed with instructors.

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[68] T 73.

[69] T 80.

[70] T 425.

[71] T 422 – T 423.

[72] T 86 – T 87.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Disproportionate representation of Aboriginal people in pursuit related fatalities

137. The pursuit relating to Raymond Noel's tragic passing was not racially motivated. The investigation and inquest into his passing did not examine 'race', by which I mean Raymond Noel's Aboriginality – he was a proud Gunnai Gunditjmara and Wiradjuri man – and whether it played any role in decision-making on the night he passed; this was because there was no evidentiary basis from which to do so arising from the coronial brief.

138. I opened my Finding with reference to Raymond Noel's parents moving recollections of a son 'made of pure love', expressed the grief created by his loss as a 'hole in [their] heart' that 'will never heal' and powerfully reminded me, and everyone else present, of the broader – post-colonial – context of their son's tragic passing.

139. Uncle Ray recounted an incident from Raymond Noel's childhood when he and his brothers were visiting family in country Victoria:

> "… the boys were playing on a woodchip mound, you know, on the docks with a couple of other cousins. Just being young boys, ten or eleven years old. Just what they do. And two police officers came along and their cousins run off and two police apprehended our boys, handcuffed them and made them sit on the gutter and one of the officers said, "If you move I'll shoot ya". Now, that's the first interaction with police for a ten year old, eleven year old. So you could imagine the fear they must have felt…"
>
> […]
>
> "So that was the first interaction with the police, and there's other incidents throughout their teenage years, but it was nothing to do with the criminal activities, just being, um, racially profiled and pulled up in the street and, you know, searched for no reason"

140. In talking about the fatal pursuit, he said:

> "I can just imagine the fear that Ray must have been experiencing that night, right up until the very end".

141. Raymond Noel and his family's adverse interactions with police is sadly the reality of the lived experience of many Aboriginal people in our community. Whilst we will never know why Raymond Noel took flight, the potential contribution of his adverse experiences with police cannot be excluded.

142. Aboriginal and Torres Strait Islander communities across Australia have a long and complex history with police. One of the most significant findings of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was the over-representation of Aboriginal people in all forms of custody, and most particularly, in police custody.[73] It found that a great deal of police intervention in the lives of Aboriginal people was not in response to potentially harmful conduct but was routine,[74] with the final report stating that "far too much police intervention in the lives of Aboriginal people throughout Australia has been arbitrary, discriminatory, racist and violent".[75]

143. The high level of police contact with Aboriginal people continues today with Aboriginal people experiencing a much higher rate of contact with the criminal justice system, as both offenders and victims, than non-Aboriginal people.[76] Moreover, between 2000 and 2011 there were 218 deaths resulting from fatal pursuit-related vehicle crashes, 17% of which were Indigenous[77], a significant overrepresentation of Aboriginal and Torres Strait Islander people, who comprise only 3.3% of Australia's population.[78]

144. The RCIADIC report, and experiences like that recounted by Uncle Ray, demonstrate that many Aboriginal people in our community bear the scars of adverse interactions with police; it can be an inter-generational legacy as well as the lived experience of individuals, in their past and in their present. The nature of previous interactions with police is likely to inform an Aboriginal person's response to police intervention, and an appreciation of this legacy is vital

[73] *Final Report of the Royal Commission into Aboriginal Deaths in Custody* (1991, vol 2) 13.1.2

[74] *Final Report of the Royal Commission into Aboriginal Deaths in Custody* (1991, vol 2) 13.1.2

[75] *Final Report of the Royal Commission into Aboriginal Deaths in Custody* (1991, vol 2) 13.2.3

[76] Productivity Commission 2016. Overcoming Indigenous Disadvantage: Key Indicators report 2016 available online: https://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2016/report-documents/oid-2016-overcoming-indigenous-disadvantage-key-indicators-2016-overview.pdf

[77] For the purposes of this study, 'Indigenous' refers to Aboriginal and Torres Strait Islanders

[78] Lyneham, M. & Hewitt-Rau, A.. (2013). Motor vehicle pursuit-related fatalities in Australia, 2000-11. Trends and Issues in Crime and Criminal Justice.

to police members seeking to understand and contextualise the actions, reactions and perceptions of Aboriginal drivers intercepted by police.

145. It would be beneficial for Victoria Police's pursuit training to canvas the disproportionate representation of Aboriginal people in pursuit-related deaths, and to alert police members to the possibility that the complex relationship between Aboriginal communities and police may inform Aboriginal responses to and perceptions of police intervention. I note that AC Murphy acknowledged the overrepresentation of Indigenous people in pursuit-related deaths and was willing to consider incorporating training on the issues to which I have alluded.

146. I take this opportunity to acknowledge the significant contribution the Koori Engagement Unit has made to our Court. In particular, through the leadership of Troy Williamson. We recognise the importance to continually learn and improve our engagement with the Aboriginal community in Victoria.

Urgent duty driving

147. In this investigation I have heard evidence that it is not uncommon for police to reach very high speeds without emergency lights operating in order to attempt an intercept for minor traffic matters. I cannot envisage any circumstance in which such a scenario is acceptable. Clearly, there will be circumstances where police are required to perform urgent duty driving without foreshadowing their imminent arrival, for example, a siege, potential shooting or abduction. But I cannot fathom or justify any circumstance in which operational police members under the guise of urgent duty driving dramatically exceed the speed limit without emergency lights warning other road users. And certainly in the case of attempting to intercept a driver on a minor driving matter there is no reasonable justification for so doing.

Internal Reviews

148. This case has revealed an alarming lack of internal rigour in reviewing the circumstances of the pursuit. It follows, there was a missed opportunity to learn and improve. I accept the genuine apology of CCOP and further accept the absolute conviction that such a response will never happen again. I have no doubt CCOP is determined to improve safety of the public and members and the identified internal review shortcomings in this case, do not reflect CCOP approach to police pursuit police education, training, and compliance.

149. I cannot overstate the importance to rigorously review every pursuit to ensure compliance with the policy.

Pursuit's technology and training

150. It is important that all police vehicles of a class permitted to be involved in a police pursuit, be fitted with a fully calibrated LED display that displays the accurate speed the police vehicle is travelling and that the LED Display be positioned in a location that can be viewed by the observer and allows the observer to advise the driver and the Pursuit Controller of accurate speeds at regular intervals during a pursuit.

151. In respect of all vehicles of a class permitted to be involved in a police pursuit, that CCOP consider fitting an In Car Video (ICV) system.

152. It is vital the police training on the Pursuit Policy be continuing and involve elements of practical training behind the wheel, and, if possible, through the use of simulators, allowing interactive learning and through the use of video of actual pursuits, where possible, conducted under the policy then in force.

Termination of pursuits

153. Whenever a pursuit is terminated, members must immediately disengage, pull over, and deactivate lights and sirens.

RECOMMENDATIONS

154. Due to the extreme danger of high-speed police pursuits, and the reality that a small number of drivers flee to avoid intercept, a pursuit must never be justified in respect to the manner of driving which is the result of an attempt to avoid intercept. That is, a vehicle taking flight.

155. I make the following recommendations pursuant to section 72(2) of the Act:

    a) That the Pursuits Policy mandate that the following requirement must be satisfied before commencing a pursuit:

        A serious risk to health or safety of a person must exist before the decision to intercept, that is before police involvement.

    b) Training must ensure there is no scope for interpretation of the above. That the policy means what it says.

    c) Policy must require neither UDD nor pursuit be conducted unless police are always aware of their speeds.

d) In every pursuit, irrespective of outcome, policy require members to record for review, the serious risk which existed before the decision to intercept, that is before police involvement.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Uncle Ray and Aunty Debbie Thomas, c/- Victorian Aboriginal Legal Service

Melissa Terrick

Chief Commissioner of Police, c/- Victorian Government Solicitors Office

Signature:

Date : 20 September 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.