CORONER'S COURT

Inquest:	Inquest into the death of Skye Sassine
Hearing dates:	3-5 June 2014
Date of findings:	15 May 2015
Place of findings:	Coroner's Court, Glebe
Findings of:	Paul MacMahon Deputy State Coroner
Catchwords:	CORONIAL LAW – Mandatory Inquest, Death in a Police Operation, Suspension of Inquest, Resumption of Inquest following Suspension, Police Pursuit, Conduct of police during Pursuit,
File number:	2009/474054
Representation:	Mr D Mitchell – Counsel Assisting Mr P Saidi – Commissioner of Police Mr R Hood – Senior Constables Troy Skinner and Andrew McNeice

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

- Exhibit 3, Volume 1 Tab 7 paragraphs 100 (fourth line),172,177 and 215,
- Exhibit 3, Volume 1 Tab 15 paragraphs 184-196,
- Exhibit 3, Volume 1 Tab 29 paragraph 8 lines 8-12,
- Exhibit 3, Volume 1 Tab 30 paragraphs 7-9,
- Exhibit 3, Volume 3, Tabs 100, 104, 105, 111, 123, 124, 125, 126, 127 and 129,
- Exhibit 3, Volume 3 Tab 119 *'Safe Driving Policy'* page 22 - the whole of the page, page 24 *Responding to Urgent Duty* dot points 3 and 4, page 25 – all the words from '*RE – Initiation* to *Termination of the pursuit'* three lines below, page 26 *'Pursuit Guidelines'* numbers 2,4,6 and 9, page 27 *Vehicle Categorisation for Pursuits* first and second dot points, and *'Pursuit Response* Point *(1) Drivers and Escorts'* second dot point (e) and fourth dot point, page 28 dot points 1, 2 3 4 and 8, and page 31*Termination of Pursuit* points 1 – 9.*
- Exhibit 3, Volume 4 Tab 9 photographs 27, 28 and 29, and
- Exhibit 4

*These non-publication orders were amended on 25 May 2015

Findings made in accordance with Section 81(1) Coroners Act 2009:

Skye Sassine (born on 26 May 2008) died on 31 December 2009 at Liverpool Hospital, Liverpool in the State of New South Wales. The cause of her death was head injury that she sustained when the motor vehicle in which she was a passenger was struck at high speed by a motor vehicle which, at the time, was the subject of a police pursuit.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

To the Commissioner of Police

That amendment's be made to the NSWPF Safe Driving Policy (SDP) to:

1. Provide that where a death occurs during the course of, or following a police pursuit, the driving of the officer(s) in the pursuing vehicle(s) during the pursuit itself, and any preceding period of urgent duty or catch up, be reviewed by a Safe Driving Panel to assess the compliance of the driver(s) with the SDP.
2. That a Safe Driving Panel, having assessed the driving of an officer (s) in such circumstances, prepare a written statement of the matters considered, the conclusions it has reached and the reasons for any recommendation it has made.
3. Such statement of conclusions, recommendations and reasons be retained in the records of the Safe Driving Panel and a copy provided to the officer the subject of the review.
4. That the role of Police Aviation Support Branch (PASB) in circumstances of urgent duty or pursuit be reviewed in order to clarify such role so as to ensure that such role can be reasonably undertaken having regard to the capacity of available technology and resources.
5. Having clarified the role of PASB officers in circumstances of urgent duty or pursuit, appropriate training should be provided to members of the PASB and other police officers likely to be involved in such situations such as communication operators, VKG Supervisors and Duty Operations Inspectors.

Paul MacMahon
Deputy State Coroner
15 May 2015

Reasons:

Skye Sassine was born on 26 May 2008 (in these Reasons I will refer to her as 'Skye'). On 31 December 2009 Skye was nineteen months old. A little after 6 pm that day Skye was a passenger in a motor vehicle being driven by her mother on the F5 freeway at Ingleburn. She was in the rear of the vehicle seated in a child restraint seat. Skye's father was seated in the front passenger seat of the vehicle.

At about 6.55pm, at a point about 300 metres north of the St Andrews Road overpass of the F5 freeway, motor vehicle registration number UVM630 driven by William Ngati (Ngati) has collided with the vehicle in which Skye was a passenger. As a result of the collision Skye's mother lost control of the vehicle she was driving and it has then collided with a concrete barrier on the western side of the roadway.

As a result of the collision Skye suffered significant injuries. Skye was transported by ambulance officers to Liverpool Hospital arriving at 7.38pm. Efforts to save her life were however unsuccessful and she was pronounced deceased at 7.49pm that day.

At the time of the collision Ngati was driving his vehicle at high speed in an attempt to evade police who were, at the time, in pursuit.

Role and Function of the Coroner

The Coroners Act 2009 (the Act) governs the role and function of the Coroner.

The Objects of that Act are set out in Section 3 and include the jurisdiction:

> *(c) To enable coroners to investigate certain kinds of deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths, and*
> *(e) To enable coroners to make recommendations in relation to matters in connection with an inquest*

The certain kinds of death that a coroner is able to investigate are *reportable deaths*.

Section 6 defines a *reportable death* as including one where a person died a *violent or unnatural death* or under *suspicious or unusual circumstances.*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

Section 27(1) (b) provides that if it appears to a coroner that a person died, or might have died, in circumstances to which Section 23 applies then an inquest is mandatory.

Section 23 gives exclusive jurisdiction in respect of the investigation of certain deaths to Senior Coroners.

Section 22 (1) defines a Senior Coroner as being the State Coroner or a Deputy State Coroner.

The exclusive jurisdiction given to senior coroners includes the investigation of deaths that occur *as a result of or in the course of a police operation* (Section 23 (c)).

The primary function of the coroner when an inquest is held is to be found in Section 81(1). That section requires that, at the conclusion of the inquest, the coroner is to establish, should sufficient evidence be available, the fact that a person has died, and the identity of that person, the date and place of their death and the cause and manner thereof.

In addition to the matters to be determined in accordance with Section 81(1), in a case where a death occurs *as a result of or in the course of a police operation* it is important that the contribution of police action, if any, to the circumstances of the death be the subject of a full and public inquiry.

The Parliament requires that inquests in such circumstances be conducted so as to provide a positive incentive to police to ensure that their actions in the course of the performance of their duties are appropriate in all situations and to satisfy the community that those deaths that occur when police are involved are properly investigated. It is also in the interest of the police that such deaths be properly investigated so as to ensure that the officers involved, and police in general, are not the subject of unsubstantiated or malicious allegations.

Sections 78(1) (a) and (2) provide that where it appears to the coroner conducting an inquest that a person has been charged with an indictable offence, and the indictable offence raises the issue of whether the person caused the death with which the inquest is concerned, then the coroner may commence or continue the inquest but only for the purpose of taking evidence to establish the identity of the deceased and the date and place of their death after which the inquest must be suspended.

Section 79 provides that where an inquest has been suspended in accordance with Section 78 and the relevant charges have been finally determined then the coroner who suspended the inquest has the discretion to either dispense with the resumption of the inquest or, subject to a direction by the State Coroner not to do so, to resume the inquest.

Section 82 (1) of the Act provides that a coroner conducting an inquest may make such recommendations, as he or she considers necessary, or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

History of the Coronial Proceedings

On 23 July 2010 I commenced an inquest into Skye's death. At the time I received certain evidence. Having regard to the evidence tendered I formed the opinion that a known person (William Ngati - who I will refer to as 'Ngati') had been charged with an indictable offence that satisfied the meaning of Section 78 (1) (a).

Following consideration of the evidence available and in accordance with Section 78 (2) (a) (i) I made findings that:

> *Skye Sassine died on 31 December 2009 at Liverpool Hospital, Liverpool NSW 2170*.

I then suspended the inquest in accordance with Section 78(2) (b).

On 25 May 2011 Ngati was convicted and sentenced in respect of the relevant indictable offence. He subsequently lodged a notice of intention to appeal his conviction and sentence. The notice of intention was extended on a number of occasions however expired in September 2013. With the expiration of the Notice of Intention to appeal Ngati could not proceed with an appeal without an extension of time being granted by the Court.

The charge that had resulted in the suspension of the inquest having been finally determined (Section 79(4)) it was necessary for me to determine whether the inquest should be resumed or whether the resumption of the inquest should be dispensed with (Section 79(1)). I considered that it was appropriate to resume the inquest and gave notice to the State Coroner of my intention do so (Section 79 (2A)). I did not receive a direction from the State Coroner not to resume the inquest (Section 79 (5A)).

The Resumed Inquest

The inquest was resumed and evidence taken between 3 and 5 June 2014.

Section 81(1) findings

The findings to be made in accordance with Section 81(1) in this matter were not in contention. It was not in dispute that Skye died on 31 December 2009 at Liverpool Hospital, Liverpool in the State of New South Wales and that the cause of her death was the head injuries she sustained when the motor vehicle in which she was a passenger was involved in a motor vehicle collision.

It was also not in dispute that the motor vehicle collision that resulted in Skye's death occurred when a vehicle, that was at the time the subject of a high speed police pursuit, collided with the motor vehicle in which Skye was a passenger. In the circumstances Skye's death *occurred as a result of, or in the course, of police operations* and the provisions of Sections 22, 23 (c) and 27(1)(b) were applicable.

Issues for Inquest

As the applicable Section 81(1) findings were not in contention the issues for examination at inquest related to the conduct of the police officers during the course of the relevant police operation and whether or not it was necessary or desirable for me to make recommendations in accordance with Section 82.

Counsel Assisting identified the issues for determination at the inquest in the following terms:

1. *The cause of Skye's death,*
2. *The manner of her death,*
3. *Whether the actions of officers Skinner, McNeice and Marr during the police pursuit of Ngati were in accordance with the NSW Police Safe Driving Policy (SDP),*
4. *Whether this pursuit highlights any inadequacies, or room for improvement, in the SDP or NSW Police practice in relation to the calling*

of pursuits by what are known as Alpha Units (police vehicles occupied by a single police officer), and

5. *The role of the Police Helicopter Air Wing known as PolAir,*
6. *The relevance of the type of vehicle being driven by the pursued to decisions as to whether or not to pursue, and*
7. *The manner of reporting the findings by Safe Driving Panels the internal body that reviews such pursuits within the NSWPF.*

As I have already indicated issues 1 and 2 were not matters of contention at the inquest.

The Evidence

At the resumed inquest I received an extensive brief of evidence prepared by Detective Inspector Christopher Goddard who was the officer responsible for the investigation of the death of Skye on behalf of the coroner. Detective Inspector Goddard also gave evidence.

In addition to Detective Inspector Goddard's evidence, evidence was received at inquest from:

- Senior Sergeant Wayne Robert Hill – the Head of Police Driver Training since 2006. Senior Sergeant Hill provided evidence and explanations to assist in the understanding of what the in car video (ICV) that was in Senior Constable Skinner's vehicle recorded as well as aspects of the training received by officers Skinner and McNeice at the Police Driver Training School,,
- Senior Sergeant Benjamin James Macfarlane – Officer in Charge Highway Patrol Cluster – Western Region NSWPF who was, at the relevant time, the Senior Policy Advisor to the Traffic Services Branch of NSWPF. Senior Sergeant Macfarlane reviewed the conduct of the pursuit by officers Skinner, McNeice and Marr and made certain observations which he explained,
- Bruce Charlton Nagle – a former Sergeant who in 2009 was Acting Duty Operations Inspector (DOI) and who had previously had extensive highway patrol experience. On 31 December 2009 he was the DOI and was monitoring the pursuit. In his role as DOI he had authority to terminate the pursuit at any

time. He gave evidence as to the information he had available to him and the factors that were material to him allowing the pursuit to continue, and

- Sergeant Connie Marr – who was, in 2009, a senior constable undertaking the role of an air crew observer with PolAir and was the observer on board the helicopter that was involved in the pursuit of Ngati on 31 December 2009. Sergeant Marr gave evidence of her actions at the time and her understanding of her obligations under the SDP.

Senior Constables Skinner and McNeice were invited to give evidence at inquest. They declined to do so. I did not require them to do so as for my purposes as a coroner I did not consider that it was necessary. I had available to me statements and records of interviews given by them shortly after the incident and thus, to some extent, had some understanding of their thinking during the course of the pursuit. In addition the relevant VKG and ICV recordings and film of the latter part of the incident taken from PolAir was also available.

The circumstances that led up to the collision that ended in Skye's death began at about 6.34pm on 31 December 2009 when news of an armed robbery at the Little Bottle-O at East Hills was broadcast over police radio (VKG). At about 6.41pm general duties police in BK38 observed a white Chrysler van at the corner of Western Street and Uranus Street, Revesby that was believed to have been involved in the robbery. The drivers of BK38 attempted to block the vehicle however that was unsuccessful as it drove around them. A pursuit was then commenced by Senior Constable Draper, the driver of BK38. The pursuit concluded some 15 minutes later after which Ngati, and the passenger in the van Kane Bell, were apprehended.

At or about the time the that pursuit commenced highway patrol units were conducting random breath testing at Henry Lawson Drive, Revesby Heights near the Boomerang Reserve. When the pursuit was announced on VKG Senior Constable's Skinner (driving BK226) and McNeice (driving BK 229) left the RBT site and sought to provide assistance to the officers engaged in the pursuit. They are recorded as having left the RBT site at about 6.41pm. They ultimately caught up to the vehicle engaged in the pursuit and then took the lead in it. It took officers Skinner and McNeice about 7 minutes to travel the two and a half kilometres necessary for them

to catch up with the pursuit. Once they had taken over the pursuit, for the most part Senior Constable Skinner was the driver of the primary vehicle and Senior Constable McNeice the driver of the secondary vehicle. They continued the pursuit for about another eight minutes and it concluded only after the collision that led to Skye's death occurred.

Contribution of police action to Skye's death

There was no evidence to suggest that the actions of any of the police officers involved in this incident directly caused the collision that resulted in Skye's death. Ngati's actions of driving his vehicle at high speed and weaving in and out of traffic whilst seeking to evade the police vehicles that were pursuing him led to the collision with the vehicle in which Skye was travelling as a passenger. Skye's death therefore occurred during a police operation rather than as a result of a police operation.

One cannot, however, escape from the fact that at the time of the collision Ngati was being pursued by police at high speed. Had the pursuit not have commenced or, had it been terminated earlier, the collision that resulted in Skye's death may not have occurred. These possibilities can, however, only be matters of speculation.

Actions of police officers

The actions of police in circumstances such as occurred on 31 December 2009 are governed by the NSW Police Safe Driving Policy (the SDP).

The SDP sets out the general responsibilities of police when using a motor vehicle in the course of their duties. The SDP provides, among other things, that:

> *All employees of the NSW Police Force have (the) responsibility to operate police vehicles in a safe manner to enhance safety and promote a professional image.*

And that police drivers will:

- *Display the highest level of professional conduct whilst driving motor vehicles, both on and off duty.*

- *Drive vehicles in compliance with road transport legislation in NSW Police Force guidelines, and*
- *Be held responsible and accountable for your actions in regard to the operation of police vehicles.*

In order to achieve the objectives of the SDP a number of strategies are established. The goal of Strategy 1 is to:

> *Encourage all employees of the NSW Police Force to behave in a manner conducive to road safety, including urgent duty and pursuit driving.*

'Urgent duty' and *'pursuits'* are dealt with in Part 6 of the SDP. Urgent Duty and Pursuits are defined.

Urgent Duty is:

> *Duty which has become pressing or demanding prompt action.*

A Pursuit, and the time it commences, is defined as follows:

> *A pursuit commences at the time you decide to pursue a vehicle that has ignored a direction to stop.*

And:

> *An attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them.*

The SDP also provides that:

> *A pursuit is deemed to continue if you FOLLOW the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your police vehicle is displaying warning lights or sounding a siren.*

The SDP guidelines for Urgent Duty acknowledge that in such circumstances a police officer could be required to travel in excess of the prevailing speed limit. It requires that, where this occurs, all emergency warning devices are to be activated giving the best practical warning to the public of the approaching police vehicle.

High-speed urgent duty is said to be a last resort. The SDP provides that:

It is only to be engaged when the gravity and seriousness of the circumstances requires such action and there are no other immediate means of responding

There are similar guidelines for the conduct of pursuits including, of relevance, the SDP states that:

- *The decision to initiate and/or continue a pursuit requires weighing the need to immediately apprehend the offender, against the degree of risk to the community and police as a result of the pursuit,*
- *You are under no legal obligation to initiate a pursuit and in **many** circumstances the safety of the community and the police will dictate that **no** pursuit be initiated. Similarly when a pursuit is considered to be too dangerous it must be terminated, and*
- *When engaging in a pursuit, you should ensure that there is reasonable cause to believe that the person being pursued has committed, or has attempted to commit, an offence; and the offender is attempting to evade apprehension.*

Where a pursuit is commenced the SDP requires that the involved officer(s) activate all emergency warning devices and inform the Duty Operations Inspector (DOI) and the VKG Supervisor that the pursuit has commenced and then, when requested, provide certain specified information to those officers. This allows senior officers to have overall supervision of a pursuit.

The SDP provides a number of guidelines for the conduct of a pursuit including the requirement that [redacted]

The SDP provides that an officer engaged in a pursuit will terminate that pursuit if instructed to do so by the DOI, the VKG Supervisor or any other specified senior officer. The officer engaged in the pursuit is also required to constantly reassess the circumstances in which a pursuit is being conducted and terminate the pursuit if various specified circumstances arise. In particular an officer engaged in a pursuit is required to terminate that pursuit where:

The danger to the pursuing police or to the public outweighs the need for the immediate apprehension of the offender/s.

The division in the SDP between urgent duties and a pursuit is, to some extent, an artificial one. It has greater relevance to the ordinary conduct of police in circumstances where the death of a person is not involved. In applying the SDP to various factual circumstances it might be a matter of debate as to when the action of the police officers involved was Urgent Duty and when it was a Pursuit. For a coroner to perform his or her function, however, it is the totality of the police action involved that is to be examined during the coronial investigation and the subsequent inquest.

Commencement of the pursuit

There can be no doubt that in the circumstances of this case the requirements for the exercise of the discretion to commence a pursuit were available. On the evidence available I am satisfied that the officers in BK38 (Senior Constables Toni Draper as driver and Senior Constable James Kalantzis as observer) had reasonable cause to believe that the person being pursued had committed, or had attempted to commit, an offence and was attempting to evade apprehension.

The pursuit involving BK38 was called by Senior Constable Draper at about 6.41pm and continued for about the next seven minutes. It was then taken over by Senior Constables Skinner and McNeice in BK226 and BK229 respectively and continued until the collision occurred.

At some point after Senior Constables Skinner and McNeice had taken responsibility for the pursuit Senior Constables Draper and Kalantzis lost sight of the vehicle being driven by Ngati. Because Senior Constables Draper and Kalantzis were not participating in the pursuit at the time of the collision their actions were not examined in detail at inquest.

Senior Constables Skinner and McNeice

On 31 December 2009 Senior Constable Skinner was the driver in BK 226 whilst Senior Constable McNeice was the driver of BK229. The evidence shows that BK226 and BK229 left the RBT site at about 6.41pm and travelled urgent duty in

order to assist in the pursuit. In the initial stages BK226 was the leading vehicle however at about 6.50pm BK229 took over as lead vehicle. This continued until about 6.52pm when BK226 resumed as the lead vehicle. This situation then continued until the collision occurred. The ICV in BK226 was operational on the day and the recording was an exhibit at inquest. The ICV in BK229 was not operational.

The actions of Senior Constables Skinner and McNeice during the periods of urgent duty and pursuit on 31 December 2009 have been recorded in detail in the evidence available at inquest. I do not propose to analyse it in detail.

The evidence available however shows that in the period between leaving the RBT and the collision Senior Constable Skinner driving BK226:

- Travelled through red traffic lights on at least 14 occasions at speeds of up to 118 km/h,
- Travelled through green traffic lights on at least 6 occasions at speeds of up to 160km/h,
- Travelled, on multiple occasions, on the incorrect side on single lane roads in residential areas (some with unbroken double lines) at speeds of up to 157km/h,

[redacted]

- At 6.43pm travelled on the incorrect side of the road (2 lanes both directions) through a green traffic light overtaking a semi-trailer in lane 2 and two vehicles in lane 1 with oncoming traffic. Then crossed to the correct side of the road in the intersection with oncoming traffic. This action occurred at a speed of 131km/h reducing to 84km/h,
- At 6.46pm moved from lane 2 to lane 1 and then weaved at 71km/h between cars in lanes 1 and 2,
- Shortly after travelled through a red traffic light at 82km/h. At the same time a bus travelled into the intersection from the left (turning right) with BK 226 going around the rear of the bus at 51km/h,
- At 6.48pm travelled through a red traffic light. At the same time the rear of the vehicle lost traction suggesting that traction control on the vehicle had been turned off,

- At 6.50pm BK226 accelerated to 108km/h then pulled to the left and undertook a U turn in front of a vehicle waiting to turn right in the presence of other traffic around. During the course of this action Senior Constable Skinner appears to undertake a handbrake turn. In addition the vehicle again appears to lose traction suggesting, once again, that the traction control was off,
- At 6.51pm drove over a roundabout hump at 108km/h,
- Shortly after, when stopped at an intersection due to traffic, blasts the horn and yelled obscenities at the other drivers present then conducted a right turn with vehicle once again losing traction and proceeding through a red traffic light,
- At 6.53pm on the F6 south bound lane followed the VOI into the breakdown lane overtaking 4 vehicles on the nearside,
- At 6.54pm followed the VOI from lane 3 to lane 1 passing a semi-trailer, then into the breakdown lane overtaking another vehicle on the nearside following which he forced his vehicle between a vehicle in lane 1 and a semi-trailer in lane 2,
- Less than a minute later, following the collision between the VOI and the vehicle in which Skye was travelling, collided with the right side of the VOI.

As mentioned the ICV in BK229 driven by Senior Constable McNeice was not operational on 31 December 2009 so there is no ICV record of the actions of that vehicle. BK229, however, left the RBT site at the same time as BK226 and arrived at the collision site, impacting with Ngati as he tried to escape, very shortly after BK 226. It is therefore reasonable to infer, and I do so infer, that the driving by Senior Constable McNeice was of a similar character to that of Senior Constable Skinner.

The driving of Senior Constable Skinner on 31 December 2009 was reviewed by, among others, Senior Sergeant Hill the head teacher of the Police Driver Training unit at Goulburn. Senior Sergeant Hill prepared a report of his observations and conclusions and also gave evidence at the inquest. Senior Sergeant Hill was of the opinion that in a number of respects the actions of Senior Constable Skinner on 31 December 2009 were not in accordance with the SDP. I do not need to go to his

report in detail in these reasons. The evidence available supports Senior Sergeant Hill's conclusions.

Of significance however, in describing the training and assessment requirements to successfully complete the training for the relevant police driving certification, Senior Sergeant Hill's evidence was that, among other things, police drivers were taught:

- To come to a complete stop before proceeding through a red traffic light or stop sign,
- To reduce speed and make an assessment before proceeding through a green traffic light, and
- Not to pass onto the incorrect side of the roadway without first obtaining permission from VKG or another supervisor.

In the light of Senior Sergeant Hill's evidence it was apparent, from an examination of the ICV recording of the event, that had Senior Constable Skinner driven in the manner he did on 31 December 2009 whilst undertaking a police driver assessment he would have failed that assessment. This would have had obvious consequences for his employment as a member of the police highway patrol.

It was also Senior Sergeant Hill's evidence that Police Driver Training does not teach or promote the use of the handbrake in undertaking a turn or driving a vehicle with the traction control disabled. In his evidence Senior Sergeant Hill explained why he had formed the opinion that a handbrake turn had occurred and that the traction control had been disabled. Senior Sergeant Hill's evidence was both cogent and persuasive. I accept the conclusion that he reached on these issues.

The SDP provides for the review of police pursuits. The SDP provides for the constitution of a Safe Driving Panel (SD Panel) in a Local Area Command (LAC) that is required to review all police pursuits conducted in an LAC and, among other things, to identify any problem or pattern in driver behaviour and any training and/or

education requirements, and where appropriate reduce an officers response classification of driving status.

Following the events of 31 December 2009 SD Panels were established to review the circumstances of the pursuit. A SD Panel reviewed Senior Constable Skinner's involvement in the pursuit on 8 March 2010. The record of that consideration reads as follows:

> *ICV/Polair footage viewed by panel.*
>
> *Issues: Travelling through red lights at excessive speed 121/160*
>
> *Police travelling on the incorrect side of the roadway on Macquarie Street Liverpool*
>
> *Needs – are they essential in protecting community*
>
> *History of officers*
>
> *Relayed info to VKG of the offending vehicle, indicating*
>
> *Light traffic when offenders vehicle on the incorrect side*
>
> *Of roadway*
>
> *Speed of HYP is on hold for a period and then the*
>
> *Speed is not displayed*
>
> *Email sent to officer / SDS updated – decertified 1 month*
>
> - *2 weeks drive supervised From 9/4/10*
> - *4 x FTODD drives*

Following this SD Panel meeting an email was sent that described the outcome in similar terms. It was as follows:

> *Pursuit on 31 December 2010 involving S/Cst T SKINNER commencing at Revesby and ending at St Andrews*
>
> *Viewed ICV and Polair footage.*
>
> *Issues: Proceeds through red light at 121km/h at Revesby*
>
> *Incorrect side of the roadway – Macquarie Street, Liverpool*
>
> *Relay of information to VKG of offending vehicle travelling on the incorrect side with light traffic appeared incorrect due to speed of both vehicles approaching oncoming vehicles.*

Previous Management Strategy invoked with Officer after the Critical Incident.

Recommendation: 1 month decertification, then 2 weeks supervised driving, then 4 x ftodd drives with Sgt Gavin Taylor and S/Cst Matthew Bennett

The last recommendation has been consulted (sic) by Shane Woods to Troy Skinner after the meeting.

Senior Constable McNeice's involvement in the pursuit was also the subject of consideration by a SD Panel on 9 February 2010. The record of that consideration and outcome was, unhelpfully, recorded as follows:

5 weeks supervision of Snr officer

Decertified for 2 months commencing this date

No record of what matters were considered by the SD Panel or the reasoning behind their decision relating to Senior Constable McNeice was available.

Sergeant Connie Marr gave evidence at the inquest. On 31 December 2009 she was an observer with Police Aviation and in a Police helicopter that attended the vicinity of the pursuit. Another officer in the helicopter recorded part of the pursuit on camera. That recording was an exhibit in the proceedings.

The SDP provides for the involvement of Police Aviation in pursuits where their resources are available. In her evidence Sergeant Marr outlined her actions on the day. Her evidence was that although she had an understanding of the SDP from her time as a general duties police officer, on 31 December 2009, she had no understanding of the role PolAir was to play in pursuits. She said that she had never undertaken any training as to what her involvement would be in a pursuit. This appears to have resulted in some confusion during the course of the pursuit when PolAir was asked by VKG whether they were in a position to 'call' the pursuit. At this time Sergeant Marr said however that what she understood by her response and what other people understood by her response appears to have been different and therefore confusing.

Bruce Charlton Nagle gave evidence. He was the DOI who was supervising the pursuit on 31 December 2009. He had the authority to terminate the pursuit at any time. He outlined in his evidence the factual matters that he was aware of at the time and the matters he took into consideration in allowing the pursuit to continue. I am satisfied that there is nothing in the evidence available to me to suggest that Mr Nagle undertook his function on the night in other than a competent and professional manner.

Consideration and Discussion

In this case, as I have already indicated, the findings that are required to be made in accordance with Section 81(1) of the Act were not in contention. The resumed inquest examined the actions of police in order to determine whether or not the circumstances of Skye's death made it *necessary or desirable* for recommendations to be made in accordance with Section 82(1) of the Act.

The evidence shows that Senior Constable Skinner in firstly undertaking urgent duty and subsequently engaging in the pursuit on 31 December 2009 did so in utter disregard for the requirements imposed on him by the SDP. Watching the ICV record of his actions one is left with the impression that charged with adrenalin he thought he was on a race track and determined to be first past the winning post.

It is also hard to know what Senior Constable Skinner hoped to achieve by his driving on the day. Of significant concern were [redacted] and thus add to the risk of injury to the participants in the pursuit or innocent third parties such as Skye.

Also of concern was Senior Constable Skinner's action of weaving in and out of traffic rather than travelling in the right lane and waiting for the vehicles in front of him to move left to allow him to pass. Senior Sergeant Macfarlane's evidence was that the public would ordinarily pull to the left to allow emergency vehicles to pass them. Weaving in and out of traffic at high speed would therefore create a degree of uncertainty for other road users and thus aggravate the risk of injury to third parties.

Although we do not have a record of Senior Constable McNeice's driving it is clear that the only time he was not behind Senior Constable Skinner's vehicle was when his vehicle was in front of it. His driving must therefore have been of a similar character to that of Senior Constable Skinner.

The right of a police officer to disregard the road rules is one that is given in limited circumstances and only to be used in the public interest and never for personal excitement. It is hard not to come to the conclusion that in this case the latter was the motive for the actions displayed by both officers.

The Commissioner of Police in his Forward to the SDP says that the NSWPF *is working hard to reduce road trauma and its devastating costs* and that *our commitment to safe driving practices, as set down in this Safe Driving Policy, is part of these efforts.* In the light of the NSWPF commitment to ensuring that the SDP is complied with, the outcome in this case is perplexing when the response by the SD Panels is considered.

As indicated, the review of the driving of Senior Constables Skinner and McNeice resulted in each of them being decertified for a short period and then required to undergo a period of supervised driving. It is not my function to act as an review process for the actions of the SD Panels involved however the resultant action did not appear to give real significance to the apparent seriousness of the breaches of the SDP that were identified even if only the period of the pursuit itself, and not the urgent duty or catch up, is considered.

This apparent contradiction is highlighted with the evidence of Senior Sergeant Hill who said that such breaches of safety during an assessment at the Driver Training School would result in the officer failing the assessment with the obvious resultant consequences.

It is hard to imagine but there may well be good and cogent reasons for the action taken by the SD Panels on this occasion. Unfortunately the record of their consideration is such that where it exists at all it does not allow a third party to gain understanding of what matters were taken into account, what conclusions were reached and why the action taken was decided upon. In respect of these matters I consider that it is necessary and desirable that a recommendation be made for the

improvement of such procedures. I therefore propose to make a recommendation to this effect.

The evidence available also showed that at the time of this pursuit there was confusion as to the role to be played by the Police Air Wing. Sergeant Marr had received no training as to the role of Pol Air in a police pursuit and was, at the time, unaware of the provisions of the SDP as it related to PolAir. It is trite to say that clarity of roles and an understanding of such roles is an important aspect in avoiding confusion in such situations. I consider that the SDP should be reviewed to ensure that the roles are clear and that relevant officers receive appropriate training to ensure that this is achieved. I propose to make a recommendation to this effect.

During the course of the inquest the issue was raised as to the difficulty of police drivers complying with the reporting obligations found in the SDP during a pursuit where they are alone. Those obligations require the driver to hold and operate a radio whilst at the same time travelling at high speed. This raises obvious practical and safety difficulties. It was suggested that I should make recommendations that the suitability of driver only vehicles being involved in pursuits be reviewed and that, in addition, the feasibility of replacing handheld radios with hands free equipment be examined. Whilst these issues are important matters, and obviously have merit, I do not consider that the evidence available to me in this matter was sufficiently developed for me to make such a recommendation at this time.

Paul MacMahon

Deputy State Coroner

15 May 2015