



**CORONERS COURT  
OF NEW SOUTH WALES**

<b>Inquest:</b>	Inquest into the death of Andrew Ngo
<b>Hearing dates:</b>	25 – 29 November 2019; 13 December 2019.
<b>Date of findings:</b>	28 January 2020
<b>Place of findings:</b>	NSW Coroners Court - Lidcombe
<b>Findings of:</b>	Magistrate Elizabeth Ryan, Deputy State Coroner
<b>Catchwords:</b>	CORONIAL LAW – death following police pursuit – whether involved police officers complied with applicable policies – whether police pursuit caused or contributed to Andrew Ngo’s death - recommendations.
<b>File number:</b>	2017/373943

<p><b>Representation:</b></p>	<p>Counsel Assisting the Inquest: J Hopper of Counsel i/b NSW Crown Solicitor's Office.</p> <p>Counsel Assisting the Inquest, in relation to the NSW Commissioner of Police's application for protective orders: K Edwards of Counsel i/b NSW Crown Solicitor's Office.</p> <p>The NSW Police Force and NSW Commissioner of Police: K Burke of Counsel i/b Office of General Counsel, NSW Police.</p> <p>The NSW Commissioner of Police, in relation to application for protective orders: R Coffey of Counsel i/b NSW Crown Solicitor's Office.</p> <p>The Tran family: M Ayache, One Group Legal.</p> <p>NSW Police Officers B Thurling, N Crawford, S Andrews, M Falconer and M Keating: P Madden of Counsel i/b Walter Madden Jenkins.</p> <p>Chief Inspector P Brooks, Sergeant M Down, NSW Police Officers J Denney, C Hannon, A Rice, J McNally, L Myers, D Roden, M Bombell, C Gilbey, D Potter: B Haverfield of Counsel i/b Walter Madden Jenkins.</p> <p>Snr Sergeant C Palombo: R Hood of Counsel i/b Greg Willis Criminal Defence Lawyers.</p>
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<p><b>Findings:</b></p>	<p><b>Identity</b> The person who died is Andrew Ngo.</p> <p><b>Date of death</b> Andrew Ngo died on 9 December 2017.</p> <p><b>Place of death</b> Andrew Ngo died at Nepean Hospital, Penrith NSW 2750</p> <p><b>Cause of death</b> Andrew Ngo died as a result of multiple injuries, with a significant contributing condition of multidrug toxicity.</p> <p><b>Manner of death</b> Andrew Ngo received unsurvivable injuries when the car he was driving collided with a tree following a police pursuit.</p>
<p><b>Recommendations:</b></p>	<p>That the NSW Commissioner of Police consider:</p> <ul style="list-style-type: none"> <li>1. Amending the wording of the NSW Police Force's Safe Driving Policy at dot point 4 of Part 7.5.1, to correspond with the wording of dot point 4 of Part 6.4, such that pursuing police officers [REDACTED]</li> <li>2. Incorporating in the Safe Driving Policy's Part 6 'Urgent Duty' and Part 7 'Pursuits', similar provisions to those in Parts 3.9 and 3.10 of the AFP National Guideline on Urgent Duty and Pursuits.</li> </ul>

## **Non-Publication Orders pursuant to section 74 of the Coroners Act 2009**

### **Orders made pursuant to section 65 of the Coroners Act 2009**

On 27 September 2019 and on 27 November 2019 the Court made orders pursuant to sections 74 and 65 of the Coroners Act 2009, prohibiting publication and access to certain evidence in this inquest. On 29 November 2019 the Court made orders pursuant to section 65 prohibiting access to further evidence.

All the above orders are located on the Registry file.

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to the date and place of the death, and its cause and manner.

These are the findings of an inquest into the death of Andrew Ngo.

## **Introduction**

1. Andrew Ngo was 35 years old when he died at Nepean Hospital on the night of 9 December 2017. He had been taken there by ambulance after the car he was driving collided with a tree near Lapstone, at the foot of the Blue Mountains. Mr Ngo suffered unsurvivable injuries and he died shortly afterwards.
2. Just prior to the fatal collision a police pursuit was underway to arrest Andrew Ngo, after he had failed to stop following a direction to do so at a Random Breath Testing site. A number of police cars were involved in the pursuit.
3. This is a mandatory inquest pursuant to sections 23(1)(c) and 27(1)(b) of the Act. An inquest is mandated when it appears, or there is reasonable cause to suspect, that a person has died '*as the result of police operations*'. The purpose is to ensure there is an independent and transparent investigation of the circumstances of the death, and the conduct of any involved police officers.

## **Andrew Tran's life**

4. In March 2008 Andrew Ngo registered a change of name to Andrew Ngo from his birth name of Giang Dinh Tran. However his mother and sister requested that during the inquest he be referred to as Andrew Tran. Although I refer to him as Andrew Ngo in the formal findings as to date, place, cause and manner of death, I will call him Andrew Tran in the body of these findings.
5. Andrew Tran was born in Hong Kong on 8 November 1982. His mother Thi Lan Tran had migrated there from Vietnam on a refugee visa with her daughter Thi Lien Vu, who now uses her married name of Lien Issa. In 1984 Ms Tran left with her two children to live in Sydney. The family lived in Marrickville and then in Bossley Park.
6. Mr Tran left school in Year 11 and began to spend a lot of his time with friends. It was around this time that his sister Ms Issa started to suspect he was using illicit drugs. According to his friends, Mr Tran used drugs on a daily basis including Xanax, heroin and methylamphetamine. During his twenties and thirties he had periods of time in jail for offences of drug use, burglary and disqualified driving. In 2010 while driving under the influence of methylamphetamine he crashed his car, as a result of which his passenger died. He was convicted and sentenced for dangerous driving causing death.

7. In July 2017 while on parole, Mr Tran discussed with his sister the idea of going to rehabilitation, telling her that he was afraid of going back to prison. He had previously made attempts to remain on the methadone program. Ms Issa very much wanted to help her brother overcome his addiction problems. She commenced arrangements for him to enter a rehabilitation facility in Perth. Unfortunately this didn't happen, and in October 2017 Mr Tran was charged with fresh offences of disqualified driving and engaging in a police pursuit. Police had been unable to serve him with Court Attendance Notices, so warrants for his arrest were current at the time of his death.
8. Mr Tran's mother Thi Lan Tran was emotionally unable to attend the inquest, but his sister Lien and her husband attended each day. At the close of the evidence, at Ms Issa's request Mr Ayache read to the court a loving tribute to Andrew which she had prepared on behalf of her family. She wrote of a caring brother and son, and of how she and her mother wanted to help him overcome his addictions but did not know how. It was clear that despite his struggles Andrew Tran was much loved by his family, and they grieve his loss deeply.

### **The issues examined at the inquest**

9. The first four issues examined at the inquest concern the conduct of the involved police officers, and whether it complied with the provisions of the NSW Police Force's Safe Driving Policy [the SDP]. The applicable version of the SDP at the time of Mr Tran's death had come into force in December 2017. It has since received minor revisions, none of which are relevant to the issues of this inquest. I will cite only those provisions which bear directly upon these issues.
10. The issues examined at the inquest were:
  - Was there a proper basis to commence the pursuit?
  - Should the pursuit have been terminated at an earlier stage?
  - Did officers comply with the road spikes requirements of the SDP?
  - Did officers comply with the 'Urgent Duty' requirements of the SDP?
  - Did the pursuit cause or contribute to Mr Tran's death?
11. The conduct of the pursuit was reviewed by Senior Sergeant Jennifer McWhinnie, who is appointed to perform this task within the Traffic and Highway Patrol Command Traffic Policy Unit. She provided a report and gave evidence at the inquest. Her report identified breaches of the SDP by a number of the involved officers.
12. As will be seen, in these findings I reach the conclusion that the evidence supports many of Senior Sgt McWhinnie's conclusions. I wish to acknowledge however that some police officers whose conduct breached pursuit policies were the first to arrive at the fatal crash site, and immediately commenced first aid in an attempt to save Mr Tran's life. Other police officers involved themselves in emergency traffic duties, ensuring that no other road users came to harm in the hours following the crash. I believe that in the inquest into the circumstances of Mr Tran's death, this capable and conscientious work on their part deserves to be acknowledged.

### **The cause of Mr Tran's death**

13. The cause of Mr Tran's death is clear on the evidence. The autopsy report of forensic pathologist Dr Istvan Szentmariay found he had died as a result of multiple injuries, with a significant contributing condition of multidrug toxicity. Mr Tran had suffered fractures to his skull, ribs, sacrum and pelvis. He had also suffered haemorrhages to the brain and acutely compressed abdominal organs.
14. Testing of Mr Tran's blood samples showed the presence of methylamphetamine, morphine and alprazolam. The test results were examined by Dr Judith Perl, toxicologist. She provided an expert opinion that the level of methylamphetamine in Mr Tran's blood was very high. It was very likely to have had significant impairing effects upon his psychomotor functioning, driving skills and decision-making, creating an increased risk of having a collision. In Dr Perl's opinion his ingestion of morphine, which had been recent, was likely to have contributed to the impairment.

### **The Random Breath Test operation**

15. On the nights of 8 and 9 December 2017 NSW Police were conducting a Random Breath Testing [RBT] operation along the westbound length of the M4 motorway, commencing at Parramatta. A number of stationary RBT sites had been set up. One of these was located near Lapstone at the foot of the Blue Mountains, where the M4 motorway is known as the Great Western Highway.
16. The M4 motorway and Great Western Highway is a divided dual carriageway with three lanes westbound. Near Lapstone the three westbound lanes merge to two lanes and there is a marked turning lane allowing vehicles to exit from the Highway into Governors Drive, Lapstone ['the Governors Drive exit']. It was at this RBT site on the turning lane that the police pursuit commenced.

### **The lead up to the police pursuit**

17. Mr Tran had spent the afternoon of 9 December at the house of a friend, Mr Raymond Reynolds. At Mr Tran's request, Mr Reynolds drove him to Merrylands at about 8pm. Mr Reynolds presumed this was because of Mr Tran's unlicensed status. Soon afterwards Mr Tran drove off unaccompanied in a black Mitsubishi Sedan. This car was registered in the name of his mother.
18. Mr Tran rang another friend to tell her he was driving to meet someone in Penrith. Then at about 9.30pm Mr Tran told Mr Reynolds by phone that he was now on the M4 and there were police at every exit. Mr Reynolds encouraged Mr Tran to pull over, leave the car and walk, but Mr Tran replied he would '*rather pull a chase than walk*'.

19. Soon afterwards another friend Mr Matthew Kovacik received a call from Mr Tran. According to Mr Kovacik, Mr Tran sounded panicked and told him police had blocked all the exits on the M4.
20. Shortly after 10pm Mr Tran was signaled by an RBT stopping officer to pull over for a random breath test at the Governors Drive exit site. Mr Tran did not pull over, but continued driving at an estimated speed of 10 -15 kph. Senior Constable Barry Thurling then stepped forward and gave a second signal to him to pull over, at which point Mr Tran accelerated and drove away into Governors Drive at an estimated speed of 70kph. This road leads into streets within a residential area of Lapstone.
21. It was around this time that Mr Kovacik received another phone call from Mr Tran. According to Mr Kovacik, Mr Tran said *'I'm gone, I'm gone, there's no way off'*. Like Mr Reynolds, Mr Kovacik encouraged Mr Tran to pull over but he replied: *'No, I can't, I can't ... I've turned off. I'm on the back streets, I can't talk, there's police'*. There were no further calls from Mr Tran.
22. SC Thurling got into his Highway Patrol car and commenced pursuit of Mr Tran. The time was 10.13pm. The ensuing pursuit took place for a period of six minutes, through suburban streets in Lapstone.
23. The course of the pursuit is further described below, but briefly it can be said that just after it was terminated at 10.19pm Mr Tran was once again back on the Great Western Highway, this time driving eastward in its westbound lanes. He had used the same Governors Drive exit to enter the Highway, despite this being a one-way road for traffic to exit the Highway.
24. On the Great Western Highway Mr Tran drove at speed for some 1.5kms before losing control of his car. It mounted the median strip and collided heavily with a tree. The impact was severe and caused his car to be broken into two parts. Mr Tran's injuries were fatal. He received first aid at the site from police officers and from an off duty nurse who had pulled over to assist. An ambulance arrived very shortly afterwards, but Mr Tran died soon after arrival at hospital. Police later found a small quantity of methylamphetamine in plastic bags inside his car.
25. A number of police officers were involved in the pursuit of Mr Tran's car. To assist in understanding the course of the pursuit I list their names below, with the call signs of their cars:
 

NWM 246	SC Barry Thurling
NWM 248	SC Natasha Crawford and Sgt Mark Falconer
NWM 247	SC Mary Louise Keating and SC Scott Andrews
NWM 203	Senior Sgt Chris Palombo and SC Douglas Roden
NWM 245	Sgt Joshua Denny
NWM 249	SC Michael Bombell
NWM 294	SC David Potter and SC Christopher Gilbey
Penrith 175	SC Kevin Hannon and SC Alison Rice
Penrith 36	SC Joshua McNally and Constable Lisa Myers
Penrith 37	SC James Cager and SC Andrew Locke.



26. That night the VKG police radio supervisor was Sergeant Brett Kleyn. He had been an accredited pursuit manager since 2007, and was stationed at Penrith Police Station. From his location in the radio room he was able to monitor the radio despatches of the pursuit, and to communicate instructions via the VKG radio despatcher, Steven Carter.
27. The Duty Operations Inspector role for the Blue Mountains region that night was Acting Inspector Michael Down. He was stationed at Blue Mountains Police Station, and monitored the pursuit using his own police radio.
28. None of the RBT police knew Mr Tran's identity as a driver who was the subject of outstanding warrants, and his selection for a breath test was entirely random. Nor during the pursuit were any of the involved police officers aware of the warrants, or of Mr Tran's status as a disqualified driver. It was clear from their evidence at inquest that their pursuit was based on his failure to pull over at the RBT site.

### **The course of the pursuit**

29. At 10.13pm SC Thurling activated the lights and sirens on his car and broadcast to VKG radio that he was in pursuit. In accordance with the NSW Police Force's Safe Driving Policy [the SDP], this signified the commencement of the pursuit. SC Thurling was the sole occupant of his police car.
30. The VKG despatcher responded by broadcasting that car NWM 246 was in pursuit. He directed that *'all cars stand by unless urgent'*. Car NWM 247 responded, notifying it was *'about three minutes away'*. Over the next few minutes the following happened:
  - Mr Tran continued to drive, making circuits of the suburban streets surrounding Governors Drive
  - the VKG despatcher indicated on a number of occasions he wanted the radio airway kept clear for NWM 246's update reports
  - NWM 248 joined the pursuit, mistakenly broadcasting its car call sign as '245'. It requested and received Sgt Kleyn's permission to deploy road spikes
  - NWM 248 made two attempts to use the road spikes. On the first occasion the spikes were thrown out and merely contacted the headlights of Mr Tran's oncoming car. On the second occasion, Mr Tran avoided the spikes by driving his car partly onto the footpath
  - NWM 245 made the third attempt to deploy road spikes but Mr Tran again avoided them.
31. Mr Tran was by now driving back along Governors Drive in the direction of the Great Western Highway, still with NWM 246 in pursuit. Travelling at speed, Mr Tran suddenly veered his car to the right, driving onto the exit ramp which came up from the Great Western Highway. Seeing Mr Tran enter the exit ramp SC Thurling applied his own brakes, but his car collided with the concrete median strip and caught alight. He broadcast to VKG that he had *'destroyed the car'*.

32. Hearing from car NWM 204 that Mr Tran was now [REDACTED], the VKG despatcher broadcast that the pursuit was to terminate. It was 10.19pm.
33. At this point Mr Tran's car had just passed police cars Penrith 175 and Penrith 36. These two cars had decided to participate and were proceeding in the correct direction up the exit ramp. Mr Tran's car contacted the two police cars, causing minor damage. He continued driving eastwards past the RBT site, at an estimated speed of between 130 and 150 kph.
34. It was soon afterwards that Mr Tran lost control of his car and suffered the fatal collision.
35. I now turn to consider the issues examined at the inquest.

### **Was there a proper basis to commence the pursuit?**

36. In the opinion of Senior Sgt McWhinnie, SC Thurling met the requirement imposed by Part 7.2.9 of the SDP, that an officer deciding to instigate a pursuit have reasonable cause to believe that the person has committed an offence and is attempting to evade apprehension. SC Thurling's evidence was that he decided to pursue Mr Tran because he had failed to comply with a direction to pull into the RBT site, and had accelerated away. This is an offence under Schedule 3 of the *Road Transport Act 2013*.
37. Sgt McWhinnie noted that in his directed interview SC Thurling had not been asked about his decision-making regarding other key aspects of commencing a pursuit. Notably, Part 7.2.1 provides that the decision:  
*'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'*.

- [REDACTED]
39. Notwithstanding the lack of evidence regarding SC Thurling's thought processes, it can be concluded from other evidence that [REDACTED]  
[REDACTED]  
[REDACTED] The conclusion I reach is that SC Thurling's decision to initiate the pursuit and his continuation of it in its early stages was reasonable having regard to the guidelines within Part 7.2.
  40. It was submitted on behalf of Mr Tran's family that SC Thurling had other options reasonably open to him, other than commencing a police pursuit. One

of these was to trace the identity of the driver by use of the car's registration plates. The driver could then have been issued with a Court Attendance Notice regarding his failure to comply at the RBT site.

41. At the RBT site SC Thurling did not record the registration number of the car being driven by Mr Tran. He caught sight of the registration plates only after about two minutes of pursuit, and broadcast these details. He agreed in his evidence that at that point there was an option of terminating the pursuit and attempting to trace the driver using the car's registration details.
42. It was noted however that there were a number of potential impediments to this course. The car was not registered to Mr Tran but to his mother. It was not known, then or now, if she was in a position to name him as the driver that night. If she was not, it may not have been possible to take action against Mr Tran for the offence.
43. Given this I accept the submission of Counsel Assisting that SC Thurling's decision to take the option of a pursuit was neither in breach of the SDP nor unreasonable in the circumstances.

#### **Should the pursuit have been terminated at an earlier stage?**

44. Part 7.6 of the SDP sets out the circumstances in which a pursuit must be terminated. The primary task is to [REDACTED]  
[REDACTED]  
Once a termination has been called all vehicles must cease to pursue, stop following and return to the legal speed limit.
45. Factors to be taken into account in determining whether to terminate include [REDACTED]  
[REDACTED] The pursuing officer is required to continually re-assess these factors throughout the pursuit: Part 7.2.5.
46. A key component of the SDP is that the overriding control of a pursuit situation rests with the Duty Operations Inspector [DOI], or the VKG Supervisor in areas where VKG radio is not controlled by a DOI. The necessity for a senior officer to coordinate the progress of a pursuit and make decisions about its termination is obvious, in the interests of police and community safety.
47. As noted by Senior Sgt McWhinney at paragraph 24 of her report:  
  
*'It is imperative police involved in pursuits provide accurate and frequent information. This allows all roles as defined in the Safe Driving Policy who are monitoring and managing the pursuit to decide if the pursuit should continue or triggers have been identified to terminate the pursuit.'*
48. Thus to fulfil their function the DOI or VKG Supervisor relies upon frequent status reports from officers involved in the pursuit, [REDACTED]  
[REDACTED]  
The DOI or VKG Supervisor must also be kept updated on [REDACTED]

[REDACTED]. It is the responsibility of officers involved in the pursuit to broadcast these updates over VKG radio: Part 7.5.1.

49. In her report and evidence Senior Sgt McWhinnie identified numerous occasions where SC Thurling did not notify VKG of information which she considered would have been relevant to the question of whether the pursuit ought to have been terminated. These included:

[REDACTED] sixteen instances during the six minutes of the pursuit where [REDACTED]

- twelve occasions where DSC Thurling [REDACTED]

[REDACTED] instances where SC Thurling [REDACTED]

50. Senior Sgt McWhinnie noted that SC Thurling did not relay any of the above information to the VKG despatcher.
51. Communication is critical to the effective management of a police pursuit. This was highlighted in the evidence of Sergeant Brett Kleyn. In his directed interview he agreed that the decisions he made when supervising pursuits were based on the information he received via VKG from the pursuit vehicle or vehicles. On the basis of the information relayed by SC Thurling, he said that he had seen no reason to terminate this pursuit at a point earlier than he did. [REDACTED] and SC Thurling was an experienced highway patrol officer. As Sgt Kleyn put it in his interview: *‘that was good enough to keep it [the pursuit] running’*.

52. However at no point was Sgt Kleyn advised that [REDACTED]. Further, at no point was Sgt Kleyn made aware that SC Thurling’s car [REDACTED]

[REDACTED] In his evidence Sgt Kleyn was at pains to emphasise, as was Senior Sgt McWhinnie, [REDACTED]. However Sgt Kleyn’s evidence at the inquest was clear that he *would* have directed termination of this pursuit had he been advised that on numerous occasions [REDACTED]

It is significant that in his directed interview, Acting Inspector Down also adverted to the fact that [REDACTED]. He was familiar with the Lapstone streets through which the pursuit took place, and stated: [REDACTED]

55. I should note there was some controversy as to the actual speeds at which SC Thurling drove. When a police car's In Car Video is in operation, a dynamic speed is shown in one corner of the screen. In her report and evidence Senior Sgt McWhinnie used these speeds, shown in the footage derived from car NWM 246, as an indication of its actual speeds. But the court heard that this speed was not visible to the driver, who relied on the car's dashboard speedometer. The court heard further that the two methods of recording speed are known to show variances.
56. In response to this, Senior Sgt McWhinnie stated she was reasonably confident that the speeds shown on NWM 246's ICV were an accurate reflection of its actual speeds. She noted that on the occasions when SC Thurling had broadcast his speeds to VKG, these corresponded with the speeds shown on the ICV screen at that point. On this basis I am satisfied that the speeds of car NWM 246 referred to by Senior Sgt McWhinnie in her report may reasonably be relied upon.
57. It is clear from the evidence that in the course of the pursuit SC Thurling did not relay information which, on the evidence of Sgt Kleyn and Acting Inspector Down, would have been relevant to a decision whether to terminate the pursuit. That is, the information would have been relevant to the determination [REDACTED].
- [REDACTED] As to whether in light of this information the pursuit ought to have been terminated at an earlier stage, I place weight upon the evidence of Sgt Kleyn, an experienced pursuit manager, that he would have taken this course had he known the above details of SC Thurling's manner of driving
58. I conclude that this pursuit should have been terminated at an earlier stage than it was, in view of the risk to community safety that SC Thurling's manner of driving posed. In reaching this conclusion I accept, as did Sgt Kleyn and Acting Inspector Down, that [REDACTED].
- [REDACTED] I also acknowledge that it is relatively easy to make judgements in hindsight about the conduct of police officers. In the midst of a dynamic situation they face unpredictable circumstances and often have to make decisions within a very short timeframe.
59. However I have also taken into account that this pursuit took place over a period of six minutes, during which time SC Thurling [REDACTED].
- [REDACTED] The pursuit was not brief and during this time it may be presumed he had opportunities to turn his mind

to the risk assessment that he was required to make, and to his obligation to assist Sgt Kleyn with relevant information. It is concerning that he appears not to have done so. I conclude that he did not comply with the requirement pursuant to Part 7.5.1 of the SDP to keep the VKG supervisor sufficiently informed of relevant information about the conduct of the pursuit.

60. In his evidence SC Thurling acknowledged that he [REDACTED]. [REDACTED]. As to why he had not transmitted this information, he pointed to the difficulties of doing so while he was the sole occupant of the car. Maintaining control of his car under pursuit conditions meant that he was simply unable to keep adequately in communication with VKG.
61. In circumstances where the driver of the primary pursuit car is its sole occupant it can readily be imagined that there could be difficulties in complying with the SDP's communication obligations. I am unable to say whether this problem is a prevalent one. If it is, it may be a matter which, I respectfully suggest, the NSW Commissioner examine further.
62. I accept the submission of Counsel Assisting that no criticism should attach to Sgt Kleyn or Acting Inspector Down for not terminating the pursuit at an earlier stage. The evidence establishes that they were not made aware of circumstances which would have been relevant to that decision.

#### **Did officers comply with the road spikes requirements of the SDP?**

63. In her report Senior Sgt McWhinnie identified instances where other police officers involved in the pursuit did not comply with the requirements of the SDP. One of these areas involved the attempts to stop Mr Tran's car with use of road spikes.
64. Police officers are able to deploy road spikes (officially known as 'Tyre Deflation Devices') when they are properly accredited and they receive authorisation to do so from nominated senior officers. These include DOI's and VKG supervisors. SC Crawford and Sgt Falconer in car NWM 248 sought and received permission from Sgt Kleyn to lay road spikes at a location in Governors Drive. Their two attempts were unsuccessful, as described in paragraph 26 above. Senior Sgt McWhinnie noted that neither officer communicated to VKG the outcome of their attempts. She noted further that they did not store the road spikes in the manner required by the SDP.
65. In my view the above breaches of the SDP were relatively minor and in the circumstances of this case did not create any significant risk to police or community safety.
66. In her report Senior Sgt McWhinnie had stated that Sgt Denny, who made the third attempt to stop Mr Tran with road spikes, had not obtained authorisation

to do so. However she acknowledged in her evidence at the inquest that this was incorrect and that he had in fact done so.

### **Did officers comply with the 'Urgent Duty' requirements of the SDP?**

67. In her report and evidence, Senior Sgt McWhinnie identified a number of police officers who had breached the SDP by involving themselves in the pursuit without notifying VKG radio that they were responding on an 'urgent duty' basis.

Part 6.2.1 of the SDP defines urgent duty as '*Duty which has become pressing or demanding prompt action*'. [REDACTED]

69. Officers responding on an 'urgent duty' basis may drive in excess of the prevailing speed limit, but must comply with the 'Code Red' protocol set out in Part 8 of the SDP. This mandates that the officer activate emergency warning devices on the car and '*advise VKG and give an ETA*' [estimated time of arrival]. The officer's obligation to advise VKG of an urgent duty response is reiterated at Part 6.4 of the SDP.

70. In her evidence Senior Sgt McWhinnie explained that these obligations were necessary to enable those coordinating the pursuit to perform their functions. They needed accurate information about what police resources were present to assist, and whether any further resources might be needed. This was important not only for the safety of police and the community, but also for maximising the operational benefit of police resources.

71. These purposes are made explicit in Part 8 of the SDP, which describes the Coded System of Driving as having been designed:  
*'...to provide substantial safety and operational benefits to the NSW Police Force and the broader community. It provides clear parameters for police responding to urgent duty and at the same time reinforces the requirements of the Safe Driving Policy'*.

72. It is presumably for the same reason that pursuant to Part 7.2.10, [REDACTED]

73. Senior Sgt McWhinnie identified failures to comply with the SDP's 'urgent duty' protocol by the following officers:

- Officers Palombo and Roden in car NWM 203. They decided to proceed to the pursuit area, and activated their car's lights and siren. These were deactivated while they remained stationary for a period of time, before being reactivated when they went in search of Mr Tran's car once again. VKG received no notification of their involvement in the pursuit.

- Officers Hannon and Rice in car Penrith 175, and officers McNally and Myers in car Penrith 36. Both cars decided to respond 'urgent duty' and proceeded to the pursuit area. However neither car advised VKG of their response.
- Officers Potter and Gilbey in car NWM 294. They too decided to proceed to the pursuit area and activated their lights and siren. VKG received no notification of their involvement in the pursuit.
- Officer Bombell, the sole occupant of car NWM 249. His intention was to assist with road spikes, and he proceeded to the pursuit area with lights and siren activated. VKG radio was not notified of this response.

74. None of the above police cars [REDACTED] [REDACTED] It is apparent from the VKG transcript and from Sgt Kleyn's interview that in some cases he was entirely unaware of their presence. In his interview too, Acting Inspector Down said he had been aware of only two cars being involved in the pursuit. Their lack of awareness of these matters demonstrates the importance of officers' compliance with the SDP's communication obligations.
75. Yet the evidence from the involved officers highlighted practical difficulties with notifying their urgent duty response. From the outset the VKG despatcher had broadcast that car NWM 246 was in pursuit, together with the direction that '*All cars standby unless urgent*'. All officers understood this to mean that the VKG despatcher did not want them to interfere with the flow of information from car NWM 246, the primary pursuit car. In their directed interviews and evidence a number of officers explained this was why they had not advised VKG radio of their response. Officers Palombo, Roden, Hannon, Rice, McNally and Myers all adverted either to the '*standby*' direction, or to the difficulty of being able to break in on the radio transmissions to acknowledge their cars' response.
76. This problem was also highlighted by Sgt Kleyn. In his directed interview he gave the following response in answer to Questions 236-238 concerning the management of VKG radio traffic:  
*'...and if any other cars tried to jump on [the radio], like a few did somehow along the way, but we tried to limit ... other people getting on, saying you know, they're on their way ... we try to say, remind them, North West Met 246 only.'*
77. In her evidence at the inquest Senior Sgt McWhinnie acknowledged these practical difficulties. However in her view priority had to be given to the SDP's communication obligations, in the interests of ensuring that pursuit coordinators had sufficient information to manage the situation. In the present case she noted that a primary and a secondary pursuit car had already responded on VKG, as well as a police car equipped with road spikes. If other police cars had decided to respond on an 'urgent duty' basis but were unable to meet their SDP notification obligations, in her opinion they should have responded on a 'Code Blue' basis. This would mean proceeding in the direction of the pursuit area, not engaging in driving which is permitted under



'urgent duty' conditions, and not activating their lights and siren. In Senior Sgt McWhinnie's view, only when the opportunity arose to notify on VKG radio should they move to a 'Code Red' urgent duty response.

78. I did not hear evidence at the inquest in response to the above opinion of Senior Sgt McWhinnie, to enable me to determine whether it represents a workable solution to the practical problem which the responding officers faced. I can only conclude that it is clear the above officers were in breach of the requirement under Part 6.4 to acknowledge their response in accordance with the urgent duty protocol. However for the above reasons I do not think it would be appropriate to criticise them for it. Their dilemma again appears to highlight a problem with the practical implementation of the SDP, which the Commissioner may consider requires further examination.

### **Did the pursuit cause or contribute to Mr Tran's death?**

79. The evidence establishes that in the pursuit of Mr Tran, involved officers breached the requirements of the SDP in the ways that have been described above. Can it be said that their conduct caused or contributed to his death?
80. On behalf of Mr Tran's family it was submitted that the failure of police to terminate the pursuit at an earlier stage did contribute to his death. Mr Ayache noted that it was only in the final seconds of the pursuit that [REDACTED] [REDACTED] Had the pursuit been terminated at an earlier and more appropriate time this may never have happened.
81. Mr Ayache did not dispute, nor could it be denied on the evidence, that Mr Tran was determined to avoid being arrested by police. According to his friends, he was '*panicked*' at the sight of police at the exit points of the M4. He ignored their advice to pull over, telling Mr Reynolds he'd rather '*pull a chase*'. His intention to avoid being apprehended is borne out in his refusal to pull over at the RBT site. It must also be said also that he had many reasons to avoid police attention. He was a disqualified driver, there were warrants outstanding for his arrest, and he had a small quantity of illicit drugs in his car.
82. Having carefully considered the evidence however, I do not think it can be said that Mr Tran's death would have been prevented had the pursuit not been conducted, or had it been conducted in accordance with the SDP. The evidence of Dr Perl is that at the time of Mr Tran's death it was very likely that his driving ability and decision-making were significantly impaired by the effects of the methylamphetamine and possibly the morphine which he had recently ingested. In her view he had an increased risk of having a collision. I conclude therefore that due to his state of drug affectation, there remained a strong possibility of him suffering a fatal accident regardless of police involvement, and regardless of the manner in which this pursuit was conducted.

## The question of recommendations

83. At the close of evidence submissions were made on behalf of Mr Tran's family, proposing that a number of recommendations be made. I will deal with each in turn.

### Proposal 1

84. The first proposal was that NSW Police Force vehicles which are authorised to conduct pursuits be equipped with:
- cameras feeding 'real time' audio and visual footage to VKG Supervisors and/or Communications Operators, to assist them in monitoring and supervising pursuit and 'urgent duty' driving.
  - GPS and data tracking equipment enabling VKG Supervisors and/or Communications Operators to monitor the location and speed of police cars involved in pursuit and 'urgent duty' driving.
85. The clear intent of these proposals is to better assist those who are supervising pursuit and 'urgent duty' driving to assess the conditions of the pursuit. The evidence at inquest revealed practical deficiencies in the current system which relies upon VKG radio broadcasts from the individual officers involved.
86. In response it was submitted on behalf of the NSW Commissioner that the proposals would not be opposed, on the basis that the recommendation be that the Commissioner consider it.
87. At the inquest both Sgt Kleyn and Senior Sgt McWhinnie were asked whether in their opinion the above proposals would be useful, in the interests of enhancing the supervisor's understanding of the pursuit as it unfolded. Sgt Kleyn acknowledged there was room for improvement on the present system. However he expressed doubt as to how as a practical matter, multiple and simultaneous sources of audio coming from the police cars might be managed. Senior Sgt McWhinnie was unsure whether the proposals would help or hinder the VKG supervisor.
88. In my view the proposal that 'real time' speed tracking devices be introduced has merit, in particular as under the current system an objective source of this information only becomes available after the pursuit, with the availability of the ICV footage. However I am mindful of the requirement that recommendations made in an inquest be '*necessary or desirable*'. This requires evidence that the proposed measure is directed at remedying an identified problem, and that it will be effective in doing so. This evidence was not available at the inquest, nor any evidence as to the logistical factors which would be involved. (This is not a criticism of those appearing at the inquest.) For these reasons, while I think the proposal for speed tracking devices has potential, I do not think it would be appropriate to recommend it in this inquest.

## Proposal 2

89. The second proposal was that two amendments be made the SDP. The first was to amend the wording of a section of Part 7.5.1 regarding pursuit driving, to make it consistent with a corresponding provision in Part 6.4 regarding 'urgent duty' driving. Both require that the responding officer [REDACTED]  
[REDACTED]  
[REDACTED] It is not clear why the two provisions differ in this respect, and whether there is any practical difference between driving [REDACTED]  
[REDACTED]
90. I accept the submission made on behalf of the Tran family, that in the interests of providing greater clarity I should recommend that the Commissioner consider whether the wording in these two provisions ought to be aligned.
91. The second proposed amendment to the SDP, is that the relevant sections in its 'Urgent Duty' and 'Pursuits' parts be amended, to align with Parts 3.9 and 3.10 of the Australian Federal Police's National Guideline on Urgent Duty Driving and Pursuits [the AFP Guideline].
92. Parts 3.9 and 3.10 of the AFP's Guideline deal respectively with the justification criteria for commencing and continuing a pursuit, and when a pursuit must not be conducted. Significant features of the AFP Guideline's pursuit justification criteria include that:
- the police officer must believe there is an '*urgent need*' to apprehend the vehicle
  - the apprehension is believed necessary to prevent '*an immediate or ongoing serious risk of public health and safety*'
  - an offence has been committed or is about to be committed which involves '*serious injury to or death of a person*'
  - alternative means for apprehending the vehicle's occupant are not feasible.
93. Also significant is the provision within Part 3.10 of the AFP Guideline, that '*in ordinary circumstances a pursuit must not be initiated for any property or traffic offences*'.
94. In this inquest the court did not hear evidence regarding the AFP Guideline. However it is apparent that its pursuit justification criteria are more prescriptive than those of the SDP. In addition, pursuit is justified in a more restricted range of circumstances. It appears likely for example, that if the AFP Guideline had applied in NSW at the time of Mr Tran's death, a pursuit could not lawfully have been initiated based on the facts known at the time to the pursuing police.
95. It is beyond the scope of this inquest to determine whether the approach to police pursuits adopted in the AFP Guideline is to be preferred to that in the SDP. Evidence would be needed on a range of matters, including whether

there are differences in the geographical features and criminal activity profiles of the ACT and of NSW which might require a different law enforcement approach. Relevant also would be evidence as to the efficacy as a law enforcement measure of the existing arrangements for police pursuits in NSW, taking into account the extent to which they achieve crime prevention and detection objectives, the resources needed to conduct them, and the safety risks for police and community. It is also evident that opinions differ as to where the balance lies in weighing the public interests in community safety and law enforcement.

96. I am aware that a review of the SDP is currently underway. This provides an opportunity to consider whether the more prescriptive and restrictive approach to pursuits adopted in the AFP Guideline would be of benefit to law enforcement in NSW. For this reason I will make the recommendation that the Commissioner consider doing so.
97. In submissions on behalf of the Commissioner, Ms Burke stated that the Commissioner would not oppose the above proposals, provided they were made as recommendations that the Commissioner consider them.

### **Proposal 3**

98. The terms of the third proposal are unclear to me. In written submissions on behalf of the family Mr Ayache proposed that Clause 16(1)(a) of Schedule 3 to the *Road Transport Act 2013* be amended to impose the same penalties as an offence against clause 16(1)(b). The former is the offence of failing to submit to a breath test, and carries a fine by way of penalty. The latter is the offence of failing to submit to a breath analysis, and carries the penalty of a fine and/or imprisonment, and a period of licence disqualification. Mr Ayache's submission was that a Clause 13(1)(a) offence should have a higher penalty in the interests of deterrence.
99. However the offence which initiated the pursuit of Mr Tran was one of disobeying a requirement to stop for a breath test. This is an offence pursuant to Clause 3(4) of Schedule 3. Like the Clause 16(1)(a) offence, it carries only a fine for a first offence.
100. Given the lack of clarity as to what is being proposed, I do not propose to make the recommendation.

### **Conclusion**

101. On behalf of everyone at the Coroner's Court, I offer sincere sympathy to Mr Tran's mother and sister for the loss of their son and brother.
102. I express my appreciation to Counsel Assisting Ms Justine Hopper and to the Crown Solicitor's Office for their excellent assistance throughout the inquest. I also thank the legal representatives of the many interested parties in this case. My thanks also to the Officer in Charge Detective Sergeant Inspector Brad Element for compiling a most comprehensive brief of evidence.

### **Findings required by s81(1)**

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I make the following findings.

#### **Identity**

The person who died is Andrew Ngo.

#### **Date of death**

Andrew Ngo died on 9 December 2017.

#### **Place of death**

Andrew Ngo died at Nepean Hospital, Penrith NSW 2750

#### **Cause of death**

Andrew Ngo died as a result of multiple injuries, with a significant contributing condition of multidrug toxicity.

#### **Manner of death**

Andrew Ngo received unsurvivable injuries when the car he was driving collided with a tree following a police pursuit.

### **Recommendations pursuant to section 82 of the Act**

That the NSW Commissioner of Police consider:

1. Amending the wording of the NSW Police Force's Safe Driving Policy at dot point 4 of Part 7.5.1, to correspond with the wording of dot point 4 of Part 6.4, such that pursuing police officers [REDACTED]
2. Incorporating in the Safe Driving Policy's Part 6 'Urgent Duty' and Part 7 'Pursuits', similar provisions to those in Parts 3.9 and 3.10 of the AFP National Guideline on Urgent Duty and Pursuits.

I close this inquest.

**Magistrate E Ryan**

Deputy State Coroner

**Date** 28 January 2020