



**CORONERS COURT  
OF NEW SOUTH WALES**

<b>Inquest:</b>	Inquest into the death of Ryan Auton
<b>Hearing dates:</b>	19-20 March 2019
<b>Date of findings:</b>	30 April 2019
<b>Place of findings:</b>	State Coroners Court, Lidcombe
<b>Findings of:</b>	Acting State Coroner, Magistrate Teresa O'Sullivan
<b>Catchwords:</b>	CORONERS – manner of death – NSW Police Safe Driving Policy, whether police pursuit or urgent duty occurred, reasonableness of actions of police officer, collision at intersection
<b>File number:</b>	2017/76874
<b>Representation:</b>	Dr P Dwyer, Counsel Assisting, instructed by Mr D Yang (Crown Solicitor's Office) Mr B Haverfield for Senior Constable Wright, instructed by Mr J Francis (Walter Madden Jenkins) Mr R Hood for the NSW Commissioner of Police, instructed by Ms A Wooldridge (NSW Police Office of the General Counsel)

<b>Findings:</b>	<p><b><i>The identity of the deceased</i></b> The deceased person was Ryan John Auton.</p> <p><b><i>Date of death</i></b> Ryan died on 10 March 2017.</p> <p><b><i>Place of death</i></b> Ryan died at Londonderry in New South Wales.</p> <p><b><i>Cause of death</i></b> The death was caused by multiple blunt force injuries.</p> <p><b><i>Manner of death</i></b> Ryan died after a vehicle he was driving, which was being followed by a police car, went through an intersection against a stop sign and collided with a bus that had right of way. The resultant collision caused Ryan to suffer multiple blunt force injuries, that were not survivable.</p>
<b>Recommendations:</b>	<p><b>To the Commissioner of Police, NSW Police Force:</b></p> <ol style="list-style-type: none"><li>1) That that the NSW Police Force should ensure that police officers receive appropriate instruction prior to the release of the revised Safe Driving Policy by whatever delivery education method is deemed most effective, taking into account the view of police officers themselves as to what they find most beneficial.</li><li>2) That the NSW Police Force give consideration to how police officers involved in a critical incident that results in a death can be advised of any breach of the Safe Diving Policy and offered remedial training, in a timely period after the incident.</li></ol>

**Non-Publication  
Orders s.74(1)(b)  
Coroners Act**

1. With reference to **Exhibit 1**, that there be no publication of the following, including as referred to in the oral evidence:

- Statement of Detective Sergeant Kylie Evans dated 14 September 2017 (tab 5):
  - Page 64, paragraph 346, last 3 words of line 3
  - Page 104, paragraph 546, line three, word 1 until the end of the paragraph on line 7
  - Page 105, paragraph 547, line 3, words 6 – 14, inclusive
  - Page 105, paragraph 551, all five dot points after the word “following” on line 2
  - Page 106, paragraph 553, line 2, word 4 until the end of the sentence on line 3
- ERISP transcript of Senior Constable Robert Wright dated 10 March 2017 (tab 20):
  - Page 9, answer to question 52, line 2, words 7-11 until end of line 5, inclusive
  - Page 10, first question 60 and answer, second question 60 and answer
  - Page 10, question 61 and answer
  - Page 10, answer to question 62
  - Page 10, question 65 and answer
  - Page 24, answer to question 222, line 2, word 10 until the end of the answer on line 4
  - Page 24, answer to question 223
  - Page 24, question 224 and answer words 1 – 3
  - Page 24, question 225, word 3 until the end of the question
  - Page 24, answer to question 225
  - Page 24, answer to question 226
  - Page 24, answer to question 227
  - Page 24, question 229 and answer
  - Page 24, answer to question 230
  - Page 28, question 271
  - Page 38, question 388, line 1, word 11 until the end of the question on line 3
  - Page 38, answer to question 393
  - Page 38, answer to question 394
  - Page 39, answer to question 396 until the answer to question 399, inclusive
  - Page 39, answer to question 400, word 13

- “Review in relation to motor vehicle fatality on 10 March 2017” prepared by A/ Senior Sergeant Kris Cooper (Tab 108)
  - Page 2, Paragraph 18, line 5, word 16 until the end of the paragraph on line 7
  - Pages 2-3, Paragraph 24, line 2, word 1 until the end of the paragraph on line 8
  - on page 3
  - Page 3, Paragraph 26, line two, word 19 until word 20 on line 4
- NSWPF Safe Driving Policy Version 8.2 (Tab 106)
  - Page ii, “Vehicle categories”, lines 1 – 5
  - Page iii, line 1
  - Pages 18-19, Paragraphs 5-1-4 to 5-1-8
  - Page 19, In paragraph 5-4-2 – line 2 from the word “the” up to and including the word “riding”
  - Page 19, Paragraph 5-4-4
  - Page 20, Paragraphs 6-2-4 and 6-2-6
  - Page 20, In paragraph 6-3, all the words in dot point 3
  - Page 22, In paragraph 7-1-4 – line 3, from the second word “A” until the end of line 4
  - Page 22, Paragraphs 7-1-5 and 7-1-6
  - Page 22, Paragraph 7-2-2
  - Page 23, Paragraphs 7-2-4, 7-2-8, 7-2-10 and 7-2-13
  - Page 23, Paragraphs 7-4-1 and 7-4-2
  - Page 24-25, In paragraph 7-5-1 “Drivers and Escorts”, subsections (e) & (j) and dot points 4 –11 inclusive and dot point 15.
  - Page 28, Paragraphs 7-6-2, 7-6-3, 7-6-5, 7-6-6, 7-6-7, 7-6-8 and 7-6-9
  - Page 30, Paragraph 8-2 “Code Blue” – all the words in dot point 3
  - Page 30, Paragraph 8-3 “Code Red” – all words in dot points three and four
  - Page 30, Paragraph 8-5-1
  - Page 31, Paragraph 8-6-2
  - Page 34, Definition of “re-initiation”, second and third paragraphs of definition
  - Page 34, Definition of “terminate”, all the words from “A pursuit is not” to the end of the page
  - Page 37, Eleventh line under “C”

- Pages 39 – 40, Re Duty Officer / Supervisor Pursuit Debrief Form:
- All references to Category 1, 2, 3 or 4 vehicles;
  - “Police Vehicle and Occupant Details” - all material contained in the shaded box on the right hand side of the document, except Paragraphs 1 and 5;
  - “Supervisor Details” – Paragraph 2 of the material contained in the shaded box on the right hand side of the document;
  - “Road Spikes” - Paragraph 1 of the material contained in the shaded box on the right hand side of the document.
- NSWPF Safe Driving Policy Version 8.3 (Tab 107)
  - Page ii, “Vehicle categories”, lines 1 – 5
  - Page iii, Line 1
  - Pages 18-19, Paragraphs 5-1-4 to 5-1-8 up to and including the end of the first full paragraph after the last dot point
  - Page 19, In paragraph 5-4-2 – line 2 from the word “the” up to and including the word “riding”
  - Page 19, Paragraph 5-4-4
  - Page 21, Paragraphs 6-2-4 and 6-2-6
  - Page 21, In paragraph 6-3, all the words in dot point 3
  - Page 23, In paragraph 7-1-4 – line 3, from the second word “A” until the end of line 4
  - Page 23, Paragraphs 7-1-5 and 7-1-6
  - Page 23, Paragraph 7-2-2
  - Page 24, Paragraphs 7-2-4, 7-2-8, 7-2-10 and 7-2-13
  - Page 24, Paragraphs 7-4-1 and 7-4-2
  - Page 25-26, In paragraph 7-5-1 “Drivers and Escorts”, subsections (e) & (j) and dot points 4 –11 inclusive and dot point 15
  - Page 29, Paragraphs 7-6-2, 7-6-3, 7-6-5, 7-6-6, 7-6-7, 7-6-8 and 7-6-9
  - Page 31, Paragraph 8-2 “Code Blue” – all the words in dot point 3
  - Page 31, Paragraph 8-3 “Code Red” – all words in dot points three and four

	<ul style="list-style-type: none"> <li>○ Page 31, Paragraph 8-5-1</li> <li>○ Page 32, Paragraph 8-6-2</li> <li>○ Page 35, Definition of “re-initiation”, second and third paragraphs of definition</li> <li>○ Page 35, Definition of “terminate”, all the words from “A pursuit is not” to the end of the page</li> <li>○ Page 38, Eleventh line under “C”</li> <li>○ Pages 40 – 41 Re Duty Officer / Supervisor Pursuit Debrief Form: <ul style="list-style-type: none"> <li>▪ All references to Category 1, 2, 3 or 4 vehicles;</li> <li>▪ “Police Vehicle and Occupant Details” - all material contained in the shaded box on the right hand side of the document, except Paragraph 1 and 5;</li> <li>▪ “Supervisor Details” – Paragraph 2 of the material contained in the shaded box on the right hand side of the document;</li> <li>▪ “Road Spikes” - Paragraph 1 of the material contained in the shaded box on the right hand side of the document.</li> </ul> </li> </ul>
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*The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

*These are the findings of an inquest into the death of Ryan John Auton.*

## **Introduction:**

1. Ryan John Auton was only 18 years old when he died on 10 March 2017 as a result of multiple blunt force injuries sustained in a collision between the Nissan Skyline he was driving and a large school bus carrying primary school children.
2. Shortly after 7am on the morning of 10 March 2017, Ryan's mother, Tracey Auton, woke him up and cooked him breakfast, reminding him that he was running late for TAFE, which started at 8am. Ryan left his home at Yellow Rock at around 7.20am in his silver coloured Nissan Skyline, and dropped his girlfriend off at Springwood Railway Station 10 minutes later, before heading on to TAFE in Richmond.
3. That morning, Senior Constable Robert Wright, attached to Traffic and Highway Patrol Command, was working in the Hawkesbury Police Area Command and was performing stationary speed enforcement duties in an unmarked Highway Patrol vehicle parked 1.5 kilometres towards Agnes Banks on the Driftway at Londonderry.
4. At about 7.57am, Senior Constable Wright identified the Nissan Skyline driven by Ryan travelling East at 108 km/h in an 80 km/h zone, and he pulled out from the curb and commenced to follow behind. Senior Constable Wright did not activate lights and sirens, but sped up significantly to try to close the gap between him and the Nissan Skyline, so that he could affect a traffic stop.
5. Only 26 seconds after Senior Constable Wright had pulled away from the curb to commence following the Nissan Skyline, Ryan drove his car through the intersection against a stop sign, and collided with a school bus travelling north on Londonderry road. The bus, which had right of way, entered the intersection before the Nissan and the front of the bus was almost clear of the intersection when the front of the Nissan collided heavily with the rear door area of the bus.
6. Ryan suffered major injuries and despite the assistance of emergency services, he did not survive them. The medical cause of Ryan's death was massive blunt force injuries sustained in the collision. Although a number of the children on the bus suffered physical injuries, mercifully none of them were seriously hurt.
7. Ryan lived with his parents and younger sister at Yellow Rock. I read the transcript of interviews between Police and Ryan's parents, Tracey and Colin Auton, and his girlfriend. It is clear that Ryan was very much loved and will be

dearly missed. I learnt of a young man who was full of promise, who was very close to his family, girlfriend and friends.

8. Ryan attended Ellison Public School at Springwood and then Winmalee High School. He obtained an apprenticeship at Marsupial Landscape Management and then Citywide Landscape Australia and he attended TAFE once a week to learn landscaping and horticulture.
9. Ryan loved cars and was very excited to purchase a Nissan Skyline, which his father described as his “dream car”. He was a competent and confident driver, but his father was forever telling him to slow down. There were no drugs or alcohol in Ryan’s system at the time of the crash and he was fully licensed, so it is speed that is the significant causative factor in the crash. It is an absolute tragedy that this young, vibrant man, who was just beginning his journey in life and was so full of promise and love, has died.

## **The Inquest:**

10. In the circumstances of Ryan’s death, an inquest is mandatory pursuant to s. 23(c) and s. 27(1)(b) of the *Coroner’s Act*, which at the relevant time required an inquest to be held where a person has died “as a result of, or in the course of, a police operation”.
11. Having a public inquest is particularly important when someone dies in a situation where the police are involved. First, opening the circumstances up to public scrutiny can be an important safeguard for the community against the misuse of police powers. Second, it is an opportunity to reassure the community that police are subject to scrutiny. Third, it can foster confidence in police officers themselves, the NSW Police Force as an institution and the strength of the rules that govern their behaviour.
12. Section 81 requires this Court to make a finding as to the identity, date and place of a person’s death and the cause and manner of their death. Cause refers to the physical cause of death. Manner refers to the circumstances leading up to and surrounding the death. Section 82 of the Act empowers the Court to make any recommendations that are considered “necessary or desirable” in relation to Ryan’s death.
13. There is no issue in this inquest in relation to Ryan’s identity, the time of his death, the place and date, or the medical cause of death. The real issue concerns the manner of Ryan’s death, or in other words, the circumstances



leading up to the collision that ended his life and the appropriateness of the actions of a police officer attempting to fulfil his traffic enforcement duties.

## **The Evidence:**

### ***Lead up to the accident***

14. At about 7.57am, Senior Constable Wright, who is attached to Traffic and Highway Patrol Command, was working in the Hawkesbury Police Area Command and was performing stationary speed enforcement duties in an unmarked Highway Patrol vehicle parked 1.5 kilometres towards Agnes Banks on the Driftway at Londonderry. The police vehicle was parked and facing in an easterly direction allowing traffic to be monitored in both directions.
15. Senior Constable Wright had been in place for a few minutes when he noticed a silver Nissan Skyline moving east that he thought was clearly exceeding the 80 km/h speed limit. He released a radar beam and locked the radar on the Nissan Skyline at 108 km/h. As a result, Senior Constable Wright moved off from his position on the curb and followed the Nissan.
16. Senior Constable Wright was the sole occupant of the police car and he had been trained to engage in high speed and urgent driving duties. He gave evidence that he did not activate the lights and sirens on his patrol car, but sped up significantly to try to close the gap between him and the Nissan Skyline, so that he could affect a traffic stop.
17. I had the benefit of objective evidence in the form of an in-car video (“ICV”) in the police vehicle driven by Senior Constable Wright. The footage depicts Senior Constable Wright pulling away from the northern shoulder of the Driftway into light traffic. The police vehicle is recorded on the ICV passing two civilian vehicles, the first at 139km/h, and the second at 173km/h. The highest speed reached by Senior Constable Wright was 192 km/h, but that speed was sustained momentarily before Senior Constable Wright began to slow down on his approach to the intersection.
18. The ICV shows that at a distance of approximately 200 metres from the intersection, Senior Constable Wright’s vehicle passed over the ‘stop sign ahead’ markings on the road surface and was reducing speed, but he was still travelling at 179km/h in the lead up to the collision. He had not caught up to Ryan’s car, which was speeding into the intersection. From the time Senior Constable Wright began to pull away from his stationary position at 7.57.05, to

the time the bus moved through the intersection at 7.57.31 is only 26 seconds. That was a very short period of time to make any decisions.

### ***The Fatal Incident:***

19. As the Nissan Skyline driven by Ryan was travelling east on the Driftway, a school bus driven by Mr Satendra Sharndill was travelling north on Londonderry road. Although Ryan faced a stop sign as he approached the intersection, he made no attempt to slow down his Nissan and continued at speed, with the intention of driving east on the Driftway. The bus, which had right of way, entered the intersection before the Nissan and the front of the bus was almost clear of the intersection when the front of the Nissan collided heavily with the rear door area of the bus. Mr Sharndill did not see the Nissan before the accident.
20. As a result of the collision, Ryan suffered major injuries and despite the assistance of emergency service, he did not survive. There were fifteen school students on board the bus, five of whom suffered injuries, but none of them major. The bus driver, who was heroic in his actions to make sure children were brought to safety, was in shock, but not physically harmed.
21. The intersection between Driftway and Londonderry road is located in the rural area of Londonderry. Both roads are single lane bitumen roads with painted line markings and are straight and flat for 1 to 1.5 kilometres before and after the intersection. They are sign posted as 80km/h. Londonderry Road is situated north south, while the Driftway is situated east west. As I have indicated above, drivers on Londonderry Road have the right of way at the intersection, whilst the Driftway is controlled by stop signs and stop line markings.
22. Constable Gabrielle Drummond, attached to the Metropolitan Crash Investigation Unit, examined the scene on the date of the collision, including the debris and road marks. She provided an expert opinion that the absence of tyre marks leading up to the collision indicates that the drivers of both the bus and the Nissan did not attempt to brake before the collision.
23. A detailed report was provided by Crime Scene Officer Simon Parker, a member of the Forensic Services Group, Collision Reconstruction. He found that the Holden Commodore driven by Senior Constable Wright was travelling approximately 184 km/hr and the Nissan Skyline was travelling approximately 164 km/h along the Driftway, approximately 250 metres prior to the intersection with Londonderry road. This expert opinion was based on the

CCTV provided by a resident of the Londonderry area. Crime Scene Officer Parker calculated the impact speed of the Nissan into the side of the bus as being between approximately 139 to 150 km/h, based on the dash camera footage supplied by the driver of a car in the area, who was a former serving police officer.

24. Crime Scene Officer Parker summarised the collision as:

*A catastrophic t-bone style collision resulting from the Nissan failing to stop at the stop sign and colliding with the central portion of the near side of the bus. The collision caused the bus to rotate anti-clockwise, travelling into the path of oncoming traffic before it started to rotate in a clockwise direction coming to rest 70 metres from the impact location at approximately 90 degrees across the road surface blocking both traffic directions.*

25. It will be obvious from what I have said about the bus driver having right of way, and not seeing the Nissan Skyline before the collision, that his driving could not be faulted. At the time of the collision, Ryan held a provisional P2 license and the Nissan he was driving was fully registered. Toxicology reports show that Ryan did not have any drugs or alcohol in his system at the time of driving. It appears to be his speed and inattention that resulted in the accident. That is not meant as any personal criticism of Ryan, but this terrible accident is a reminder of what a deadly combination cars and speed are, and how important it is for young, inexperienced drivers to learn that lesson.

### ***Autopsy Report***

26. Dr Kendall Bailey performed an autopsy and her report is in evidence. Dr Bailey found that Ryan died as a result of multiple blunt force injuries.

### ***Appropriateness of the actions of Police***

27. Senior Constable Wright gave evidence that he was intending to catch up to Ryan to try to stop him to speak to him about exceeding the speed limit. He explained that he did not activate the lights and sirens because “[b]asically I wanted to try to catch up to him, get him into a position to stop him, before I activated the lights, basically not to sort of spook him”. Senior Constable Wright gave evidence that he tends to get himself set up into a position to stop the driver before activating lights and sirens.

28. An issue arose in this inquest as to the appropriateness of the actions of Senior Constable Wright, and whether they were in accordance with the Safe

Driving Policy, which governs and guides the actions of police on our public roads. The Court had the benefit of an expert report prepared by Acting Senior Sergeant Kris Cooper of the Traffic Policy Section, Traffic and Highway Command. Acting Senior Sergeant Cooper reviewed the available brief material, attended each day of Court and provided valuable written and oral evidence.

29. In particular, my attention was drawn to sections of the Safe Driving Policy which cover what police can and should do when they are involved in “pursuits”, or in another category of driving referred to as “urgent duty”.

30. The definition of pursuit includes the following:

7-1        PURSUIT: A pursuit, regardless of speed, commenced at the time you decide to pursue a vehicle that has ignored a direction to stop.

....

31. I accept the evidence of Acting Senior Sergeant Cooper that Senior Constable Wright was not engaged in a “pursuit” for the purposes of the Safe Driver Policy. Since Senior Constable Wright did not get the opportunity to give Ryan a direction to stop, he was unable to form any view that such a direction had been ignored and the definition of pursuit is not satisfied.

32. Even when not engaged in a pursuit, a police vehicle can travel excessive speed in order to execute a traffic stop or to close the distance to a vehicle. That is a type of “Urgent duty”, which is defined in part 6-2-1 of the Safe Driving Policy as “Duty which has become pressing or demanding prompt action”.

33. Ordinarily a police officer engaged in urgent duty must activate warning devices on their vehicle and notify the VKG radio. There is, however, an exception to that requirement in certain circumstances if the Police officer is engaging in a traffic stop, takes reasonable care and it is reasonable in the circumstances not to activate warning devices.

34. Part 8-6 of the Safe Driver Policy deals with traffic stops. It provides as follows:

It is permissible for police to perform traffic stops ... or reduce the distance to an offending vehicle without informing VKG of a response code or activating warning devices. However police must take reasonable care and it must be reasonable that warning devices are not used.

35. After reviewing the circumstances of this incident, Acting Senior Sergeant Cooper expressed the opinion that Senior Constable Wright's actions in attempting a traffic stop and closing the distance without the use of warning devices was not reasonable in the circumstances and therefore not in compliance with the Safe Driving Policy. This was because the reasonableness of his actions had to be considered in the totality of the circumstances. The Driftway and its intersection with Londonderry Road is a cross section where vehicles come into conflict. In the absence of warning devices or markings there was nothing on or about the police vehicle to provide any advance warning to other vehicles on the road of its speed or actions whilst approaching the intersection. Acting Senior Sergeant Cooper did not alter his view during cross examination by Counsel for Senior Constable Wright.
36. On the other hand, Senior Constable Wright gave evidence as to why he considered that his actions were reasonable. He stated that, consistent with the footage in the ICV, at all times he was following the Nissan Skyline he was in full control of his vehicle. Senior Constable Wright thought he was in full compliance with the Safe Driving Policy and he made a calculated and reasoned decision to attempt to close the distance. For example, he gave evidence that the reason he could pass each car in front of him safely was the distance between them. It was also the view of the Officer in Charge of the investigation into Ryan's death, Detective Sergeant Kylie Evans, that Senior Constable Wright had executed his duties in adherence to the Safe Driving Policy regarding traffic stops.
37. Senior Constable Wright did not believe that Ryan had seen him pull out from the curb or commence following behind him. That was based on a number of factors, including first, that it took him a number of seconds to pull out from the curb and he had to let two vehicles pass in front before he could commence following Ryan. Second, his Highway patrol vehicle is unmarked, and was not displaying warning lights or sirens. Although members of the public might recognise an unmarked patrol car parked stationary as a police car, Ryan was travelling in front of the car and there was nothing to reveal it as a police car. Third, drivers tend to hit the brakes if they do recognise it, and that is not what Ryan did. In his police interview, Senior Constable Wright estimated being 100-130 metres behind the Nissan after he turned the car around to follow it and that he was about 100 metres from the site at the time of the collision. In oral evidence, he corrected that and said that he thought he was more likely to be 200 metres behind at the time of the collision.
38. I accept that it is possible that Ryan did not see Constable Wright's vehicle parked stationary as he sped past it at 108km/h and he may not have recognised it as a police vehicle. It is possible that he may not have known

that he was being followed at any time leading up to the collision. On the other hand, it is clear that Ryan's vehicle sped up considerably after he was followed by Senior Constable Wright. The highest speed reached by Ryan was approximately 164km/h when he was approximately 250m before the intersection. Even travelling at up to 192km/h, Senior Constable Wright was unable to catch up to Ryan. It is feasible that Ryan recognised the unmarked highway patrol vehicle as a Police sedan and then saw it momentarily in his rear view mirror, or at least was worried that it would pursue him for doing the wrong thing.

39. Ultimately, I am unable to determine whether or not Ryan knew that he was being followed by a Police officer shortly before his collision, and it is not necessary for me to do so for the purposes of determining manner of death, or the appropriateness of the police actions. I accept the evidence of Senior Constable Wright that for the 26 seconds he was following Ryan, he did not believe that he had been seen.
40. Senior Constable Wright is a very experienced officer who attested in 1996 and has been in highway patrol for 20 years, since 1999. He has been engaged in countless urgent duty incidents and had never been involved in a fatality. I had the benefit of both a detailed police interview that Senior Constable Wright participated in on the day of the accident, and his oral evidence. I found Senior Constable Wright to be a credible and honest witness, who was doing his best to assist the Court to understand his actions. The evidence he gave in Court was sincere and thoughtful.
41. Although the Safe Driving Policy is there for the guidance of police officers, inevitably it allows for the individual officer/s to exercise considerable discretion when they make decisions, often under considerable pressure and with very little time to second guess their actions. I am satisfied that at the time he was closing the gap with Ryan's Nissan Skyline, Senior Constable Wright was attempting to comply with the Policy and to fulfil his duties in professional manner.
42. On careful reflection, I agree with Acting Senior Sergeant Cooper that there has been a breach of the Safe Driving Policy, because it was not reasonable in all circumstances for Senior Constable Wright to close the gap with the Nissan Skyline without activating the warning devices of his highway patrol vehicle. In coming to that conclusion, I rely on the written and oral evidence of Acting Senior Sergeant Cooper and take into account the speeds reached by Senior Constable Wright over the 26 seconds, the fact he was approaching an intersection and the number of other cars on the road. However, I also agree with Acting Senior Sergeant Cooper that this breach was not causative of the accident. For the reasons outlined above, I do not suggest that Senior

Constable Wright should be subject to any personal criticism and I commend him for his credibility and openness when giving evidence and his years of service.

### ***Safety issues at the Causeway intersection***

43. I was grateful to receive information as to the state of the intersection and the efforts made immediately prior to Ryan's death to upgrade the safety features. Since there has already been significant work done in that regard, it is not necessary for me to make further recommendations relating to this.
44. Since the Driftway and its intersection with Londonderry Road is a place where vehicles have previously been the subject of serious collisions, an investigation commissioned by Hawkesbury City Council led to advanced safety measures being implemented prior to Ryan's death. They included advanced stop warning signs, pavement markings and central medial islands and associated line markings.
45. A road safety nomination incorporating the installation of vehicle activated signs on both east and west approaches to the Driftway was proposed, and that strategy was implemented in the afternoon of 9 March 2017, a day before Ryan's death. After Ryan's accident a further investigation was undertaken to determine whether there were any further safety measures required. I received a statement from Mr Manjur Rahmen, the Network Development Leader employed by the Roads and Maritime Services ("RMS") as well as a statement from Christopher Amit, the Manager of Design and Mapping Services at the Hawkesbury City Council, and they are satisfied that no further action has is appropriate or necessary.

### ***Recommendations***

46. During the course of the inquest, it became clear that there is still some ambiguity in the way in which sections of the Safe Driving Policy are interpreted by police officers charged with the duty of implementing it in real life situations. One example was that Senior Constable Wright did not realise that Part 8-6 of the Safe Driving Policy dealing with traffic stops, should be read as being subject to Part 6, the urgent duty provisions. It appears from the questioning of Senior Constable Wright by his own Counsel, that this was a surprise to him and not consistent with how he thought the Policy should be read.

47. Further, Senior Constable Wright had a different view of what was reasonable with respect to the use of warning devices for a traffic stop, than did Acting Senior Sergeant Cooper, although both had sound reasons for their opinions. Police officers will always have to have some measure of discretion in interpreting the Safe Driving Policy, but the Policy and instruction should be as clear as possible. Otherwise, even the most professional and conscientious Police officers are left open to making genuine mistakes which they are later held accountable for.
48. I understand that the Safe Driving Policy is to be amended by the NSW Police Force soon and a revised version will be in place, although the exact timing is not known. I expect that the revisions will take into account the findings at numerous coronial inquests, as well as the expertise available to Police from their own officers.
49. To this end, at the end of the oral evidence Counsel Assisting suggested a number of recommendations that the NSW Police Force has had an opportunity to consider, and I received a written response to the original draft distributed. I have taken into account the submissions made on behalf of the NSW Police Force and have modified the original draft of these recommendations. I acknowledge the expertise of the NSW Police Force to help design the best solutions to the challenges that arise from the interpretation and implementation of the Safe Driving Policy.

## **Findings required by s. 81(1)**

50. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

### ***The identity of the deceased***

The deceased person was Ryan John Auton.

### ***Date of death***

Ryan died on 10 March 2017.

### ***Place of death***

Ryan died at Londonderry in New South Wales.

### ***Cause of death***

The death was caused by multiple blunt force injuries.



### ***Manner of death***

Ryan died after a vehicle he was driving, which was being followed by a police car, went through an intersection against a stop sign and collided with a bus that had right of way. The resultant collision caused Ryan to suffer multiple blunt force injuries, that were not survivable.

### ***Recommendations***

51. To the Commissioner of Police, NSW Police Force:

- 1) That that the NSW Police Force should ensure that police officers receive appropriate instruction prior to the release of the revised Safe Driving Policy by whatever delivery education method is deemed most effective, taking into account the view of police officers themselves as to what they find most beneficial.
- 2) That the NSW Police Force give consideration to how police officers involved in a critical incident that results in a death can be advised of any breach of the Safe Diving Policy and offered remedial training, in a timely period after the incident.

### ***Concluding remarks***

52. I express my sincere sympathies to the family and friends of Ryan Auton for the loss of their much loved son.

53. I thank the Officer in Charge of this inquest, Detective Sergeant Kylie Evans, for the excellent job that she did to prepare this brief and present the evidence at inquest.

54. I thank my Counsel Assisting, Dr Peggy Dwyer and her instructing solicitor, Mr David Yang from the Crown Solicitor's Office, for the enormous amount of work they put into assisting me in this inquest.

I close this inquest.

Teresa O'Sullivan  
**A/State Coroner**  
**Date 30 April 2019**