



STATE CORONER'S COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dylan Thomas Maher
Hearing dates:	12-13 October 2015
Date of findings:	23 November 2015
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	Coronial Law, Police Pursuit, Safe Driving Policy
File number:	2014/192992
Representation:	<p>Mr Peter Aitken – Counsel assisting, instructed by Anders Mykkeltvedt of the Crown Solicitor's Office</p> <p>Mr David Porter – Solicitor, Redfern Legal Centre - for the Maher family</p> <p>Mr Raymond Hood instructed by Detective Chief Inspector Michael Nibbs of the Office of General Counsel, for the Commissioner of Police and the NSW Police Force</p>
Findings:	<p>On the balance of probabilities, I find that</p> <ul style="list-style-type: none">• Dylan Maher died at approximately 3.21pm on 27 June 2014 on the roadside of Northcliff Drive, Berkley, NSW• The cause of Dylan's death was multiple injuries

sustained as a result of the collision of the car he was driving with a power pole and from being ejected from that vehicle.

- The manner of Dylan's death was as a result of crashing during a police pursuit.

Non Publication Orders

- **A non publication order is made pursuant to section 74 (1) of the *Coroners Act 2009 (NSW)* relating to aspects of the Safe Driving Policy of the NSW Police Force – Exhibit 2**

Specifically the following material

New South Wales Police Force's "Safe Driving Policy"
(version 7.2)

Page 22

Page 24 "Responding to Urgent Duty" dot points 3&4

Page 25 From "Re-initiation" onwards

Page 26 "Pursuit Guidelines" numbers 2,4,6 and 9

Page 27 "Vehicle categorisation for Pursuits" dot points 1&2, "Pursuit response (1) Drivers and Escorts" dot point 2 (e) and dot point 4.

Page 28 dot points 1,2,3,4 and 8

Page 31 "Termination of Pursuits", dot points 1-9 inclusive

- **A non publication order is made in relation to the Statement of Sergeant Kris Cooper – Exhibit 6**

Specifically the following material

Quotes from the SDP found at paragraphs 33,34,40.

- **A non publication order is made in relation to the evidence given by Sergeant Cooper on 13/6/15 relating to the above matters.**
- **A corresponding non publication order is made in relation to the evidence given by other officers touching on specific aspects of the SDP referred to above.**

**THIS DECISION HAS BEEN PREPARED WITHOUT THE BENEFIT OF A
TRANSCRIPT.**

IN THE STATE CORONER'S COURT
GLEBE
NSW
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

1. This inquest concerns the death of Dylan Thomas Maher.

Introduction

2. Dylan was a 25 year old man living in the Illawarra region of NSW. He was well loved by his close family and community. He was described as a kind and generous uncle and loving son. He was outgoing and had many friends.¹
3. At the time of his death, Dylan had a substance abuse issue and was known to use ice and cannabis.²

The role of the Coroner and scope of the inquest.

4. The role of the Coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The Coroner is also to address issues concerning the manner and cause of the person's death.³ In addition, the Coroner may make recommendations in relation to matters that have the capacity to improve public health and safety.⁴

¹ Statement of Stevie McPhee, Exhibit 1 Tab 97

² Statement of Stevie McPhee, Exhibit 1, Tab 97

³ Section 81 *Coroners Act 2009* (NSW)

⁴ Section 82 *Coroners Act 2009* (NSW)

5. In this case there is no dispute in relation to the identity, time and place of death or in relation to the medical cause of death. The inquest focussed on the tragic manner of Dylan's death and to questions about whether his death could have been avoided.
6. Dylan died during a police pursuit and for this reason the inquest has been conducted by a senior coroner, pursuant to the *Coroners Act 2009* ("the Act").⁵ It has been observed that

"The purposes of a s 23 Inquest are to fully examine the circumstances of any death in which police...have been involved, in order that the public, the relatives and the relevant agency can become aware of those circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers...will be thoroughly reviewed. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s 82."⁶

7. In recent times the complex issues surrounding police pursuits have been widely debated in public and have been the subject of significant research and investigation throughout many parts of the world. A number of the issues as they relate to NSW have previously been examined extensively in this Court.⁷ The issues clearly have a wide public interest. The question of whether or in what circumstances police should pursue a vehicle is a complex one and one that has been approached differently in various jurisdictions. There are no obvious or easy answers and reasonable people may differ on the correct approach to take. Ultimately it involves a careful balance between interests that at times conflict – the need to ensure the road safety of all citizens and the need for consistent law enforcement. Providing police with sound guidance in the operation of their discretion to pursue becomes a difficult but necessary task,

⁵ Section 23 *Coroners Act 2009* (NSW)

⁶ Waller's *Coronial Law and Practice in New South Wales*, 4th edition (2010) paragraph 23.7, page 106.

⁷ See in particular Deputy State Coroner Dillon's findings in the Inquest into the death of Hamish Raj (7 April 2014) also findings in Inquest into the death of Aaron Magarry (18/9/15), Inquest into the death of Trent Lenthall (3/6/15), Inquest into the death of James Ciappara (16/1/15) Inquest into the death of William James Robson-Pearce (14/6/14) among others.

particularly because decisions to pursue are so often made quickly and in highly stressful circumstances.

8. Over the years, many in the community have been rightly concerned at the number of deaths arising from police pursuits. As the Commissioner of Police, Mr Andrew Scipione states in his foreword to the current Police Safe Driving Policy,

“the police motor vehicle, if used irresponsibly and inappropriately can result in it being the most deadly weapon in the police arsenal. Police do not have to keep going until told to terminate...Please be assured that any decision to terminate a pursuit, for your safety or others, will not result in criticism.”⁸

9. A list of issues relevant to Dylan’s death was circulated prior to the inquest commencing. The following questions were posed.

- Was the pursuit conducted in accordance with the NSW Police Force Safe Driving Policy (SDP)? In particular;
 - a) Was it reasonable to commence and continue the pursuit?
 - b) Did the conduct of the pursuit comply with the SDP (including the adequacy of the communication with police radio VKG)?
- Have any changes in the NSW Police Force practice or policy been instituted as a result of this incident or in response to recent coronial recommendations?
- Ought any recommendations be made pursuant to s 82 of the Coroners Act 2009?

10. The Inquest proceeded over two days. A large number of statements were tendered, as were photographs, maps of the area, expert reports, and audio and visual recordings. Oral evidence was also received, including from both officers involved in the pursuit.

⁸ Safe Driving Policy, p iv, Exhibit 2

Background

11. On 27 June 2014, Dylan Maher was driving a red Holden commodore (BH93JV) in the Berkley area. The car did not belong to Dylan and had been reported stolen on 13 June 2014 from a service station in Wollongong.
12. At around 3.20pm Senior Constable Mark Deans and Sergeant Shane Brown from Lake Illawarra Target Action Group were driving in a fully marked police vehicle on Winnima Way, Berkley when they saw the red Commodore. At that time the officers had no idea the vehicle was stolen and noticed it only because of the way it was being driven.
13. Senior Constable Mark Deans was driving, and Sergeant Shane Brown was in the passenger seat. Senior Constable Mark Deans activated the lights and sirens on the police vehicle in an attempt to signal the driver to pull over, instead, the red car drove off at speed. Policed then notified VKG that they were in pursuit. Almost immediately the Police vehicle struck traffic and the officers lost sight of the red car for a short time.
14. Just 72 seconds after the pursuit had been notified, Senior Constable Mark Deans told VKG that there had been an accident. The red car had hit a power pole on Northcliff Drive and the driver, later identified as Dylan Maher, had been ejected from the vehicle. He was unconscious. The ambulance and NSW Fire brigade attended. Dylan was treated at the scene, but did not recover and was later pronounced dead at Wollongong Hospital.

Identification

15. Dylan was identified at the scene that evening by his cousin, Alana Maher. Police also found that there were personal documents including his birth certificate on the roadway and inside the vehicle. Dylan's identity was later formally confirmed by fingerprints.

The Autopsy

16. On 28 June 2014, an autopsy was conducted by Dr Rebecca Irvine at The Department of Forensic Medicine, Glebe . Dylan was found to have multiple injuries as a result of the accident. The most serious of which included avulsion of the brain stem and multiple skull fractures. It was the Doctor's view that the brain stem injury was significant enough to have caused virtually immediate brain death. Dylan also had lung collapse, other multiple bodily fractures and lacerations to his kidney and liver, among other injuries.
17. Toxicological examination revealed the presence of methylamphetamine in a blood concentration that would be classed as within the lethal range. However, there is significant overlap between toxic and non-toxic concentrations and it appears from other evidence that Dylan was a regular user of the drug.⁹ He also tested positive to cannabinoids.
18. Expert opinion was obtained from Dr William Allender, of the NSW Police Force's Clinical Forensic Medicine Unit¹⁰ in relation to the likely impact of the observed drug levels on Dylan's capacity to control a motor vehicle. Given the high levels found in his blood, it was Dr Allender's view that at the time of driving Dylan would have been under the influence of methylamphetamine and cannabis "to the extent that his driving ability would have been substantially impaired".

The Investigation

19. After the collision there was an extensive police investigation into all aspects of Dylan's death. The death was quickly identified as a "critical incident"¹¹ and Detective Senior Sergeant Darren Kelly was tasked to take charge of the investigation. It appears that the relevant investigative protocols were correctly undertaken. Both officers involved were separated and drug and alcohol tested. They were directed and gave typed interviews within an appropriate time frame. Outside officers were brought in to assist and ensure independence. A substantial effort was made immediately and in the days following to

⁹ Statement of Stevie McPhee, Exhibit 1 Tab 97

¹⁰ Exhibit 1, Tab 53

¹¹ A "critical incident" pursuant to NSW Police Force "Critical Incident Guidelines"

locate independent witnesses to the collision and to the course of driving that preceded it. A canvass occurred in the local area and CCTV, where available, was obtained. The relevant police radio recordings were secured. The roadway and both vehicles were examined and tested. I am of the view that the investigation of this tragic incident was both thorough and properly conducted.

Dylan's manner of driving prior to the pursuit

20. Over forty independent witness statements were obtained in this matter. Taken together they assist the Court in understanding how the pursuit developed and how the collision occurred.
21. As one would expect, there was some individual variation in the statements and some conflicting details such as when or if the lights and sirens were turned on and in relation to the estimates of the exact speed each vehicle was travelling. However it is important to note that there is no suggestion in any statement that the police car was directly behind the vehicle Dylan was driving at the time of the crash or that it touched his car or forced it towards the pole. This is of course consistent with the forensic examination of the motor vehicles at the scene. It is also important to note that the weight of the evidence is that the vehicle Dylan was driving was going well above the speed limit and way too fast for the road conditions. An expert estimated that the vehicle Dylan was driving was travelling a minimum of 119.91 kilometres per hour around the time of the collision, substantially above the posted 70km/h limit.¹²
22. Two independent eye witnesses were also called to give oral evidence. Around 3.20pm on Friday 27 June 2014, Geoffrey Manksie¹³ and his partner Carly Dorahy¹⁴ were driving to a doctor's appointment at the Berkley Medical Centre. Carly was driving and they were both familiar with the area. As they drove towards the intersection of Parkway Avenue and Winnima Way they both noticed a red Commodore coming in the opposite direction towards them.

¹² Statement of Sergeant Burlin, Exhibit 1, Volume 1, Tab 9.

¹³ Statement of Geoffrey Manksie, Exhibit 1, Volume 2, Tab 68 and Evidence at Inquest 12/10/15

¹⁴ Statement of Carly Dorahy, Exhibit 1, Volume 2, Tab 69 and Evidence at Inquest 12/10/15

23. In his statement to police Mr Manskie stated that the driver of the red car “was driving along at a normal speed for the conditions at about 40 or 50 kilometres an hour but that quickly changed”. He noticed the police car behind the red vehicle and almost immediately “the red Commodore accelerated off towards Parkway Avenue at an erratic speed.” He observed the vehicle to be travelling fast and noticed that it did not slow down to give them right of way. He commented that if his partner had not slowed, there would have been a serious accident. Mr Manskie said he watched the red Commodore as it went down Parkway Avenue and he saw that the car moved onto the wrong side of the road, the driver was not wearing a seatbelt and it looked dangerous. In court he agreed the red car was driving in a reckless and foolhardy manner.
24. Ms Dorahy’s account was similar. She stated that she had to stop to avoid a collision with the red car. The red vehicle did not indicate and took the corner at around 80km an hour. She saw the car “fish tail” up Parkway Avenue. Ms Dorahy was worried about the real danger to pedestrians and remembered commenting to her partner “that guy is going to kill someone. Or himself”. She saw the police chase the red car. It was her view that the police were also travelling at speed but appeared to be “more in control”.
25. She gave strong oral evidence, she confirmed the red car was “going too fast”, it was “flying” and “erratic”. As she watched it go down Winnima Way, it was “fishtailing” and swerving. Ms Dorahy gave evidence of the police lights coming on and of the pursuit commencing. She was very concerned at how dangerous the situation was and thought the police officers acted appropriately in trying to stop the car.

What was the reason given for the commencement of the pursuit?

26. Both the driver of the police vehicle, Senior Constable Mark Deans and his passenger, Sergeant Shane Brown gave directed interviews on the evening of 27 June 2014 and gave oral evidence before me. Their evidence to the inquest was clear and forthright . In my view they were trying to assist the court by giving their honest recollection of events at all times. While it is possible their assessment of Dylan’s driving is affected to some degree with hindsight of the tragedy that unfolded, I am certainly satisfied, given the independent eye witness accounts, that police had sufficient cause to attempt to stop the red car when they did.

27. Senior Constable Mark Deans was an experienced police officer with silver certification as a police driver. He had previous experience of being involved in a variety of police pursuits. He was aware of the Safe Driving Policy and the factors he needed to consider when initiating a pursuit.
28. On 27 June 2015 Senior Constable Deans was driving a fully marked police vehicle on Winnima Way, when he noticed a white sedan come around the corner near the Berkley Sports and Social Club. Immediately afterwards he noticed a red coloured Commodore sedan come at speed around the same corner as the white vehicle. What raised his attention was "the speed it was doing and how close it was to the other car"¹⁵ At that time Sergeant Brown said to him "we'll have a look at that one". As they passed the red car the driver leaned down and it was Senior Constable Deans' view that he was trying to avoid being identified. The officer immediately conducted a u-turn with the intention of pulling the red car over for a breath test. Shortly afterwards Sergeant Brown told him to hit the sirens as "I think we are going to be in pursuit".
29. In his evidence to the inquest, Senior Constable Deans clarified that the red car was to be stopped for its speed, dangerous manner of driving and to conduct a breath test.¹⁶ He considered the offences serious, noting that the "drive in a manner dangerous" charge was "gaolable". He was unable to get a number plate and his vehicle was not fitted with a number plate recognition facility. He did not know the car was stolen and was not able to recognise the driver. Once the car had failed to stop he believed he was well within policy to pursue it.
30. Sergeant Brown was also an experienced police officer with silver certification. He gave evidence in similar terms. It was the manner and speed of the red vehicle that caught his attention. It was so close to the car in front, Sergeant Brown was of the view it could not have safely stopped had it needed to. It was Sergeant Brown's evidence that he called the pursuit halfway down Parkway Avenue. He was of the view that they had no other means of responding to what was obviously dangerous driving. Once the vehicle pulled away there was no chance to get the registration plates or any chance of identifying the driver.

¹⁵ Directed statement of Senior Constable Mark Deans, Exhibit 1, Tab14

¹⁶ Senior Constable Mark Deans, Evidence at Inquest 12/10/15

The course of the pursuit

- 31.** The Court received detailed evidence outlining the course of the pursuit.¹⁷ It was a short course of driving, and while it is somewhat hard to determine the exact moment the pursuit commenced, it can be safely estimated to have been less than 2 kilometres in total length. The pursuit commenced in or near a shopping precinct. Winnima Way is a built up area and has a speed limit of 50 km per hour. The road loops back on itself and is connected by Parkway Avenue. There is a pedestrian crossing where the cars would have travelled from Parkway Avenue south on Winnima Way towards Wilkinson Street. After several hundred metres Winnima Way merges into Wilkinson Street as the road bends to the left. There is a stop sign at the intersection of Wilkinson Street and Northcliff Drive.¹⁸
- 32.** The route the cars took continued east onto Northcliff Drive. The road at that point is a two lane sealed bitumen carriageway with a grass median. There is also a breakdown lane. At Venn Street there is a 40 kilometre per hour school zone sign that continues until the George Street intersection. This school zone, adjacent to the playground of Illawarra Sports High School was operational at the time of the pursuit. From the intersection at George Street a 70 kilometre per hour speed limit commences and the breakdown lane is merged. There remains a dual carriageway with a grass median and the road starts to veer to the right rising up to the crest of a hill. From Caroon Street there is a metal Armco railing that runs along the grass central strip.
- 33.** Prior to reaching the crest of the hill there is a slight dip in the road. At the crest the road bends to the left somewhat and narrows at the collision site.
- 34.** During the course of the pursuit, the police officers lost sight of the red vehicle due to other traffic on the road. It appears that as a result, Dylan Maher was able to gain some distance on the police. When the police vehicle crested the hill, the collision had already occurred. It appears that Dylan had lost control of the vehicle and collided heavily with a power pole. He was not wearing a seatbelt and was ejected from the vehicle onto the roadway.

¹⁷ See for example Exhibit 5, satellite map of the area and Exhibit 4, a street map of the area.

¹⁸ Statement of Detective Senior Sergeant Darren Kelly, Exhibit 1, Tab 8

35. Beyond the collision site, the road continues its downhill slope and travels through another school zone.

The Safe Driving Policy

36. The Safe Driving Policy¹⁹ (SDP) is a NSW Police Force internal policy document which guides police driving practice and strategies, including the conduct of high speed pursuits. The Traffic Services Branch is responsible for the policy, which is updated from time to time. The latest version (7.2) was published in November 2009, and has a stated review date of November 2010. A copy of that document was tendered. The Court was also greatly assisted by the evidence of Sergeant Kris Cooper who is the Senior Policy Advisor to the Assistant Commissioner for Traffic. He has responsibility for policy aspects in relation to the review of the SDP.
37. Since the last review of this policy, there have been significant changes to similar policies in other Australian jurisdictions and overseas. The Court was informed that Queensland, for example has greatly restricted the circumstances where pursuits are commenced.²⁰ There have also been a number of recommendations from NSW Coroners about the current operation of the policy in NSW.
38. Unfortunately, while it appears certain a substantial review of the policy has already occurred, the new document has not yet been released. Sergeant Kris Cooper, of the Traffic Policy Section²¹ gave evidence at the inquest, indicating that there were some substantial changes to the wording of the policy likely to emerge from the review process but given that the document was still with the Minister for Police, the proposed changes could not yet be revealed. It was even suggested that further Coronial recommendations in relation to the SDP might slow the process for the release of the new policy. Given this evidence it certainly appears to be a task of no lasting benefit to embark on a detailed critique of a policy that is, in effect, already surpassed. Nevertheless it is necessary to consider the policy at least in general terms.

¹⁹ Safe Driving Policy, NSW Police Force. Exhibit 2

²⁰ Evidence of Sergeant Kris Cooper at Inquest 13/10/15

²¹ Statement of Sergeant Kris Cooper, Exhibit 6 and Evidence at Inquest 13/10/15

Part 6 of the SDP deals with 'Urgent Duty and Pursuits'.

[REDACTED]

40. Deciding to initiate a pursuit is an inherently difficult balancing exercise

[REDACTED]

I am of the view that the policy issues raised in this regard have been well ventilated in Deputy State Coroner Dillon's detailed findings in the Inquest into the Death Of Hamish Raj, and given the evidence of Sergeant Cooper that those considerations have recently been considered, it seems unnecessary to repeat them at this point.

²² Page 25 SDP, Exhibit 2

²³ Page 24 SDP, Exhibit 2

²⁴ See for example the recommendations in Inquest into the Death of Hamish Raj (7/4/14)

Was the pursuit compliant with the Safe Driving Policy?

41. The Safe Driving Policy mandates, among other matters, [REDACTED] and level of driver certification that are pre-requisites for a pursuit. In this case [REDACTED]
[REDACTED]
[REDACTED] Sergeant Cooper's review of the incident on 27 June 2014 found it compliant in relation to all matters clearly mandated in the policy and I note that an alternative analysis was not suggested by the legal representative who appeared for the Maher Family. [REDACTED]
[REDACTED] I accept Sergeant Cooper's analysis in relation to these matters.
42. From the evidence before me, the decision to pursue was also compliant with the policy, given the broad discretion involved. In simple terms, the officers regarded the driving conduct as dangerous, they signalled for the driver to stop and when he did not, they called a pursuit, immediately contacting police radio. Having listened to the VKG tape, it is clear the siren was engaged, giving Dylan fair warning to pull over. I accept that the police were unable to see the registration plates or to identify the driver, which may have given them an alternative option of dealing with him by a court attendance notice at a later date. I am also satisfied that given the length of the pursuit – that is around 72 seconds, there is no clear evidence that the police continued the pursuit improperly. I note both officers gave evidence that once they got to the top of the hill they would have reconsidered the pursuit, taking into account whether or not they could still see the red vehicle, among other factors. It was Sergeant Brown's evidence that termination was already in his mind as an as yet uncommunicated possibility.
43. As the Safe Driving Policy is currently worded, police are given a wide discretion about when it is appropriate to commence and continue with a pursuit. There is no specific guidance given to forbidding or discouraging pursuits in certain areas or at certain times of the day [REDACTED]
[REDACTED] there are few mandatory requirements once there is reasonable cause to believe an offence has been committed or attempted and the alleged offender has commenced to evade apprehension. The

decision to initiate a pursuit involves weighing the need to immediately apprehend the offender against the degree of risk to the community and police as a result of the pursuit. In practice, police are required to make a quick decision and to evaluate whether to continue while concentrating on assessing the various specific dangers as they arise.

44. Once a pursuit has been commenced, police are obliged under the policy to continually re-evaluate this decision to pursue and to decide whether to continue or not by again “weighing the need to immediately apprehend the offender against the risk to the community and police as a result of the pursuit”.
45. Both police officers had some knowledge of the local conditions which they said they took into account when assessing the risks involved once the pursuit was underway. Senior Constable Deans, for example stated that he took into account the dangers posed by the school zone at Illawarra Sports High School, but was aware that the school was set back from the road and that students did not generally congregate around the Northcliff Drive area. Both officers said they took into account what they observed in terms of the number of people around and the amount of traffic present. Sergeant Cooper described the risk assessment process as an evolving or dynamic situation, which needs to recognise that conditions can change depending on all kinds of factors including the time of day, weather and number of people about.
46. Both officers were examined in relation to the potential dangers ahead, including the fact that had the pursuit continued the vehicles would have entered another school zone, this time relating to a primary school situated closer to the road. They were questioned on the difficulty of assessing this kind of risk in circumstances where the other vehicle has already pulled away and may already be confronting dangers unseen or un contemplated by the pursuing vehicle.
47. The policy provides that the VKG supervisor also has the right to terminate a pursuit. However, given the pursuit only lasted 72 seconds, there was in my view little chance that real guidance or oversight was possible from the VKG supervisor in this case. The VKG operator had only just begun to get the necessary information from the police involved by the time the collision had actually occurred. Sergeant McCann, the VKG supervisor had very little information with which to properly consider termination. He

did not even know the reason for the pursuit. Sergeant Brown was only able to communicate a small amount of information once the broadcast channel had been cleared.

48. The challenge of providing proper oversight of pursuits is a real one. Sergeant Cooper gave evidence that during the last year, 67% of pursuits conducted by NSW Police were concluded in two minutes, 19% were over in one minute. Realistically, as we have seen in the circumstances of this case, that provides limited opportunity for meaningful oversight, particularly in urban areas or where the radio is not immediately cleared so that information can be shared quickly.
49. It is clear that technological advancements may continue to assist in this regard. In this case the police vehicle involved in the pursuit does not appear to have been fitted with a mobile CAD unit that could transmit its location directly to the supervisor monitoring the pursuit. However it was Sergeant Cooper's evidence that a broad roll out of that technology, providing the capacity for more accurate and objective information for supervising officers, is currently a priority for the NSW Police Force. Similarly in certain circumstances the need for some pursuits may be less pressing with the continued roll out of mobile Automatic Number Plate Recognition (ANPR) technology.

Was Dylan's death avoidable?

50. Dylan Maher's death is a terrible tragedy that commenced with a traffic offence. It is crucial that as a community we are able to question whether the balance struck by law enforcement on that day was the correct one and to question the basis of the policies involved.
51. In this case it is difficult to know what might have happened had the police decided not to pursue the red car or had decided to terminate the pursuit prior to reaching the crest of the hill. It is important to note that such a decision would also have been compliant with current policy. With hindsight it is clear from the toxicology results that Dylan was drug affected and that his driving and judgement may have been impaired to a significant extent. He knew he was in a stolen car and may have made a decision to flee as soon as he saw the police, that is, even prior to the police decision to commence a pursuit. It certainly seems likely from the evidence of independent witnesses that

Dylan's driving was affected prior to the police giving chase. It follows that it is also possible, given his manner of driving, that an accident injuring himself or others may have occurred even without police involvement. Equally it is possible that his risky manner of driving may have continued even if police had terminated their pursuit. At the time of the collision Dylan was already well out of sight. He would not have immediately known had the pursuit been terminated, even if police had stopped well prior to reaching the crest of the hill. It is certainly possible that he may have lost control believing police were still behind him, even if the pursuit had already been terminated. At the time of his collision Dylan was hurtling towards another school zone, just 800 metres ahead, the potential danger at that time was certainly extreme.

52. In some circumstances, without the benefit of hindsight, it is difficult to know with any certainty whether a police pursuit will increase or decrease the risk of a road fatality. Sergeant Cooper stated in evidence that statistics for the last year showed that 30% of offending drivers stop once a pursuit commences and for this reason it must properly be regarded as a valid law enforcement technique. Nevertheless pursuits are inherently dangerous and should perhaps be reserved for situations where the dangers clearly outweigh the risks involved.
53. The decision to pursue on this occasion was made in a manner that was compliant with the Police Force's current Safe Driving Policy. It may be that the policy does not provide adequate guidance for officers in the field. [REDACTED]
[REDACTED]
[REDACTED] This Court awaits the new policy document with great expectation.

Recommendations

54. It appeared from the evidence of Sergeant Cooper that Deputy State Coroner Dillon's detailed recommendations made in relation to the Safe Driving Policy at the conclusion of the Inquest into the Death of Hamish Raj, have already been considered as part of the current policy review. This includes such issues as clarifying the language of the policy that guides police discretion in relation to the initiation and continuation of pursuits. In

particular, Sergeant Cooper indicated that the guidance given to police in the exercise of their discretion had been carefully considered and change is afoot. I am of the view that the facts of this case do not raise issues which extend beyond those already raised by Deputy State Coroner Dillon in his comprehensive review of the SDP in the Raj inquest and for that reason I am satisfied that any concerns this court may have arising out of the circumstances of this inquest, will already have been recently considered by those redrafting the relevant policy.

55. It is disappointing that a new policy has not been released 5 years after its stated review date. I am keen not to delay the release of that document any further. I support the recommendations made in the Raj inquest, but I decline to make any further formal recommendations in this matter.

Findings

56. On the balance of probabilities, I find that

- Dylan Maher died at approximately 3.21pm on 27 June 2014 on the roadside of Northcliff Drive, Berkley.
- The cause of death was multiple injuries sustained as a result of the collision of the car he was driving with a power pole and from being ejected from that vehicle.
- The manner of his death was as a result of crashing during a police pursuit.

Dylan's death was a terrible tragedy. I offer my sincere condolences to his family and community.



Magistrate Harriet Grahame
Deputy State Coroner