QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Angus William Keith FERGUSON**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/810
DELIVERED ON:	22 August 2012
DELIVERED AT:	Maroochydore
HEARING DATE(s):	3 May 2012, 20-21 August 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Police pursuits;

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Stephen Westby:	Mr Steve Zillman (instructed by McGinness & Asociates)
Senior Constable Cameron McLean & Senior Constbale Matthew Mayo:	Mr Craig Pratt (Gilshenan & Luton Legal Group)
QPS Commissioner:	Ms Melanie Johnston (QPS Solicitors Office)

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The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Angus William Keith Ferguson. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

On the evening of Sunday, 6 March 2011 18-year-old Angus Ferguson was riding his Kawasaki motorcycle northbound along Duporth Avenue at Maroochydore having recently left work at a nearby restaurant. As he negotiated a right-hand turn at a set of traffic lights he overtook a car on the left, despite there being only a single lane at that point. This action was observed by two police officers driving in the opposite direction. The officers decided to intercept the motorcycle. However they were unable to close the distance between the two vehicles before the motorcycle crashed about 850 metres from where police had first seen it. After momentarily losing sight of the motorcycle but continuing in the same direction, the officers came across Mr Ferguson and his motorcycle lying on the roadway. Prompt medical attention from a doctor residing nearby the scene of the collision was unable to save Mr Ferguson.

These findings:

- confirm the identity of the deceased person, the time, place and medical cause of his death;
- establish the circumstances in which the fatal injuries were sustained;
- consider whether the police officers involved in the events leading to the death acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force;
- consider whether the actions of three police officers subsequent to the death accorded with the same policies and procedures; and
- examine the adequacy of communication between the QPS and the family of the deceased following his death.

The investigation

Inspector Paul Schmidt of the Ethical Standards Command (ESC) conducted an investigation into the circumstances surrounding the death of Mr Ferguson and later provided a report to the Office of the State Coroner.

Inspector Schmidt was contacted at 10:30pm on 6 March 2011 and arrived at the scene of the collision at 12:15am. In the interim he had ongoing contact with senior police officers at the scene. He was advised that the two police officers involved in the attempted intercept, Senior Constable Westby and Senior Constable McLean had been separated. Inspector Schmidt ensured that both officers were required to provide a specimen of breath for analysis.

Traffic accident investigation officers and scenes of crime officers attended the scene and a series of photographs taken.

ESC officers were briefed at the scene by the District Duty Officer, Inspector Marek, and in the early hours of 7 March 2011 conducted interviews under direction with Senior Constable Westby and Senior Constable McLean. Both officers were directed to, and did, provide a urine sample.

Inspector Schmidt examined audio recordings from the police vehicle to Maroochydore communications. He later in the morning identified the three occupants of the vehicle that had been overtaken by Mr Ferguson immediately prior to the attempted intercept. Interviews were conducted with each of those people.

Later in his investigation Inspector Schmidt organised for mechanical inspections to be conducted on the motorcycle of Mr Ferguson. A report analysing the forensic aspects of the collision was provided by Senior Constable Cook of the Sunshine Coast Forensic Crash Unit. In the course of this analysis a series of re-enactments was conducted and video recorded.

When initially interviewed Senior Constable Westby specifically denied that any recording device was operational in the police vehicle or on his person at the relevant time. Three days after the crash, a lawyer acting for one of the officers who had attended the scene called the investigator and advised him his client had been told by Senior Constable Westby that he had recorded the lead up to the crash on a dash mounted camera that he had removed from the car and that he had not made the recorded vision available to the investigators. When re-interviewed, Senior Constable Westby confirmed these series of events. Inspector Schmidt extended his investigation to address the ramifications of this action and to enquire into the extent to which the actions of Senior Constable Westby were known by other police officers.

I am satisfied the investigation was thorough and professionally undertaken. I commend Inspector Schmidt on his endeavours.

The Inquest

I concluded that it was likely Mr Ferguson was attempting to evade police at the time he died. That means, for the purposes of the Act his death was a *Death in Custody* and therefore an inquest must be held.

A pre-inquest conference was held in Brisbane on 3 May 2012. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the QPS Commissioner and three police officers involved in the events preceding Mr Ferguson's death.

An inquest was held in Maroochydore from 20 to 22 August 2012. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The evidence

Personal circumstances

At the time of his death Angus Ferguson was residing at Kuluin on the Sunshine Coast. He was employed as an apprentice chef at the Boat Shed restaurant at Maroochydore where he was well liked and respected. On the evening of 6 March 2011 Mr Ferguson had worked at the restaurant and finished shortly after 10pm. His

employer, Scott McDougal, later told investigators that Mr Ferguson was in normal spirits and had not been drinking alcohol.

Mr Ferguson had obtained his motorcycle licence at the age of 18 having only obtained his “P plate” car licence some weeks earlier. His parents have since been keen advocates of change with respect to the motorcycle licensing regime in Queensland.

Mr Ferguson is survived by his parents and three brothers. It is clear that he was loved by each of them and his extended family and that he is very much missed. I offer the family my sincere condolences.

Police first observe Mr Ferguson

Senior Constable Steven Westby and Senior Constable Cameron McLean were conducting patrols in the Maroochydore area on the evening of 6 March 2011. Shortly prior to 10:15pm, Senior Constable McLean was driving a red, marked highway patrol vehicle southeast on Duporth Avenue at Maroochydore as they approached a set of traffic lights at the intersection with Beach Road. The set of traffic lights has been referred in the police report and in various interviews as being at the intersection of Duporth Avenue and First Avenue. This mistake has been the source of confusion in the ongoing communication between police and the family of Mr Ferguson.

At the same time Mr Ferguson was approaching this intersection as he travelled in a northwest direction along Duporth Avenue. He was riding his Kawasaki “Ninja” motorcycle having recently left work. As he approached the intersection he found himself behind a white sedan stopped at a red light. As the lights turned green, Mr Fergus went passed the Commodore on its left hand side and continued up Duporth Avenue. There was only a single lane at the point where Mr Ferguson performed this manoeuvre. In doing so it is now uncontroversial that he breached the road rules.

Senior Constable McLean observed the actions of Mr Ferguson and he notified his partner, Senior Constable Westby, of it. At that stage neither officer was sure whether there had been a breach of the road rules as neither officer was certain whether there was one or two lanes at the relevant point where Mr Ferguson had overtaken the Commodore. Senior Constable McLean drove to the intersection and performed a U-turn after confirming there was only a single lane. They set off in the same direction as Mr Ferguson. The accounts given by both officers when initially interviewed and at the inquest indicate they had formed an intention to intercept Mr Ferguson based on his overtaking in a single lane.

The attempted intercept

As the vehicle set off in a northerly direction along Duporth Avenue Senior Constable Westby activated the lights and sirens on the highway patrol vehicle because they went through a red light at the intersection. Both agree there was little or no other traffic on the road. They quickly caught up to the white Commodore which pulled over to the left to let the police vehicle pass. The police officers say that at this point they could see a single tail light which they estimated it to be approximately 300 – 500 metres ahead at the end of a straight section of road. In all likelihood it was Mr Ferguson’s motorcycle. The officers saw it for only a few seconds before it disappeared around a sharp left hand bend.

Senior Constable Westby estimated the police vehicle may have reached 100 km/h when passing the white car, but otherwise travelled at a maximum speed of 80 to 85

km/h. Senior Constable McLean told investigators that the police vehicle reached a maximum speed along Duporth Avenue of 80 to 90 km/h. Neither suggest they looked at the car's speedometer and so their estimates, understandably, vary somewhat. They are however supported by the driver of the white Commodore, Shirley Smith, who also agreed there was no other traffic on the road. In the circumstances I consider there was nothing inappropriate about the officer's manner of driving.

Ms Smith had spent the evening at the Maroochydore RSL with her friends Mary Cumming and Deborah Scown. She was driving the white Commodore and the other two women were passengers. Each of those women gave a version of events relating to the manoeuvre conducted by Mr Ferguson that is broadly consistent with that of the two police officers. Each of them suggests that the motorcycle accelerated quickly after passing their sedan. Ms Cumming estimates that the motorcycle was travelling at 80 kms per hour or more while Ms Scown told police it was "*flying"* At the inquest, Ms Smith said that after the motorcycle passed her; "*In a split second it was gone.*"

They variously described the speed of the police vehicle as it passed them as "*75-80 km*/h", "*80 km/h*" and unknown but not dangerous. Ms Smith and Ms Cumming recall hearing the police siren and seeing the flashing lights on the police vehicle as it approached their sedan. Both women say they don't have a recollection of hearing the police siren after it had passed the vehicle while Ms Scown on is unable to recall details in this regard.

It was made clear by Senior Constable Westby and by Ms Smith at an early stage in the investigation that they were known to each other. It seems that they had formed an acquaintance through their mutual interests and involvement in local snooker competitions. I accept that the versions given by Ms Smith and the other two occupants of the white sedan are no less reliable as a result.

Senior Constable McLean said that after they passed the white sedan the siren on the police car was turned off. He says that he had formed the view shortly after passing the white vehicle that they lost sight of the motorcycle. It appears that the mindset of both officers as they continued to drive along Duporth Avenue was that they were continuing with the attempted intercept but had not reached the point of engaging in a pursuit. There had been no radio communication between the police vehicle and the police communications centre to this point.

The collision and aftermath

At a point approximately 850 metres north-west of the traffic lights referred to earlier, Mr Ferguson lost control of his motorcycle as he attempted to negotiate a sharp left hand bend. This caused him to be flung from it and to then collide with a metal guard rail causing critical injuries to his upper torso which tragically led to his death a very short time later.

Senior Constables McLean and Westby were the first to arrive at the scene. Officer McLean said he first saw debris across the road and then the motorcycle lying on the southbound lane. He knew that immediately to the north of this was a blind crest of a bridge that crossed a canal and he was anxious to ensure on-coming traffic did not come upon the scene without warning. He therefore continued over the bridge, did a u-turn and came back to a point just north of the crash scene which was then illuminated by the lights of the police vehicle. The officers immediately saw Mr Ferguson lying against the gutter and guard rail on the eastern side of the road.

The officers went to him. Senior Constable Westby felt for a pulse. Mr Ferguson was unconscious. They were assisted a short time later by Dr Vianney McGirr, a medical practitioner employed at Nambour General Hospital. He was asleep at the time of the incident in his nearby residence but was awoken by his wife Caroline McGirr.

Dr McGirr said that when he examined Mr Ferguson he checked for a femoral, carotid and radial pulse but could not detect a pulse or any signs of life. He and an officer moved Mr Ferguson slightly to start CPR, which they continued until paramedics arrived.

Caroline McGirr told police that she had been woken from her sleep just after 10.00pm by a police siren. She told the inquest she specifically recalls hearing the siren followed by a short silence then the loud sound of a vehicle crashing. At this time she looked out of her bedroom window and saw a police vehicle with flashing lights approaching the location of the accident. She is sure that this time no siren was activated on the police vehicle.

An audio recording from the Maroochydore Communications Centre establishes that the first contact from the highway patrol vehicle in regard to this incident occurred at 10:15pm. This communication was to advise that there had been a traffic accident and that assistance was required. A more urgent communication along the same lines was made at 10:17pm. Records show that the Queensland ambulance service received a call from police at 10:18pm. The first paramedics arrived at the scene at 10:23pm. Attempts at cardiopulmonary resuscitation by Dr McGirr and later by paramedics continued for 30 minutes but were unsuccessful and Mr Ferguson was declared dead at 10:56pm.

Autopsy results

An autopsy examination was carried out on 9 March 2011 by an experienced forensic pathologist, Dr Nathan Milne. After considering toxicology results and CT scans, Dr Milne issued a report in which he noted significant injuries to the central chest and upper back amongst others.

Toxicology results showed that Mr Ferguson was not affected by alcohol at the time of his death. No other drugs were detected.

As a result of his findings, Dr Milne issued a certificate listing the cause of death as:

> *1(a) Chest injuries,* due to*,* or as a consequence of
>
> *1(b) Motorcycle collision (rider)*

Investigation findings

Test results show that neither of the police officers involved in the incident were affected by alcohol or drugs.

The mechanical inspection of the Kawasaki motorcycle did not reveal any defect which could be said to have materially contributed to the collision.

The forensic examination of the road way by Senior Constable Cook revealed 7 metres of single tyre skid-marks, 30 metres from where the motorcycle was located on the roadway. Gouge marks 5.7 metres in length ran parallel to the skid mark and red paint scrapings and cloth scuffs on the roadway support the view that the motorcycle fell onto its side resulting in Mr Ferguson and the motorcycle sliding

towards the curb and adjacent steel railing. Senior Constable Cook states in his report that the evidence points to Mr Ferguson having struck the railing approximately 15 metres further on from where the side of the bike first hit the road. Utilising the measurements taken by him at the scene, Senior Constable Cook calculated the minimum speed of the motorcycle from the point it first slid along the ground was between 49 and 67 km/h. He noted that this does not take into account any deceleration caused by breaking prior to the motorcycle commencing its slide.

As part of the investigation detailed earlier, both officers were interviewed by Detective Inspector Schmidt on the morning of 7 March 2011. During that initial interview when asked whether the events had been visually recorded, both responded in the negative. In the following days it becomes apparent this was not true.

On the evening of 9 March 2011 Senior Constable Westby arranged to meet Senior Constable McLean at his home. The two spoke while Senior Constable McLean's wife and children were nearby. Senior Constable Westby told the other officer that he had spoken to Shirley Smith the night before and she had given an account of what she told the ESC investigators. It was clear that the version of Ms Smith was favourable to the officers. Senior Constable Westby then told Senior Constable McLean that after the motorcycle collision he had *"gotten rid of*" the memory card from his video camera while "walking the dog". It was clear to Senior Constable McLean that the memory card referred to was one that had likely recorded vision of the attempted interception of Mr Ferguson. On the account of both officers, Senior Constable McLean barely responded to this information and certainly did not ask any questions about why Senior Constable Westby had taken this step. Senior Constable McLean did not report this information to anyone until he became aware Senior Constable Westby had, himself, admitted the information to senior officers.

On the morning of 9 March 2011, Senior Constable Westby became that recorded vision had been obtained from a dashboard mounted camera of Senior Constable Mayo who was in the first police car to arrive at the scene after that driven by Senior Constable McLean.

Senior Constable Westby phoned Senior Constable Mayo and asked him what was shown in the pictures. Senior Constable Westby told Senior Constable Mayo that, on the night of the crash, he had removed his own camera from the dashboard of his vehicle and "*stuck it in his pocket*". Senior Constable Mayo was puzzled as to why he was being told this information and ended the conversation quickly not wanting to be involved. He finished his shift a short time later and returned home to assist his wife with their sick children. After discussing the issue with his wife he returned to work the following morning at 7:00am and immediately attempted to contact the QPUE for advice. He was advised that he had an obligation to pass on the information to investigators.

On 10 March 2011 ESC investigators were contacted by a lawyer from the Queensland Police Union of Employees (QPUE). He passed on the information that had been conveyed to him by Senior Constable Mayo; namely, that Senior Constable Westby had made admissions to having removed his camera from the dashboard of the police vehicle and hidden it from investigators.[1] Once Senior Constable Westby

[1] Although Mayo recalls Westby telling him he had removed the "camera" and stuck it in his pocket to hide it from investigators, it is clear that Westby only did this with respect to the memory card from the camera. In any event, it was clear to Mayo that Westby had made admission to something that in his mind amounted to serious misconduct.

became aware that his admission to Senior Constable Mayo had become known to investigators he agreed to be re-interviewed where he made full admissions in all but one important respect.

In his re-interview on the afternoon of 10 March 2011, he told ESC investigators that he had removed the camera from the dashboard and placed it in a case in the back seat. He told them he had removed the memory card, broken it by bending it and then thrown it in a canal near the scene of the collision prior to his being interviewed in the early hours of 7 March 2011. At the inquest, after being given a direction to answer possible incriminating questions under s39(2) of the Coroners Act[2], Mr Westby admitted that in fact he had kept the undamaged card in his pocket until he returned home on the morning 7 March 2011. There he watched a football match on television with a neighbour while drinking several beers. After a brief sleep and still affected by alcohol he went for a walk and broke the card and discarded it into a bin on Currimundi Beach.

Mr Westby told the inquest that he made up the story about throwing the card into the canal because he thought it would reflect on him less negatively if he had discarded it immediately rather than at a time when had had an opportunity to consider his actions and to view the material stored on the card. He told the inquest that he did neither and therefore he was not aware what vision was recorded on the card. He also denied there was material relating to other incidents that may have caused him trouble or embarrassment that motivated him to get rid of the card.

He told the inquest that his rationale for removing the card was his experience of the footage from the camera having a tendency to depict the vehicle in which it was placed travelling significantly faster than was in fact the case. He said he panicked because he thought that it would reflect unfavourably and unfairly on Senior Constable McLean. At the inquest he was adamant the version he had given about the events was otherwise completely true.

Conclusion as to circumstances of the death

By withholding the digital recording of the incident from investigators and giving conflicting accounts of what happened to the memory card on which it was stored, Senior Constable Westby created a suspicion that the version given by the officers as to what had transpired was untruthful. This perception was exacerbated by the failure of Senior Constable McLean to report this to his superiors when he became aware of it two days after the crash. Further uncertainty may have arisen when it become known that Officer Westby had a social relationship with a primary civilian witness. Inadequate communication between the investigator or the family liaison officer and the family made matters worse. Undoubtedly, these complications added to the distress of the family of Mr Ferguson: not only had they to deal with the terribly sad death of their much loved son, brother and grandson, but the aggravation of an apparent attempt at a “cover-up” would be heaped on their grief. I offer them my sincere condolences.

Notwithstanding the complicating factors, I am persuaded the crash occurred in the manner described by those who gave evidence at the inquest. The versions of officers McLean and Westby are largely supported by Ms Smith and the passengers in her car and Ms McGirr. That evidence is consistent with the data gathered by the Forensic Crash Unit investigator. It all points to Angus Ferguson losing control of his motorcycle on a sharp bend as a result of his inexperience and excessive speed. In

[2] Which results in the answers not being available for use in criminal or disciplinary proceedings.

my view it is likely he noticed the police car coming towards him when he passed on the left of Ms Smith's Commodore. His apprehension that they may seek to intercept him was likely confirmed by the sight in his rear view mirrors of the blue and red flashing lights of the police vehicle when it overtook the Commodore. A few seconds later, he crashed heavily.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The deceased person was Angus William Keith Ferguson.

How he died - Mr Ferguson died from injuries sustained when the motorcycle he was riding collided with a guard rail. At the time of the crash Mr Ferguson was probably attempting to evade police who were attempting to intercept him.

Place of death – He died at Maroochydore in Queensland.

Date of death – He died on 6 March 2011.

Cause of death – Mr Ferguson died from chest injuries sustained in a motorcycle crash.

Comments and recommendations

Section 46, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The circumstances of this case give rise to consideration of three issues from that perspective:

- QPS pursuit policy;
- Communication with the bereaved; and
- Licensing of motorcycle riders.

Pursuit policy

Because police pursuits are so inherently dangerous and because that danger is so often visited on completely innocent road users not otherwise involved in the incident or fleeing motorists who have committed the most trivial of offences, the QPS has commendably developed an evidence based policy aimed at minimising the risk of harm while maximising the effectiveness of law enforcement.

Whenever a death is connected with an attempted police intercept it is appropriate in my view to reflect on whether the officers involved have complied with that policy.

When can a pursuit be commenced and continued?

The principles underpinning the QPS pursuit policy are outlined in the Operational Procedures Manual (OPM). Those of particular relevance to this case are:

(i) Pursuit driving is inherently dangerous. In most cases the risk of the pursuit will outweigh the benefits.

(ii) Pursuits should only be commenced or continued where the benefit to the community of apprehending the offender outweighs the risks.

(iii) If in doubt about commencing or continuing a pursuit, don't.

The policy assures officers that suspects who fail to stop when directed will still be the subject of law enforcement action, but less dangerous means than high speed pursuits will be utilised. It says:-

> *The revised pursuit policy seeks to shift the manner of apprehension of people who fail to be intercepted from pursuits into other strategies. The Service will continue to apprehend offenders who fail to be intercepted but pursuits will not be the principal means of effecting apprehension.*

The policy requires the pursuing officers to balance the utility of a pursuit against the risks it generates. The utility is gauged by considering the consequences of failing to intercept the pursued – the seriousness of the offences the person fleeing may have committed and the strength of the evidence indicating they have committed those offences. In this balancing exercise, issues of safety are to weigh more heavily than has been the case under earlier policies.

According to the policy, "pursuit" means the continued attempt to intercept a vehicle that has failed to comply with a direction to stop where it is believed on reasonable grounds the driver of the other vehicle is attempting to evade police.

"Intercept" means the period from deciding to direct the driver of a vehicle to stop until either the driver stops or fails to stop. It includes the period when the police vehicle closes on the subject vehicle in order to give the driver a direction to stop.

The policy specifically excludes some matters from being sufficient on their own to justify the commencement of a pursuit. These are termed "*non-pursuit matters"* and they include license and vehicle checks, random breath tests and traffic offences.

When an intercept becomes a pursuit

When an officer is attempting to intercept a vehicle, if the vehicle fails to stop as soon as reasonably practicable; and the officer reasonably believes the driver of the vehicle is attempting to evade police a pursuit is commenced if the officer continues to attempt the intercept.

The reference to "reasonably believes" means the question is not determined by the subjective views of the pursuing officer, rather, as with most aspects of law enforcement, officers must align their conduct with what a reasonable officer would do or believe in the circumstances.

If a pursuit is not justified, an attempted intercept must be abandoned. In such cases the officer must turn off the flashing lights and siren, pull over and stop the police vehicle at the first available safe position.

Urgent duty driving
Section 14.32 of the OPM provides:

> "*Urgent duty driving means driving to perform a duty which requires prompt action and may include:*
>
> *(1) the use of flashing lights and siren to obtain priority travel over other motorists; and*
> *(2) driving a Service vehicle in a manner that, if not justified, would ordinarily constitute an offence."*

The OPM goes on to set out circumstances where urgent duty driving is permitted. One such circumstance cited is "*intercepting or attempting to intercept a vehicle*".

Did the officers' actions comply with the policy?

I am satisfied that, based on his observations and suspicion of a breach of road rules, Senior Constable McLean was entitled to intercept Mr Ferguson. That he took the time to inspect road markings to ensure the basis of his suspicions militates against a suggestion of inappropriate urgency or aggressiveness in his early attempts to intercept. No signal was given to Mr Ferguson that the officers wanted him to stop until after Senior Constable McLean had ensured his understanding of the road marking was correct. By this time the motorcycle was many hundreds of metres away.

The officers say that they remain unsure whether Mr Ferguson was ever aware of their presence. The passengers in the Commodore speak of the speed of the motorcycle but none suggests a noticeable change in the manner of Mr Ferguson's riding that would suggest he had seen the police vehicle.

Even when the officers passed the Commodore with their vehicle's lights and siren operating, at least for a brief period, Mr Ferguson was so far ahead it was not clear that he would have seen the police car and was attempting to evade it. Although Mrs McGirr states she saw the police car on scene a very short time after she heard the crash of the motorcycle, she also gave evidence that the crash had occurred approximately two seconds after she heard a short siren burst. The latter evidence would be consistent with the account of the occupants of the Commodore and the officers themselves that the motorcycle disappeared from view around the bend (where the collision occurred) a very short time after the sirens were operated on the police vehicle so as to overtake the Commodore. This meant they would have been 300 – 400 metres from the motorcycle at the time of the collision.

I am of the view that it is likely Mr Ferguson was aware the police were behind him with their bar lights illuminated. That may well have caused him to increase his speed in the hope that he would lose them. Nonetheless, the officers were entitled to attempt to intercept him and in my view they had not reached a point where they could be satisfied he was resisting that attempt.

Accordingly, a pursuit had not commenced. The manner of the urgent duty driving engaged in by Senior Constable McLean was reasonable in the circumstances and sanctioned by QPS policy.

Communication with family

Understandably, when a civilian dies in connection with a police operation apprehension as to whether the matter will be impartially investigated readily arises. This tendency will be exacerbated if the family of the dead person gets the impression information is being withheld or distorted.

The inquest heard several aspects of the communication between police officers and Mr Ferguson's parents were less than optimal. At an early stage the role of liaising with the family was assigned to Senior Sergeant Josef Jaramazovic, Officer in Charge at Maroochydore. This was a departure from the process envisaged in the QPS OPM and a Commissioner's Circular last issued in October 2009, both of which indicate that the principle investigator will be the primary conduit of information to the family.

The OPM provides little in the way of guidance for family liaison officers, requiring them to offer all reasonable assistance required subject to restrictions imposed for forensic reasons or because, as in this case, some information and evidence is in the control of the Coroner.

The departure from the normal process meant that Senior Sergeant Jaramazovic was reliant on second and third hand accounts of the events when he spoke to Mr and Mrs Ferguson. To his credit he initially made attempts to speak face to face with Mrs Ferguson by visiting her home address. When he did ultimately speak to the family he advised them that Angus had likely been aware of the presence of the police patrol vehicle. He told the inquest that this is an assumption he had made.

Arrangements were made on the morning of 7 March 2011 for the identification of Angus' body to take place the following day by which time his father would have returned from his place of work in Western Australia. It seems the Inspector did not relay these details to the junior officer at the Nambour Hospital mortuary, as that junior officer then made contact with Mrs Ferguson and placed some pressure on her to view the body that day.

It also seems that the family were under the apprehension they would be provided with investigation reports when they became available via the police. Such reports must in fact be provided through my office and the QPS have developed a form that sets out these details and the relevant contact points quite adequately. Unfortunately the family of Mr Ferguson were not provided with a copy of this document.

Finally Senior Sergeant Jaramazovic acknowledged that when he was transferred, no steps were taken to advise the family who their new liaison officer would be.

The mistrust generated by these incidents was compounded when an innocent mistake by Inspector Schmidt in describing the location at which police first sighted Mr Ferguson was interpreted as a further attempt to mislead the family.

I have considered whether changes should be made to QPS policy to better delineate the role of a family liaison officer. I am wary, though of being too prescriptive in describing or setting requirements for a role that must be adapted in every case to the enormously varying factors that are involved in the manner of a death and the ways in which the deceased's loved ones may wish to interact with the QPS. I expect that many of the regrettable problems in this case would have been addressed if the family liaison role had remained with the ESC. However, I can understand why the decision was taken in this case and am not critical of it.

I trust the QPS will re-focus on the need to effectively communicate with bereaved families without the need for me to make a formal recommendation.

Motor cycle licensing regime

Mr Ferguson was not a sociopath or a hardened criminal. On the contrary, he was an upstanding young man who like so many others enjoyed the excitement of riding his motorbike but apparently had trouble doing so within the constraints of the road rules.

The magnitude of the problem is illustrated by the following statistics. During 2011, there were 46 fatalities as a result of crashes involving motorcycles. This represents 17.1% of the Queensland road toll even though motorcycles represent only 4.5% of all motor vehicles on the Queensland register.

Mr Ferguson's parents are understandably concerned at their son's ability to obtain a motor cycle license with very limited practical experience and in circumstances where he had already lost points on his provisional motor vehicle license.

Although I am sympathetic to their concerns I do not consider the facts of this case extend my jurisdiction to investigate this issue. I have also been made aware it has been the subject of extensive review and recommendation. That process is continuing with a Parliamentary Committee currently considering submissions on the adequacy and implementation of previous recommendation in this area. In circumstances where such a policy review process is already well advanced I consider there is little I could usefully add.

Referral pursuant to s48

Section 48 of the *Coroners Act* requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has committed an offence"* to give the information to the appropriate prosecuting authority.

I take "*committed an offence*" to mean there is admissible evidence that could prove the necessary elements to the criminal standard. That would include the evidence necessary to rebut any defence reasonably raised by the evidence. The use of the term "*reasonable suspicion*" is analogous to the test applied when a search warrant is sought. In that context it has been held that a suspicion is a state of mind less certain than a belief and to be reasonable it must be based on some evidence, but not necessarily well founded or factually correct and be a suspicion that a reasonable person acting without passion or prejudice might hold. As a result, a relatively low level of certainty is needed to satisfy the test.

As a result of the evidence given to the inquest by the former Senior Constable Westby, it is now known that the day after Mr Ferguson died, Mr Westby destroyed the memory card that is likely to have stored on it vision of the events leading up to the crash.

That would have been valuable evidence in these proceedings and accordingly, it raises for consideration whether I am obliged to refer the information to the DPP for determination of whether Mr Westby should be charged with an offence against section 129 of the Criminal Code - *Damaging evidence with intent*.

That section provides:

> *A person who, knowing something is or may be needed in evidence in a judicial proceeding, damages it with intent to stop it being used in evidence commits a misdemeanour. Maximum penalty—7 years imprisonment.*

As his counsel properly pointed out, the section requires the Crown to prove that the accused *damaged* the thing with the requisite intent.

In this case the only complete evidence of what happened to the memory card was provided by Mr Westby. When he was re-interviewed by Inspector Schmidt he said he threw the card away on the night of the crash. When he gave evidence he told the Court that he had broken the card by bending it in half before disposing of it in a rubbish bin the next day. However, in neither case is that evidence admissible in criminal proceedings. In each case he had been given a direction that required him to answer questions even if they might incriminate him. The *Police Service Administration Act* and the *Coroners Act* have for good reasons over-ridden the common law privilege against self incrimination. In the case of the first Act this was done to enable the Commissioner of the Police Service to effectively maintain discipline within the Service. The *Coroners Act* similarly enables a Coroner to direct a witness to answer incriminating questions so that the truth about a death can more readily be ascertained. In each case the trade off is that incriminating answers can not be used in criminal proceedings against their maker.

Senior Constable McLean was unable to remember precisely what he was told about the fate of the memory card by Senior Constable Westby, other than he was left with he impression that he had "*gotten rid of it*." The information given to Senior Constable Mayo was similarly vague.

Even were there evidence of other witnesses sufficient to prove that Mr Westby had damaged the memory card, I do not consider that it could be shown that he did so to prevent it being tendered in evidence at these proceedings. I accept that when he took the actions in question Mr Westby was severely distressed as a result of his involvement in the fatal crash and was not thinking clearly. I also accept his evidence that he destroyed the card because he thought the officer driving the police car, Senior Constable McLean, might be disciplined for breaching Service policy concerning urgent duty driving and police pursuits. I accept that these proceedings were not in Mr Westby's contemplation at the relevant time.

Accordingly, no referral to the DPP is appropriate.

Section 48 also authorises a Coroner to give information to a professional disciplinary body if the coroner considers the information might cause the body to take disciplinary action.

In this case the actions of former Senior Constable Westby obviously call for scrutiny from this perspective. However, he no doubt saw "the writing on the wall" and resigned from the QPS on 15 June 2011. He paid a very high price for a moment's foolishness. I am advised the QPS is still considering taking administrative action that will enable a formal finding to be made so that should Mr Westby seek to rejoin a police service or other government department his actions in this case will be available for scrutiny.

The nature of police work and the circumstances in which it is undertaken means that opportunities and motivations for misconduct are numerous. Much of it will only become known to other officers. Accordingly, police misconduct can only be kept in check if all officers maintain appropriate standards by demanding accountability of each other. This requires strict compliance with the obligation to report suspected misconduct.

Disciplinary action was taken against Senior Constable McLean for his failure to report to his superiors the information he gained from Mr Westby indicating that the latter had withheld the evidence contained on the digital camera's memory card. That action was appropriate. Senior Constable Mayo did report the misconduct of Mr Westby, but not until the next day. He was reminded of his obligation to report misconduct in a more timely fashion. There is therefore no basis on which I should make a referral in relation to them.

Both officers impressed me as truthful and conscientious. I hope their involvement in this sad case does not discourage them from continuing in the profession or impinge upon their advancement in the QPS.

I close the Inquest.

Michael Barnes
State Coroner
Maroochydore
22 August 2012