

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4734

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: Angus Hare

Delivered On: 24 April 2013

Delivered At: Melbourne

Hearing Dates: 24 April 2013

Findings of: Judge Ian Gray, State Coroner

Counsel Assisting the Coroner Sarah Gebert

I, JUDGE IAN GRAY, State Coroner having investigated the death of

Angus Hare

AND having held an inquest in relation to this death on 23 April 2013

at Melbourne

find that the identity of the deceased was Angus Hare

born on 10 December 1992

and the death occurred on 17 December 2011

at a location on Racecourse Road approximately 1.7 kilometres north of the intersection with the Cobram-Koonoomoo Road, Cobram

from:

1 (a) multiple injuries sustained in motor vehicle collision (Driver)

in the following circumstances:

Background

1. Angus Hare¹ (referred to in my finding as Angus) was 19 years of age at the time of his death. His mother is Karen Waterhouse and his father is Thomas Hare. Angus had an older brother, Hayden and a younger sister, Winter.
2. Angus was living in his grandmother's caravan at the northern end of Racecourse Road, Cobram following Angus getting a job at the JBS Abattoir which was also located in Racecourse Road. Angus had held the job for 3 to 4 months before his death. Both his mother and grandmother lived with Angus, on and off, during this time and his mother spent the night of 14 December 2011.
3. Prior to living at the caravan Angus resided with his mother in Berrigan, New South Wales.
4. Angus was described by his mother as '*being very active and constantly on the go and full of life*'. She also said that he '*made friends easily and was very good natured.*'

¹ Also known as Angus Waterhouse

5. Angus held a learners permit but was in the process of making arrangements to get his licence and had been to the RTA in NSW two weeks before his death for that purpose.

The evening of 17 December 2011

6. Angus was driving his white Holden Commodore (registered in NSW) in the Cobram area on the evening of 17 December 2011.
7. Leading Senior Constable Shane Weeks² and Senior Constable Christopher Westrope³ of the Cobram Highway Patrol were also performing duties in the Cobram area on that evening. SC Westrope was the driver and LSC Weeks was the observer. Both officers had good local knowledge of area and held Gold class licences.⁴
8. At approximately 9.50pm, the officers approached and stopped at the intersection of the Cobram-Koonoomoo Road and the Murray Valley Highway. From this position, LSC Weeks noticed Angus' vehicle which he had observed earlier that day while he was off duty. The vehicle had moved into the right hand turn lane to enter onto the Cobram-Koonoomoo Road and drove through the headlight beam of the police vehicle.
9. The officers both said that there was nothing adverse in the manner of Angus' driving but LSC Weeks had observed him earlier on that day and his intention was to establish his identity and investigate the issue of P plates (discussed below). Both officers characterised the interception as that of a routine check.
10. The police executed a U-turn in Cobram-Koonoomoo Road at the intersection of the Murray Valley Highway. The vehicle's emergency lights were activated at 9.51.32pm once the police commenced to follow Angus' vehicle. The police sirens were not activated at any time during the attempted interception.
11. The officers were driving a marked police vehicle which was fitted with an In Car Video capture system (ICV). The ICV operation is such that once the emergency lights are activated, it starts recording, including the 30 seconds prior to the unit being activated.

² Referred to as LSC Weeks

³ SC Westrope

⁴ In accordance with the *Victoria Police Manual* Victoria Police personnel are required to hold an Approved Driving Authority in order to drive police vehicles. This is an internal licensing system which has a colour coded system. The Victoria police fleet also have classification that are colour coded. The licence codes and vehicle codes are linked together. The highest is a Gold Class licence which enables the driver to drive a Gold Class vehicle at unrestricted speeds.

12. The evidence contained in the ICV footage allowed me to view the entire contact between the police members and Angus as well as the path travelled by Angus up to the incident after the police stopped their vehicle. This greatly assisted my investigation and was also available to family members (at their discretion) allowing them to better understand the circumstances surrounding Angus' death.
13. The evidence is that following their observations of Angus' vehicle, the police vehicle accelerated to get closer to enable a registration check to be conducted. The police said that they were in fact able to get his registration number a short time later.
14. The ICV footage shows that at 9.51.56pm Angus slowed down and overtook a vehicle. The police said that there was nothing '*untoward*' with respect to the manner of his driving during this manoeuvre.
15. The ICV footage further shows that at 9.52.06pm, Angus executed a right turn into Racecourse Road and he was observed to slow down and move to the left hand side of the road.
16. The footage also shows that the driver side door appears to be open while Angus' vehicle is in motion on a number of occasions whilst he is being followed by the police. Angus' father said that he always struggled with wearing a seat belt and he may have been attempting to put his seat belt on at that time the police observed his door opening.
17. The ICV footage shows that at 9.52.22pm, following the police executing the turn into Racecourse Road, they deactivated the lights and stopped the vehicle. The headlights were turned off at 9:52:32pm, however, Angus is seen to accelerate away.

What happened after the police stopped their vehicle?

18. Whilst stationary the police vehicle mobile radar was activated and the radar flashed up 175 km/ph which indicated that this was the speed of Angus' vehicle was travelling, as there were no other vehicles in sight.
19. A short time later, a four wheel drive came up behind the police vehicle and passed it. The officers then travelled about 100 to 200 metres down the road and noted its registration. In this position, the police also activated their lights and intercepted three vehicles they observed coming out of the racecourse. This occurred at approximately 9.53.10pm. The occupants reported that they had observed a vehicle travelling at a fast rate of speed from the direction they had come.

20. SC Westrope radioed details of Angus' vehicle to D24 advising that they had not commenced a pursuit as it looked like the driver was going to jump out and that he could be identified later.
21. At approximately 10.05pm, Angus' vehicle was observed by a security guard travelling past the entrance to the Cobram Harness Racecourse (estimated at approximately 150-160kmph) and then past the entrance of JBS Abattoir. He reported that he heard a loud bang and then silence.
22. The four wheel drive which had passed the police vehicle earlier returned to where the officers were stationed with a message from the security guard (who had flagged him to stop) that a possible accident had occurred.
23. The ICV footage shows that the officers, once being advised of this fact, left for the accident scene at 9.56.20pm.
24. The officers arrived at the scene at 9.58.35pm and discovered Angus's vehicle had been broken into two pieces. Angus had been thrown from the vehicle and was unable to be assisted.
25. The scene of the accident was located about 1.7km from where the police had stopped their vehicle.
26. SC Westrope reported that the *'night was warm, the roads were dry, and the traffic was light. The Cobram Koonoomoo Road was in good condition. Racecourse Road is in good condition on the bitumen section and is an 80km/h zone near the abattoir. Where the road surface changes to gravel and dirt, the road condition was fair but had pot holes, wheel ruts and corrugations.'*

Evidence from an accident reconstructionist

27. Detective Leading Senior Constable Hay of the Major Collision Investigation Unit, conducted a formal reconstruction and determined that when Angus lost control of his vehicle he was travelling at approximately 175 kmph before colliding with a tree. The impact was so severe it caused the vehicle to split in two. Angus was ejected from the vehicle and travelled approximately 20metres. The collision occurred on the gravel section of the road:

'I believe that the passenger side wheels entered the depression in the road surface. The Holden was then steered to the right side of the road before the driver over steered the

Holden to the left causing it to rotate and 'Yaw' to the left. The Holden then travelled onto the grass verge and impacted a tree stump and several trees. As the Holden impacted the first large tree with the driver side the vehicle rotated sharply to the right and the front section of the car was torn from the rear section. The rear section lodged against this tree. The front section travelled north, rotated clockwise and impacted another large tree. The front section of the Holden lodged against this tree with front section facing generally south toward the rear section of the car.'

28. A qualified mechanic (Acting Sergeant Leigh Booth) determined that the vehicle was in good working order and there were no faults which would have caused or contributed to the collision.
29. Acting Sergeant Booth also noted that there was no distortion to the stoplight filament and severe distortion to the taillight filament. I was advised that the type of rear lamp globe in Angus' vehicle, combined the stop (brake) light filament and the tail light filament within the same globe. This would mean that at the time of the collision the brakes lights were not on but the tail light (headlights) were. This is consistent with the tyre scuff marks at the scene which showed no clear signs of braking but rather a loss of control 'yaw' off the road and into the trees. This is consistent with the collision being an accident rather than a deliberate act.

Post Mortem Examination

30. Dr Melissa Baker, Forensic Pathologist of the Victorian Institute of Forensic Medicine, conducted a preliminary examination and determined that a reasonable cause of death as 'multiple injuries sustained in motor vehicle collision (Driver)'
31. The toxicology analysis of body fluids disclosed $\Delta 9$ -tetrahydrocannabinol (THC) detected at 15 ng/ml and a blood alcohol reading of 0.18%. The presence of THC in blood at concentrations in levels in excess of 6 ng/mL strongly suggest recent use of cannabis (within a few hours).
32. In Dr Morris Odell's opinion: *'His driving skills would have been very adversely affected by the effects of alcohol at the time of the collision. Any additional impairment from cannabis would only have worsened the situation. He would have been incapable of having proper control of a motor vehicle.'*

Recent events with police

33. There was evidence of two recent events with police. I note that:

- On 8 December 2011, Angus was booked for failing to wear his seat belt, failing to display P plates and failing to have a qualified driver with him. He was intercepted on the way home from work (police light were flashed and he pulled over) and was described as very apologetic. He was fined on that occasion.
- At about 9am, 17 December 2011 (on the date of his death), PS Weeks, who was off duty and at the McDonalds Restaurant in Cobram, observed a white VN model Holden commodore drive into the car park and noted that the driver appeared young and in the absence of 'P' plates being displayed raised suspicion about whether he should be driving (*'the driver should have at least been wearing "P" plates because he looked so young...'*). He noted that he had yellow NSW number plates. The driver was also not wearing a seat belt. PS Weeks noted that the driver got out of the vehicle, entered and later left the restaurant (hopping back in the car and driving off 'at a fast rate'). He made a note that he would keep a look out for the vehicle when he was rostered on later in the day.

34. An issue raised at inquest by Mr Hare was whether *early intervention* by PS Weeks when he sighted Angus at the McDonald's would have made a difference in this case. I note that the VPM is not prescriptive as to a members obligations when they are off duty.⁵ In this case however, I note the time of the observation and that any possible offences against Angus were essentially minor and only administrative in nature. I therefore do not make any criticism of PS Weeks in relation to this matter.

Was Angus in custody at the time of his death?

35. As part of my investigation I have turned my mind to whether, at the time of Angus' death, he was a *person placed in custody or care* in accordance with section 3 of the *Coroners Act 2008* (the Act). Section 3(j) includes:

a person who a member of the police force was attempting to take into custody

36. This question raises a number of considerations including whether I could conclude that the police were actively trying to arrest Angus at the time of his death as well as what might

⁵ VPM – Policy Rules Professional and ethical standards

have been going through Angus' mind at this time. I note at the outset that what is meant by *attempting to take into custody* is not defined in the Act.

37. The current Victoria Police Manual (VPM) sets out policies and procedures regarding the conduct of a police pursuit.⁶ The officers in this case say that they attempted to intercept Angus via the activation of lights but never intended to call a pursuit as is permitted by the VPM. LSC Weeks said: *'There had been a recent direction from Superintendent De Santo that I read where he cautioned against Police pursuits and I was well aware of that. Further to this I now had his car registration, I knew what he looked like, and because I had seen him twice in one day I knew that he was around the town. It was just not worth a pursuit.'* In addition, SC Westrope knew that Racecourse Road had a bitumen section of road and that it led to a gravel section which, from police training, was not considered a safe condition to conduct a pursuit. *'I remember from my training that I was told over and over not to pursue anyone onto a gravel or dirt road. It was about safety first for both ourselves and anyone in the cars we may pursue in the circumstances.'* I also note that the officers also considered the age of the driver.
38. There is no doubt that the police members' did not regard themselves as being in pursuit when they attempted to intercept Angus or that they were attempting to arrest him. I accept that they were not in pursuit in accordance with the VPM⁷ and I also accept that the police officers were not attempting to arrest Angus on the evening of his death.
39. How Angus was thinking at the time of his death can only be a matter of speculation. I do note however that he had recently been intercepted by police for a routine check in a similar manner and would have known what to expect. I also note that his thinking was likely to have been impaired by the substances he had consumed.
40. The evidence is that the scene of the accident was located about 1.7km from where the police had stopped their vehicle, which is a considerable distance. I think it is apparent that

⁶ The following are relevant: *Victoria Police Manual - Policy Rules - Urgent duty driving and pursuits*, *Victoria Police Manual - Procedures and Guidelines - Urgent duty driving and pursuits* and *Victoria Police Manual - Policy Rules - Police Vehicles*.

⁷ I note that there may be a divergence of opinion regarding what constitutes a 'pursuit' by police (and therefore whether someone may be *in custody* or not at the time of death) but I did not find it necessary to determine this issue as part of my investigation into Angus' death.

Angus was keen to get as far away as possible from police to avoid being intercepted but it is also likely to have been clear to Angus that the police were not actively pursuing him once they had deactivated their lights and were no longer in sight.

41. On the basis of all these matters therefore, I find that Angus was not *in custody* at the time of his death.

Conclusions

42. Having considered all the evidence I find that Mr Angus Hare born on 10 December 1992 on 17 December 2011 died as a result of multiple injuries sustained in motor vehicle collision (Driver).
43. I find that LSC Weeks and SC Westrope acted in accordance with Victoria Police policies and procedures and did not contribute to his death.
44. I have further directed that a copy of this Finding be provided to Coroner John Olle who is conducting an inquest which is examining the Victorian Police pursuit policy.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published as part of the Court record.

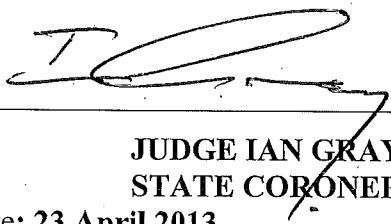
I direct that a copy of this finding be provided to the following:

Karen Waterhouse

Thomas Hare

Mark Amos, Investigating Member

Signature:



JUDGE IAN GRAY
STATE CORONER

Date: 23 April 2013

