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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act*

In the matter of the Coroner's Findings and recommendations regarding the death of Ashely Dean Ian Richards

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Pursuant to section 46B of the *Coroners Act*, I provide this Report on the findings and recommendations of the Territory Coroner, Mr Greg Cavanagh LCJ, dated 7 April 2017, regarding the death of Ashley Dean Ian Richards (the Deceased) (refer Attachment A).

The Report includes the response to the recommendations from the Commissioner of Police (the Commissioner) (refer Attachment B).

The Deceased, an 18 year old Aboriginal male, died at 5.50pm on 7 September 2015 at the Intensive Care Unit in the Royal Darwin Hospital.

The cause of death was catastrophic traumatic brain injury as a consequence of a fatal motor vehicle crash at 3.06am on the Stuart Highway at the intersection with Lambrick Avenue, Palmerston.

Recommendations of the Coroner

The Coroner may comment on a matter, including public health or the administration of justice, connected with a death being investigated (section 34(2) of the *Coroners Act*) and may report or make recommendations to the Attorney-General on a matter, including public health or the administration of justice, connected with the death being investigated (section 35(1) and (2) of the *Coroners Act*).

The Coroner made the following recommendations:

'97. I recommend that Police finalise the draft Joint Emergency Services Communications Centre Procedure as soon as possible.

98. I recommend that Police fit Automated Vehicle Locators to their vehicles as soon as possible.

99. I recommend that Police implement a system for review of all critical incidents with the intent to ensure continuous learning and improvement.'

Response to Coroners recommendations

A copy of the Coronial Findings was provided to the Commissioner on 11 May 2017, in accordance with section 46A(1) of the *Coroners Act,* requiring a response which outlines the actions that the NT Police Force is taking, has taken or will take with respect to the Coroner's recommendations.

A written response was received from the Commissioner dated 14 August 2017 (refer Attachment B), as required by section 46B(1) of the *Coroners Act*.

The Commissioner has provided the following response to the recommendations made by the Coroner at paragraphs 97, 98 and 99 of the Coroner's Report:

- the procedure is out of draft and forms part of the Joint Emergency Service Communications Centre Standard Operating Procedures (SOP) and complements other SOP around Emergency Vehicle Driving, pursuits, hostile vehicles and the deployment of tyre deflation devices. The Commissioner considers this recommendation to be complete;

- the Police Force is currently investigating available Automated Vehicle Locator solutions with a view to encompassing all NT Police, Fire and Emergency Services vehicles, including potential linkages to existing information technology and dispatch systems. This recommendation is noted to be ongoing; and

- a post operation assessment –Terms of Reference document has been created and field tested in a live incident to assess effectiveness. This process will be included as part of the review of the Major Investigation/ Major or Critical Incident plan and the requirements of this recommendation are noted to be ongoing, pending the finalisation of the plan.

I am satisfied that the NT Police Force has considered the Report of the Coroner and is taking necessary steps with respect to the recommendations made.

DATE:

- 7 SEP 2017

Natasha

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NATASHA FYLES

ATTACHMENT A

CITATION: *Inquest into the death of Ashley Dean Ian Richards* [2017] NTLC 009

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0138/2015
DELIVERED ON:	7 April 2017
DELIVERED AT:	Darwin
HEARING DATE(s):	13 & 14 February 2017
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Vehicle Hijacking and further robbery, firearm, joyriding youth, limited options for apprehension, limited coordination and control of police resources**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police:	Angus Stewart SC
Counsel for family:	Matthew Derrig

Judgment category classification:	B
Judgement ID number:	[2017] NTLC 009
Number of paragraphs:	99
Number of pages:	18

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0138/2015

In the matter of an Inquest into the death of

ASHLEY DEAN IAN RICHARDS
ON 7 SEPTEMBER 2015
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Ashley Dean Ian Richards (the deceased) was born 24 November 1996 in Barmera, South Australia to Annette Whittingham and Sean Richards. His father is an indigenous man from the Flinders Ranges. Ashley was the second of six children born in the nine years between 1995 and 2004.

2. His early life was affected by significant domestic violence from his father and substance abuse by both his parents. There was regular contact with the child protection system in South Australia. Some of the child protection reports described the living conditions in the home as "squalid".

3. While his father was in jail in 2005, his mother took the opportunity to move to the Northern Territory with Ashley and his siblings. Ashley was eight years of age. Shortly thereafter the family came to the attention of the Department of Families and Children in the Northern Territory.

4. Ashley attended Anula and Moulden Primary Schools and went to Palmerston Middle School. In year 8 he was suspended on numerous occasions for two and four weeks at a time. His attendance rate for that year was said to be between 20% and 40%. He was at the appropriate level in Physical Education but did not submit sufficient work in his other subjects to be assessed.

5. He said he enjoyed school and particularly his involvement with the Clontarf Football Academy. The Academy indicated that his behaviour and attitude while at the Academy was good and they had "absolutely no problems" with him.

6. He commenced year 9 but only stayed for a few weeks. His mother arranged alternative education for him for a period of 6 to 9 months thereafter.

7. He enjoyed working with animals and volunteered at the Animal Shelter. His long term goal was to join the Australian Army. He tried to join the cadets, but at the time he was too young.

8. By late 2010 Ashley, then 13 years of age, came to the attention of the Criminal Justice system. That was the first of many interactions. Just prior to his fifteenth birthday he was placed into the care of the Chief Executive of the Department of Family and Children until the age of 18 years.

9. Those that analysed his behaviours for the provision of sentencing options to the Court were of the opinion that the domestic violence he experienced had a significant effect on his emotional and behavioural development. They said it left him fearless and willing to involve himself in high risk situations. He expressed the main reason for his offending as "boredom and the "rush".

10. When being interviewed for the reports he commented that community work bored him, as did being confined to home. He said he preferred to spend time in detention. On one occasion he suggested that detention was even preferable to being in the care of the Department of Families and Children.

11. In 2013 he said that he wanted to transfer to South Australia and reside with his aunt and her family. He thought that moving from Darwin would allow him to break the offending cycle and allow him to "go through law" in his father's community.

12. His offending primarily related to property offences including stealing cars to go "joy riding" with his friends. He was convicted on at least 13 occasions of doing so. The cars were stolen after finding the keys in unlocked vehicles or stealing the keys from houses that were either unlocked or with only flyscreens and louvres to be removed to facilitate entry.

13. Ashley died on 7 September 2015, when just 18 years and 9 months of age from injuries received in a motor vehicle crash at 3.06am on the Stuart Highway at the intersection with Lambrick Avenue.

Circumstances

14. The crash happened when Aaron Hyde, the driver of the vehicle in which Ashley was a passenger, travelled against a red light in excess of 180 kilometres per hour, crashing into a Jeep turning across the highway. Aaron said that he thought he was being pursued by Police.

15. Police had been interested in the vehicle and its occupants due to a series of serious offences including two robberies. They had a considerable number of cars on the road at the time in an attempt to prevent further serious offences and to apprehend Ashley and his friends.

16. The offences began at 2.00am on Sunday 6 September 2015, twenty-five hours before the crash. There was an unlawful entry into a unit at Stuart Park. Keys were taken and a Mitsubishi Mirage stolen.

17. Between 5.30am and 6.00am that morning Aaron Hyde drove the Mirage to Palmerston. He dropped Ashley home with an understanding that after getting some sleep they would meet up again.

18. At 5.30pm that day (6 September 2015) Aaron drove to Ashley's home where they picked up Ashley and two younger boys.

19. They went joyriding in the Mirage. At 7.06pm they stopped at a service station in Durack. Ashley got out of the passenger seat and refuelled the vehicle. The car was driven away without paying for the fuel.

20. At 7.10pm the car stopped at the service station at Wishart Road. The two younger boys stole bottles of Coca-Cola, got back into the car and left. CCTV camera footage at the premises was viewed by Police and the two younger boys stealing the Coca-Cola were identified.

21. About 10 minutes after stealing the Coca-Cola, the youths saw a Commodore SS in Winnellie Road. The owner was driving with her husband and neighbour. Aaron Hyde intentionally rammed the back of the Commodore. Both cars stopped. Aaron and Ashley approached the Commodore yelling "Get the fuck out, get the fuck out".

22. The driver got out of the vehicle but on seeing Aaron coming toward her in a hoody got back into the Commodore and tried to shut the door. Aaron grabbed the door and then the keys from the vehicle and said "Get the fuck out". Ashley approached her husband and grabbed his arms and held them behind his back. He then yelled, "We got firearms".

23. Aaron got into the driver's seat of the Commodore. Ashley released the husband and said, "We've got firearms in the car. Don't make me use them. I've got one here and he's got a blade". As he said that he reached with his hand behind his back as if to indicate the position of the firearm. Ashley then got into the front passenger seat of the Commodore and they drove off. The owner's handbag and mobile phone remained in the car. The two younger boys drove the Mirage and followed the Commodore away from the scene.

24. The Duty Superintendent placed an entry in WEBEOC (a web based incident management system) recording the hijack of the Commodore. He noted that the vehicle that struck the Commodore was a stolen vehicle:

> "Mitsubishi was stolen from Margaret Street, Stuart Park this morning".

He added,

> "Youths also believed involved in a Drive-off from Service Station at Coles Express Durack shortly before this incident. CCTV footage being checked".

25. The Commodore and the Mirage were sighted in Palmerston at 7.58pm and again in Humpty Doo at 8.17pm. On each occasion they were pursued. On each occasion the cars went in different directions and the Police vehicle followed the Commodore. The Commodore was driven at excessive speed (over 150 k/h) and on the wrong side of the road. Police terminated the pursuit on each occasion.

26. Police were of the view that the youths were attempting to bait them into pursuits. At 8.30pm the decision was made by Police not to engage in further pursuits. At the same time Police commenced making phone calls to service stations in the area asking them not to turn their pumps on for the Commodore or Mirage.

27. At 8.44pm before a phone call was able to be made to the Caltex at Berrimah, Police Communications received a call stating that the persons in the Commodore had just pumped $35.00 of fuel into the car before driving off without paying.

28. The two younger boys in the Mirage went home. They were arrested at their home at 9.50pm that same evening. That should have been a significant breakthrough because it was possible that Police could learn the identity of those in the Commodore. However, Police did not seek that information from the two boys until after midnight.

29. Those in the Commodore continued to joyride. They picked up another male and at 11.00pm they picked up a 16 year old female from Alawa. She was Ashley's girlfriend. They sat in the rear together.

30. Ashley and the other males in the car were smoking ICE (Crystal Methamphetamine) as they continued to joyride. The ICE had been obtained on a promise of payment and they were looking to find money for payment.

31. They drove to Fannie Bay where they saw a seventeen year old pizza delivery rider on a scooter. They drew up alongside him and Ashley pointed a shotgun through the rear passenger window of the Commodore. The delivery rider stopped his scooter and the Commodore pulled across in front of him. Ashley got out of the vehicle with the shotgun and yelled, "Give me your money". The delivery rider said, "I don't have any". Ashley said, "I will shoot you". The delivery rider was then threatened by Aaron and his scooter kicked over. The delivery rider gave Ashley $210. The time was 11.58pm.

32. Due to the use of the firearm, twelve police Tactical Response Group (TRG) members were called on duty.

33. At 10 minutes past midnight the Commodore was sighted in Casuarina on Vanderlaan Drive heading toward the Highway. It travelled along Berrimah Road, Tiger Brennan Drive and Kirkland Road into Palmerston. It travelled on Elrundie Avenue towards Channel Island Road and over the Elizabeth Bridge at 12.22am. At 12.29am it was sighted travelling inbound on the Stuart Highway about two kilometres from the Arnhem Highway.

34. At 12.38am Service Stations were contacted and asked to turn pumps off and lock their doors in the event that the Commodore attempted to refuel. At 12.57am the Commodore pulled into the Caltex at Yarrawonga and filled up with 57.98 litres of unleaded fuel before driving off without paying.

35. At 1.15pm the Commodore was sighted turning right onto the Stuart Highway at Berrimah. It came to a stop outside the Showgrounds at 1.17am. A Police car pulled up behind it. The Commodore then accelerated away.

36. At about 1.40am the TRG members in four vehicles joined the search for the Commodore.

37. At 1.44am the Commodore was sighted on Dripstone Road and followed along Trower Road, Rothdale Road and outbound on McMillans Road. Those in the Commodore were aware of the Police presence and gesticulated to them and threw thongs and a shopping bag from the vehicle at Police. The TRG vehicles followed the Commodore outbound on McMillans Road.

38. TRG asked if there was a Police vehicle near the intersection of McMillans Road and the Stuart Highway. There was, and they asked whether it could attempt to ensure the Commodore headed south on the highway. The Police vehicle was positioned on the lanes turning inbound onto the Highway. As the Commodore approached the officer turned on the Police emergency beacons. The Commodore turned left onto the Stuart Highway and then accelerated away from Police.

39. Shortly after 2.00am Police lost contact with the Commodore and it was not seen until 2.42am. Unknown to Police, Aaron drove the Commodore to his home address in Cox Peninsula Road where, among other things, he changed his clothes.

40. After the robbery of the pizza delivery driver Police identified those in the Commodore by asking the youth that had been in the Mirage. The identities and home address were provided at 2.15 to the officers on the road.

41. At 2.35am after having no contact with the Commodore since 2.00am, some of the Police vehicles went to check Aaron's home address. While heading

along Cox Peninsula Road (at 2.42am) they saw the Commodore travelling in the opposite direction toward the Highway.

42. At 2.54am the Commodore was sighted on the Arnhem Highway travelling toward the Stuart Highway. A Police vehicle was stationed on the lanes turning right onto the Stuart Highway. The hope was that the Commodore would again turn left and head further out of town. However the Commodore crossed to the incorrect side of the Arnhem Highway and turned right onto the outbound lanes (the incorrect side) of the Stuart Highway.

43. Driving outbound was the Palmerston Supervising Sergeant. On seeing the vehicle coming toward him he flashed his lights on high beam. The Commodore crossed to the correct side of the road. The Supervising Sergeant waited for the following Police vehicles to pass before also turning to follow. The Commodore accelerated to an estimated 200 kilometres an hour.

44. The evidence later taken from the youths in the Commodore was that they were growing tired of the joyride and were seeking to put some distance between themselves and the Police so that they could dump the car unobserved in Palmerston.

45. The Police had positioned cars at various intersections along the Stuart Highway to observe the Commodore. One of those was at the Lambrick Avenue intersection.

46. The time was just after 3.00am and there was little other traffic. The Commodore passed the only other civilian vehicle on the Highway. The driver of that vehicle described the extreme speed of the Commodore and also the flashing amber lights signalling that the lights were changing at the Lambrick Avenue intersection.

47. After the lights changed a person on a motorcycle rode across the intersection on his way to work. Behind the motorcycle a black Jeep was crossing the intersection turning right onto the Highway. The left side of the Commodore crashed into Jeep. The Jeep spun throwing the driver 20 metres onto the verge. The engine from the Jeep came to rest 25 meters away not far from where the driver was thrown.

48. After the collision the Commodore rotated counter-clockwise before the right rear side of the vehicle came into contact with a light pole on the median strip. The impact knocked the light over and cast the intersection into darkness. The Commodore then rotated in the opposite direction coming to rest in the outbound lanes. The time was 3.06am.

49. The Police at the intersection immediately went to the aid of the driver of the Jeep. About thirty seconds later the first of the following Police vehicles arrived. They went to the Commodore. They found the driver's door open. The driver had fled.

50. In the front passenger seat was a young man. He was unconscious and had his seatbelt on. In the rear seat on the passenger side they found Ashley and underneath him his girlfriend. Neither was wearing a seatbelt. They were both unconscious. The girlfriend was able to be removed and regained consciousness. She was released from Hospital the same day.

51. Ashley remained unconscious. He sounded as if he was groaning with each breath. He was cut from the vehicle and taken by Ambulance to the Royal Darwin Hospital. He was found to have suffered a catastrophic traumatic brain injury. He died in the Intensive Care Unit at 5.50pm the same day (7 September 2015).

52. Aaron Hyde, the driver of the Commodore, was arrested just after midday. He made admissions and received a sentence of 11 years imprisonment for

the offences including the robberies and the driving that caused the death of Ashley. The minimum sentence to be served was set at six years.

Issues

53. The escalation of offending and risks leading to the eventual crash require examination. It is important for the community and Police to learn as much as possible so as to find better ways to manage and mitigate the very high risks evident in this case.

54. In the seven and a half hours after the hijacking of the Commodore, the youth demonstrated that they were a serious danger to the public and willing to use a firearm in their offending.

55. It was important that Police keep them under observation to prevent further serious crimes on members of the public. The manner of their driving also posed a significant risk to the public and themselves. It was desirable they be apprehended as soon as possible.

56. However, the apprehension of the youth was only achieved after they crashed. The crash killed Ashley. It could also so easily have killed the driver of the Jeep and the other three youth in the Commodore.

57. The events illustrate the high risks involved for both the public and the youth arising from joyriding in stolen vehicles. They also raise the limited options available to Police when attempting an apprehension.

58. The management of the challenges that these events provided was the focus of this inquest. For the sake of convenience Police management might be divided into:

    a. Coordination of police information and resources;

    b. Situational awareness of police and the technologies at their disposal;

c. Resolution strategies available to police.

Coordination

59. Coordination and control of police information and resources was the responsibility of the Duty Superintendent along with the Watch Commander and the Supervisor of Police Communications (Joint Emergency Services Communication Centre).

60. However those persons are required to deal with incidents throughout the Northern Territory and so the question arises as to when further resources should be utilised to manage such incidents.

61. Police have a system, the *Northern Territory Incident Control System – An Incident Management Framework for any Emergency or Operation* (NTICS). It is said to be a "scalable" system and can be used for interstate operations, interagency operations or incidents such as these when coordinating a Police only response.

62. There are reasons to think that specific incident management may have been beneficial in this case. For instance:

a. Police were unable to prevent the youths refilling the Commodore on two occasions;

b. Police failed to coordinate the investigations between the different teams into the theft of the Mirage and the robbery of the Commodore. That meant that they did not identify the youth in the Commodore in a timely fashion;

c. Police did not seek to use the owner's phone that was left in the vehicle;

d. There was no central coordination of the Police vehicles following and searching for the Commodore. Police on the road listened to the radio

chatter of where the Commodore had been sighted and the officers in each vehicle then determined where they thought it best to position themselves. The result was often five or more vehicles in the same place looking for the Commodore or following it.

63. However the *Northern Territory Incident Control System* was not utilised by police at any time during this incident. The Police Officer investigating Ashley's death on behalf of the Coroner was of the opinion that the NTICS should have been utilised after the hijacking of the Commodore. With the benefit of hindsight so did the Duty Superintendent on that shift.

64. The Acting Assistant Commissioner acknowledged in his affidavit a clearly defined incident management should have been established. Amongst other things that was to assist Police in identifying the offenders earlier.[1]

65. However in evidence he stated that those functions should have been managed without the need for an Incident Control Team.[2] The Watch Commander on the shift also disagreed that there should have been an Incident Control Team.

66. If nothing else that indicates that despite the seventeen months that have elapsed since this incident, Police still find the issue of when to use the NTICS confusing.

67. Attached to the statement of the Acting Assistant Commissioner was a draft *Joint Emergency Services Communications Centre Procedure*. The draft procedure requires that in high risk situations an Incident Control Team be established.

68. That draft procedure provides definitions to determine if an incident is high risk or not. Those definitions indicate that this incident would have been

[1] Paragraph 60 That must have meant well before the second robbery because its benefit would have been if operating shortly after 9.50pm.
[2] Transcript 119 - 122

categorised as high risk from the time the hijacking of the vehicle became known to Police.

69. Where an incident is high risk, the procedure indicates that the Incident Control Team should be activated.

70. One of the Duty Superintendents stated that he uses the draft procedure as a guide even though it is still in draft form. There is clearly a void to be filled. I encourage Police to finalise the draft as soon as possible.

Situational awareness

71. There are two aspects to situational awareness as relevant to these circumstances. The first is that Police do not have a system that shows the location of Police vehicles. It is surprising given the fact that many vehicle fleets have had such systems for a considerable period. The absence of such a system obviously impedes coordination of Police vehicles.

72. Police indicated that they have plans to fit Automated Vehicle Locators to their vehicles. I was informed that would only happen after an upgrade to their Communications. That was not due for about six months.

73. The second aspect is the situational awareness of the target vehicle. Police in this case could only ascertain where the vehicle was by searching for it and when found attempting to follow it.

74. At times that proved unsuccessful. The persons in the Commodore were able to stop and refuel twice, go home on one occasion and for lengthy periods drive undetected.

75. Police had commenced a review of tactics and technology for both situational awareness and resolution strategies in July 2016. In relation to situational awareness the review indicated a desire to have more static

numberplate recognition cameras. However Police have no current approval or timeline for the introduction of more numberplate recognition cameras.

76. Another way to improve situational awareness was indicated to be through aerial surveillance. Police said they were trialling the use of Unmanned Aerial Vehicles (UAVs) (drones) as part of disaster response and believed their capability could be adapted for tracking of target vehicles. I encourage Police to trial UAVs in that capacity.

77. Another technology mentioned as part of the Police review was "Star Chase". That was a system that sought to attach a GPS to the target vehicle. The benefits of such a system are obvious. It was said that the system may not work as well in hot or humid conditions. Police decided not to pursue a trial of that technology.

Resolution strategies

78. The resolution strategy in this case was initially the hope that the Commodore would run out of fuel. To that end Service Stations were contacted and asked not to provide fuel. That was unsuccessful.

79. From the time TRG became involved from about 1.40am the strategy was to simultaneously keep the Commodore under observation and wait until it stopped. It was considered that the best outcome was if the occupants went to a residence to rest. The next best option was if it stopped due to running out of fuel, mechanical fault or accident.

80. There was a tension between the best outcome and the fact that the youths were aware of Police presence. They were unlikely to go home with Police following. Indeed, the youths wished to rest and it was for that reason that they were attempting to distance themselves from the following Police when they crashed.

81. Police properly wanted to keep the Commodore under observation and to apprehend the youth to stop their high risk behaviours. The tension only existed because Police had few other options.

82. The high power of the Commodore provided significant challenges. TRG are trained in techniques for boxing the target vehicle with their vehicles before slowing down and forcing the target vehicle to stop. However that was unlikely to be feasible given the speeds able to be achieved in the Commodore.

83. TRG also had the ability to use spikes that could be spread on the road to deflate the tyres. However, there were a number of impediments to their use. The first was that they were possessed only by TRG. It therefore required a specific strategy to have a TRG vehicle in a location that was likely to be passed by the Commodore. The second was that no policy had been developed for their use or at what speed they were safe to be used. The third was that they needed to be deployed from the roadside. That put Police in danger particularly if the spikes were identified by the target vehicle and in the attempt to avoid them the driver of the target vehicle lost control.

84. At 3.00am it was decided to try using the spikes. However, before they could be utilised the Commodore crashed.

85. It is obvious that this incident was particularly challenging for Police. Indeed Superintendent Shaun Gill who at that time was coordinating the TRG resources told me it was the most difficult and challenging situation in his years in the TRG. I found Superintendent Gill to be a particularly impressive witness.

86. It is obvious that Police need more resolution options. Their review provided a number of possibilities. One was a technological solution that deploys spikes (tyre deflation device) onto the roadway called the

NightHawk. It can be triggered from a remote location and then immediately the target vehicle has run over the spikes, retracted.

87. Police provided evidence that they have obtained two NightHawk tyre deflation devices that are being trialled and are in the process of ordering another 20 units.

88. Certainly if the NightHawk system had been generally available to Police at the time of these events, there is the possibility that it might have been effective in assisting to apprehend the youths relatively early on 6 September 2015.

89. Police are also currently trialling a system to notify Service Stations of cars that are likely to refuel without paying called the *Service Station Automated Notification System* (SANS). Hopefully that will improve the timeliness and effectiveness of such notifications.

Police Review

90. A debriefing was conducted by some of those involved about two months after these events on 13 November 2015. A memorandum of that debriefing along with recommendations was prepared. One of the recommendations was in this form:

> "explore technologies to improve police 'situational awareness' ... solutions such as the use of drones, GPS/tracker device deployed into the vehicle of interest were considered and discussed and recommended to be explored by the NT Police Force"

91. However it is not known to Police what happened to the memorandum. Only an unsigned copy could be found. That was found in the week prior to the start of the inquest. No file was found.

92. No other form of review was undertaken. It should have been. Without proper review of critical incidents, improvement of practices and procedures is either slower than need be or not at all.

93. I was told that the *General Order – Crashes* now provides for a review of any crash in circumstances of a pursuit. That however does not seem to be the case. The review provisions relate only to crashes of Northern Territory Police Fire and Emergency Vehicles. Even if that were not the case the extent of the provisions would be limited by what Police defined as a "pursuit". It is therefore unlikely, even now, that circumstances such as these would be reviewed pursuant to those provisions.

94. Since the inquest, Police have provided to my Office a draft policy relating to the review of all major critical incidents. That is clearly appropriate and I commend the Police on their desire to ensure that proper review policy and procedures are established.

95. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Ashley Dean Ian Richards born on 24 November 1996 in Barmera, South Australia.

(ii) The time of death was 5.50pm on 7 September 2015. The place of death was the Intensive Care Unit in the Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was catastrophic traumatic brain injury.

(iv) The particulars required to register the death:

1. The deceased was Ashley Dean Ian Richards.

2. The deceased was of Aboriginal descent.

3. The deceased was not employed at the time of his death.

4. The death was reported to the coroner by the Police.

5. The cause of death was confirmed by Doctor Dianne Stephens.

6. The deceased's mother was Annette Whittingham and his father was Sean Richards.

96. Additionally, I may make recommendations pursuant to section 35(2):

> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

Recommendations

97. I **recommend** that Police finalise the draft *Joint Emergency Services Communications Centre Procedure* as soon as possible.

98. I **recommend** that Police fit Automated Vehicle Locators to their vehicles as soon as possible.

99. I **recommend** that Police implement a system for review of all critical incidents with the intent to ensure continuous learning and improvement.

Dated this 7th day of April 2017.

GREG CAVANAGH
TERRITORY CORONER

ATTACHMENT B

COMMISSIONER'S OFFICE

MIN2017/0008 : Our Ref

The Hon Natasha Fyles MLA
Attorney-General and Minister for Justice
GPO Box 3146
DARWIN NT 0801

Dear Attorney-General

I refer to your letter dated 11 May 2017, enclosing the findings of the Northern Territory (NT) Coroner, Mr Greg Cavanagh SM, regarding the death of Mr Ashley Dean Ian Richards on 7 September 2015.

The Coroner made the following recommendations to the NT Government relevant to the NT Police Force (NTPF) and I provide my response to each, as follows:

97. I recommend that police finalise the draft Joint Emergency Services Communications Centre procedure as soon as possible.

The procedure is out of draft and forms part of the Joint Emergency Service Communications Centre Standard Operating Procedures (SOP) and complements other SOP around Emergency Vehicle Driving, pursuits, hostile vehicles and the deployment of tyre deflation devices. I consider this recommendation to be complete.

98. I recommend that police fit automated vehicle locators (AVL) to their vehicles as soon as possible.

The NTPF is currently investigating available AVL solutions with a view to encompassing all NT Police, Fire and Emergency Services vehicles, including potential linkages to existing information technology and dispatch systems. I consider the requirements of this recommendation to be ongoing.

99. I recommend that police implement a system for review of all critical incidents with the intent to ensure continuous learning and improvement.

A post operation assessment – Terms of Reference document has been created and field tested in a live incident to assess effectiveness. This process will be included as part of the review of the Major Investigation / Major or Critical Incident plan. I consider the requirements of this recommendation to be ongoing, pending the finalisation of the plan.

The NTPF provide biannual updates on the status of Coronial recommendations to the NT Coroner and will continue to do so.

If you have any queries, my contact officer on this matter is the Chief of Staff, Office of the Commissioner and Chief Executive Officer Branch, Mr David Rose on telephone 8985 8803 or via email on David.Rose@pfes.nt.gov.au .

Yours sincerely

Reece P Kershaw APM
Commissioner of Police

14 August 2017

cc Mr Greg Shanahan
Chief Executive Officer
Department of the Attorney-General and Justice