

CITATION: *Inquest into the death of Delvene Thompson* [2023] NTLC 24

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO(s): D0085/2021

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FINDING OF: Judge Elisabeth Armitage

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**REPRESENTATION:**

Counsel Assisting: Chrissy McConnel

Counsel for Northern Territory Police: Michael McCarthy

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

No. D0085/2021

In the matter of an Inquest into the death of

**DELVENE THOMPSON**

**ON: 16 May 2021**

**AT: Darwin**

**FINDINGS**

Judge Elisabeth Armitage

**Introduction**

1. Miss Thompson<sup>1</sup> was born in Katherine on 12 March 1985 to Dorcas Wulwanga Ashley and Alexander Bunguruta Thompson. She grew up in a large and happy family with seven siblings. She spent her younger years in Ngukurr but when her parents separated she moved with her mother and a younger brother to Katherine in 1997. During her primary school years Miss Thompson was a good student and enjoyed playing sport. She was popular and had many friends. She attended high school in Katherine until about year 10. Following school she met her first partner and they had a son in 2010. That relationship ended in 2013. Miss Thompson went on to have other relationships and more children.

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<sup>1</sup> The deceased's family requested that she be referred to as Miss Thompson

She worked as a traffic controller for a period when living in Eva Valley and moved to Darwin in 2020 with family.

2. On 16 May 2021 Miss Thompson was a passenger in a car that crashed in Darwin. The driver and other passengers survived, some with serious injuries, but tragically Miss Thompson passed away. Moments before the crash the car was pursued by police and in those circumstances it was determined that an inquest should be held.
3. Miss Thompson's older sister, Margaret, and her aunty, Faith, attended the inquest via video from Ngukurr. Through their victim impact statements the family explained their shock, disbelief and suffering following Miss Thompson's passing. I thank them for participating in the inquest and offer my sincere condolences to Miss Thompson's children, her extended family and community for her tragic passing.

#### **The events of 15 & 16 May 2021**

4. On Saturday 15 May 2021 Miss Thompson was with family members, Greg Hall and Barbara Silver, in Palmerston. Miss Silver's boyfriend, Peter Lynch, arrived and they all went out in his uncle's silver Holden Astra (the Astra). The Astra was unregistered and uninsured and should not have been driven on the road.
5. At around 2.10am on Sunday 16 May 2021, two police officers were patrolling Darwin city in a marked police sedan with call sign Tango 206. There was a lot of vehicle and pedestrian traffic in the city because the Bass in the Grass music festival had just finished and festival goers had moved into the city's clubs and pubs.
6. The police in Tango 206 spotted the Astra on Smith Street. Even though he was unlicensed, Mr Lynch was driving. Mr Hall was in the front passenger seat. Miss Thompson was sitting in the rear seat on the

driver's side and Miss Silver was sitting in the rear seat on the passenger's side.

7. The police noticed that the Astra was in poor repair. They conducted a registration check which revealed that the registration had expired on 17 December 2020 and the listed owner was disqualified from driving. Based on this information the police decided to conduct a traffic apprehension (TRAP), that is, they decided to pull the car over. As it was too busy to safely do this in the middle of the city they followed the Astra waiting for a safe location.
8. The Astra travelled along Mitchell Street, right onto Daly Street, and right again back onto Smith Street. The Astra was now heading back towards the heavier city traffic but, as they were in the quieter end of Smith Street, the police decided it was safe to conduct the TRAP. Lights were activated indicating to the driver that he was required to pull over. Initially Mr Lynch complied and he pulled over near 106 Smith Street. The police pulled in behind.
9. One officer exited the police car and approached the Astra. But Mr Lynch did not wait to be spoken to and took off at speed. The officer ran back to Tango 206. Lights and sirens were activated and for about 16 seconds the police chased the Astra along Smith Street. However, due to the volume of traffic and pedestrians, they quickly determined it was unsafe to continue. They deactivated their lights and sirens, pulled over and stopped.
10. At 2.13am Tango 206 radioed Police Communications (JESCC) and reported the attempted TRAP, adding that the Astra had taken off at speed, it was unregistered, and linked to a disqualified driver. They reported they had not pursued due to "the significant number of

drunken pedestrians in the area.”<sup>2</sup> Other on duty police listened to these reports over the police radio.

11. Mr Lynch drove through Darwin city dangerously. Police officers in a police vehicle on Smith Street,<sup>3</sup> saw the Astra on the wrong side of the road driving towards the Smith Street Mall at a speed estimated to be around 80-100km/h. It turned right onto Knuckey Street and was caught on CCTV<sup>4</sup> crossing the centre lane, speeding down the wrong side of the road, and travelling through the Knuckey/Mitchell Street intersection against a red light.
12. Superintendent Daniel Shean was sitting in an unmarked police car at the Knuckey/Mitchell Street intersection. He was the rostered incident controller for Bass in the Grass. Although his shift ended at 2am he was still assessing the number of pedestrians in the city, and their behaviour, to ensure there were sufficient police on duty for the safety of the public.
13. Superintendent Shean heard the radio communications<sup>5</sup> and saw the Astra speeding past him on the wrong side of the road and proceeding through a red light. It turned north onto The Esplanade, undercutting the turn and narrowly missing a white SUV travelling south.<sup>6</sup> Superintendent Shean decided to follow at a safe distance until the Astra was out of the city. He intended to re-engage the vehicle and apprehend the driver when it was safe to do so.
14. From about 2.13am Superintendent Shean covertly monitored the Astra without alerting the driver that he was police.<sup>7</sup> He provided updates

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<sup>2</sup> Folio 3, Police Radio Communications

<sup>3</sup> Folio 5.15

<sup>4</sup> Folio 7.9, CCTV

<sup>5</sup> T 106.

<sup>6</sup> Folio 7.9, CCTV

<sup>7</sup> T 107.

over the police radio on its location and manner of driving. These were monitored by other police on the road and by JESCC.<sup>8</sup>

15. A police member from the dog operations unit driving an unmarked car (the dog unit) heard the radio communications and fell in behind Superintendent Shean on Dick Ward Drive. The dog unit had a patrol dog on board that was trained to apprehend people and this was communicated over the police radio. The police in Tango 206 also took up a position behind the Astra. This meant that three police vehicles were following the Astra: Superintendent Shean, Tango 206 and the dog unit.
16. Police in a marked police paddy wagon (the paddy wagon) were also monitoring the radio and were driving in the middle lane on Trower Road, in the direction of Casuarina. They were carrying a Tyre Deflation Device (TDD) and planned to be in the general vicinity of the Astra in case their assistance was required.
17. From Dick Ward Drive the Astra turned right onto Progress Drive, right onto Nightcliff Drive and, via the slip lane, left onto Trower Road in the direction of Casuarina. Coincidentally, when the Astra turned onto Trower Road in the left lane, the paddy wagon which was travelling in the middle lane, pulled alongside next to the Astra.
18. Within moments of seeing the paddy wagon, Superintendent Shean pulled into the middle lane behind the paddy wagon, overtook the paddy wagon, moved left in front of it and then left again in front of the Astra. He deliberately slowed down forcing the Astra to also slow down.
19. Although there were no radio communications between any of the police vehicles, the other police quickly understood that Superintendent Shean was attempting a TRAP. Tango 206 and the dog

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<sup>8</sup> Folio 3, Police Radio Communications

unit, which were still behind the Astra, identified themselves as police by activating their emergency lights and closed in. In an attempt to ‘box in’ the Astra, the paddy wagon slowed along its right side. However, the execution of the manoeuvre was misjudged. The gap between the rear of Superintendent Shean’s car and the front of the paddy wagon was big enough for the Astra to pass through. Mr Lynch took the opportunity to squeeze through the gap and once again escaped at speed.

### ***The crash and its consequences***

20. With lights and sirens activated on all police vehicles, a police pursuit was called by the dog unit at 2.22am, “urgent, urgent, urgent, now in pursuit of that silver Holden Astra, we’re inbound towards Casuarina on Trower Road, breached a red light and going to let 206 take over when they can get in front.”<sup>9</sup>
21. CCTV and body worn video depicts all police cars in pursuit with their emergency lights and sirens activated.<sup>10</sup> Tango 206 (a designated pursuit vehicle) took the lead. The video footage also depicts a number of civilian vehicles on the road at that time.
22. Mr Lynch sped along Trower Road and proceeded through the Rapid Creek Road intersection against a red light. He continued speeding to the Lakeside Drive intersection. A grey Honda CRV on Lakeside Drive had a green light and commenced turning right onto Trower Road. Although Mr Lynch had a red light he again proceeded through this intersection and crashed into the turning Honda. The point of impact is shown in the following photo.

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<sup>9</sup> Folio 3, Police Radio Communications

<sup>10</sup> Death in Custody Presentation – Operation Grover, 04:45 – 05:15

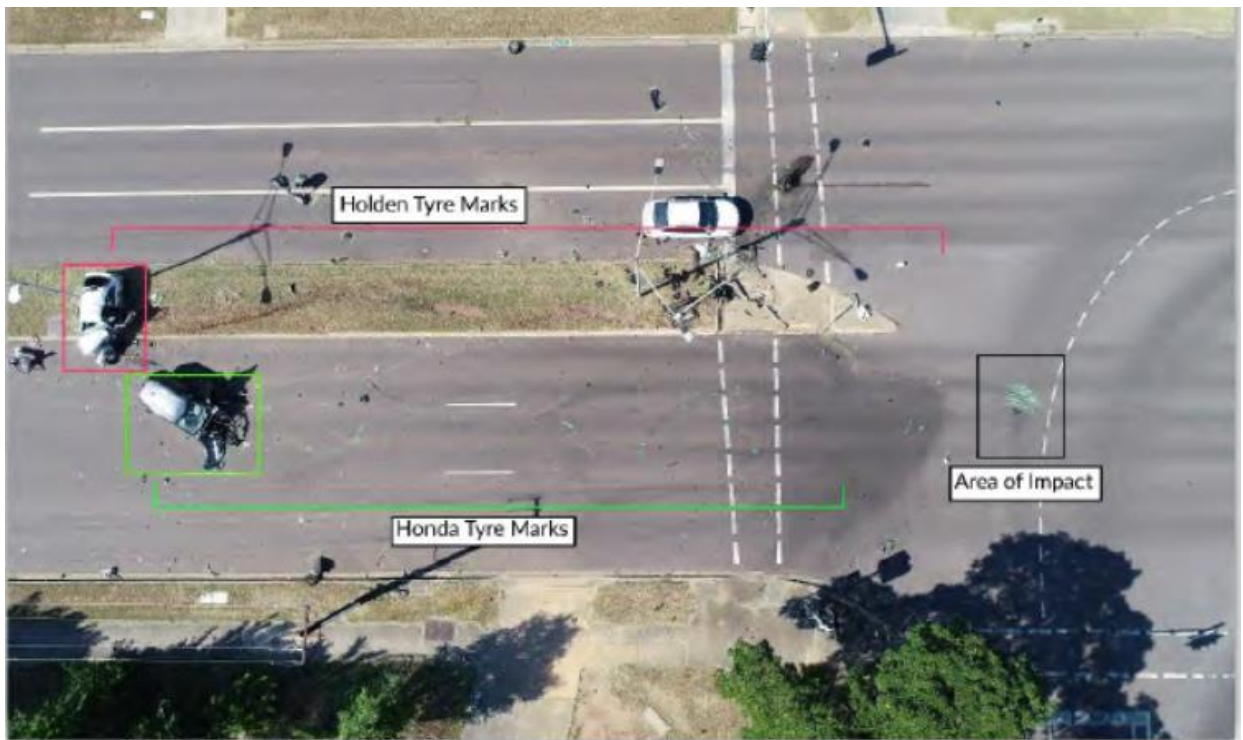


Figure 10: Aerial view of crash scene.

23. The crash occurred at 2.23am, about 31 seconds after Mr Lynch fled the attempted TRAP on Trower Road and about 10 minutes after he evaded police on Smith Street.
24. The impact sent the Honda spinning in a counter-clockwise direction before it came to a stop on Trower Road. Its engine block was torn from the vehicle and ended up on the opposite side of Trower Road. The damage to the Honda is depicted in the following photographs.





**Figure 17: Front of Honda.**



**Figure 18: Driver's side of Honda.**



**Figure 19: Rear of Honda.**



**Figure 20: Passenger's side of Honda.**

25. The Astra rotated in a counter-clockwise direction and struck a traffic light which caused its rotation to reverse. It side swiped a light pole and stopped on the median strip. The course of its travel is depicted in the reconstruction photo below and the damage to the Astra is depicted in the further photos.



Figure 13: Front of Holden.



Figure 14: Driver's side of Holden.



Figure 15: Rear of Holden.



Figure 16: Passenger's side of Holden.

26. The pursuing police officers immediately provided first aid to the occupants of both vehicles. Mr Hall suffered a fractured leg and pelvis and a ruptured bladder. Miss Silver had a lacerated liver, a broken finger and fractured ribs. Mr Lynch suffered severe injuries to his left leg which resulted in a below knee amputation. Blood taken at the hospital revealed Mr Lynch had a blood alcohol reading of 0.097 g/100mls, placing him in the medium range for drink driving.
27. The driver of the Honda suffered 7 broken ribs and prolonged psychological and emotional distress. His passenger suffered back pain and psychological trauma.
28. Miss Thompson was removed from the vehicle and police administered CPR. However, her injuries were fatal and the attending paramedics declared her deceased at the scene.
29. An autopsy was conducted on 17 May 2021 by Forensic Pathologist, Dr Bjorn Swigelaar. He identified injuries consistent with Miss Thompson wearing a seat belt at the time of the crash. The internal examination revealed extensive trauma. He concluded that she died from blunt force injuries to the neck caused by the crash.
30. Detective Acting Sergeant Jeshua Kelly, conducted the crash analysis, and provided the following evidence and opinions:
  - At the point of impact the speed limit was 70kph.
  - The pre-impact speed of the Astra was between 157 and 164kph.
  - The pre-impact speed of the Honda was less than 30kph.
  - Trower Road was displaying a red traffic signal for 7.5 seconds prior to the crash, and the yellow traffic signal had been activated for 5.5 seconds prior to that.
  - The driver of the Astra had sufficient time to stop once the signal turned red.

- The cause of the crash is consistent with the driver of the Astra deliberately proceeding against the red traffic signal.<sup>11</sup>

31. Mr Lynch was charged and pleaded guilty to: driving dangerously while being pursued by police;<sup>12</sup> recklessly engaging in conduct that causes death;<sup>13</sup> and recklessly engaging in conduct that gave rise to the danger of death.<sup>14</sup> He was 21 years of age at the time of the crash and 22 when he was sentenced to 8 years imprisonment with a non-parole period of 4 years. In sentencing remarks, Justice Southwood described the driving as extremely dangerous, motivated by a desire to evade police and escape arrest. His Honour said that it was not a momentary or fleeting decision to flee police, rather it was a lengthy course of conduct and a deliberate choice. He found that Miss Thompson had suffered a very violent death and the way Mr Lynch drove before the crash must have terrified his passengers.<sup>15</sup>

### **Formal Findings**

32. Pursuant to section 34 of the *Coroners Act*, I make the following findings:

- (1) The identity of the deceased is Miss Thompson, born on 12 March 1985 in Katherine in the Northern Territory.
- (2) The time of death was approximately 2.30am on Sunday 16 May 2021. The place of death was Trower Road, Alawa, Northern Territory.
- (3) The cause of death was blunt force injuries to the neck due to a motor vehicle accident.

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<sup>11</sup> Folio 2.1, Major Crash Investigation Unit, Crash Analysis Report dated 16 May 2021

<sup>12</sup> *Criminal Code* s 174 FB

<sup>13</sup> *Criminal Code* s 160

<sup>14</sup> *Criminal Code* s174C and 174G(a)

<sup>15</sup> *R v Peter Lynch* SCC 22115329, Southwood J, 15 November 2022

- (4) The particulars required to register the death will be provided to the Office of Births, Deaths and Marriages.

### **Issues for the inquest**

33. It was first necessary to determine whether this was a death in custody. Additionally, the inquest considered whether relevant police policies and procedures had been followed and whether they were appropriate and sufficient.
34. While it is clear from the factual circumstances that it was the dangerous driving of Mr Lynch that caused the crash and the death of Miss Thompson, I was concerned that police decisions and actions may have heightened the risk or acted as a catalyst for his shocking decision to drive so dangerously.

### ***Was this a death in custody?***

35. The definition of a ‘person held in custody’ includes a person in the process of being taken into or escaping from the custody or control of a police officer.<sup>16</sup> As it was the driver, Mr Lynch, who police were attempting to apprehend and not his passenger, Miss Thompson, I concluded that her death was not a death in custody.
36. Because her death was not a death in custody, the police general order *Coronial Investigations and Inquests*<sup>17</sup> did not apply. However, as this was a fatal incident resulting from police contact with the public, another General Order required that the Territory Duty Superintendent be notified, and that a Commissioned Officer be appointed to be in charge of the investigation to ensure all aspects of the investigation

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<sup>16</sup> *Coroner's Act 1993* s 12

<sup>17</sup> General Order Op-C14, promulgated 4 December 2014, last updated 8 September 2016

were carried out competently and thoroughly.<sup>18</sup> Both of these General Orders have now been replaced with a new single General Order: *Crime (Homicide and Serious) Investigation*.<sup>19</sup>

37. The new General Order applies to deaths in custody, reportable deaths and serious crimes. Applying the definitions of the new general order to the circumstances of this case, Miss Thompson's death was a reportable death and a serious crime. Under the new General Order a crash resulting in death is to be investigated as a serious crime until a Deputy Commissioner determines the extent of the investigation. While deaths in custody are required to have a senior investigating officer of at least the rank of a detective superintendent allocated, serious crime investigations may be allocated to less senior investigators.<sup>20</sup>

38. In order to ensure that deaths connected to a police pursuit are investigated thoroughly and at the highest level, I was pleased to hear from Assistant Commissioner Travis Wurst that the Senior Executive Team had agreed that the new General Order would be amended to ensure that deaths occurring in the context of a police pursuit are investigated in the same way and as thoroughly as a death in custody.<sup>21</sup> These types of investigations are not limited to investigations of fact. They require a robust review of police decisions and conduct to determine whether all the relevant police policies and training have been followed. They should also consider whether the policies, guidelines and training programs are sufficient and appropriate to meet the needs of the police and the public. Given those complexities I

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<sup>18</sup> General Order Op-C1, *Deaths in Custody and investigation of serious and/or fatal incidents resulting from police contact with the public*, promulgated 10 November 2011, last updated 8 September 2016

<sup>19</sup> Promulgated 22 November 2022

<sup>20</sup> General Order, *Crime (Homicide and Serious) Investigation*, 22/11/22 p 15

<sup>21</sup> Supplementary Affidavit, Assistant Commissioner Travis Wurst, 29 May 2023



consider it is necessary and appropriate for a Commissioned Officer to investigate all deaths arising from or connected to police pursuits.

39. As this was not a death in custody an inquest was not mandatory. However, it was appropriate to hold an inquest because it was a death connected to a police pursuit. In those circumstances it was prudent to scrutinise police conduct, policies, procedures and training to determine whether policy had been complied with, whether the policies were adequate, and whether there were any changes that should be made with a view to preventing similar deaths in the future.

***Did police engage in a 16 second pursuit on Smith Street?***

40. Under the police General Orders<sup>22</sup> a **TRAP** means the actions of a police driver who in the course of undertaking law enforcement activities, seeks to engage with and stop a motor vehicle. A successful TRAP involves the police issuing a direction to stop and the target vehicle pulling over. A **direction to stop** is any action or instruction given by a police officer to indicate that the driver is to stop, including, hand signals, signs, or lights and sirens.

41. The general order also provides the following definitions:

13.8 **Evading driver** is the driver of a motor vehicle who, through their actions,....fails to comply with a direction of police and/or fails to stop as soon as practicable.

13.9 **Hostile vehicle** is a vehicle that is non-compliant with police directions to stop.

42. On discovering the Astra was unregistered and possibly driven by a disqualified driver, the police in Tango 206 had sufficient grounds to execute a TRAP. But it was not safe to do so immediately because, according to one of the police officers, “during our earlier laps around

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<sup>22</sup> *General Order – Emergency Vehicle Driving (EVD) & Pursuit Driving*, 23 February 2017 updated 6 June 2019, [13.21]

town there were people in various states of intoxication, staggering all around the road. It was just mayhem, people walking out against crossings.”<sup>23</sup> Having assessed the risks, the police appropriately delayed executing the TRAP until they determined it was safe to do so.

43. Once they decided to perform a TRAP their training required them to notify JESCC: of that intention, their location, and details of the vehicle of interest.<sup>24</sup> In this instance the police failed to notify JESCC. I will return to this later in these findings.

44. When the police lights were illuminated, Mr Lynch initially pulled over and clearly demonstrated that he understood he had been directed to stop. However, his apparent obedience was a ruse because, when one of the officers exited the police car, he used the opportunity to take off at speed. Applying the General Order definitions, Mr Lynch was now an ‘evading driver’ and the Astra was a ‘hostile vehicle’.

45. He headed back towards the city centre, the very location where the police had previously determined it was too risky to stop him. In spite of that recent risk assessment, the police chased with their lights and sirens activated for 16 seconds before again deciding it was too risky to continue.

46. There were differing opinions about this period of police driving. Some police considered that it was Emergency Vehicle Driving, a precursor to a possible pursuit, others thought it was a pursuit. The difference is important because if it was a pursuit, special rules applied.

47. The General Order provides the following:

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<sup>23</sup> Folio 5.2 p 13

<sup>24</sup> Coronial Inquest –Thompson – Organisational Review, [19] extracting *College Document, Traffic Apprehension Facilitators Guide* p 16



13.15 A police **pursuit** is when a driver indicates by their actions or continuance of their manner of driving that they have no intention of stopping for the police, and

- The police driver believes that the driver of the hostile vehicle is aware of the requirement to stop; and
- There is an active attempt by a police officer operating a motor vehicle to with emergency equipment activated, to apprehend the hostile vehicle.

13.5 **Emergency Vehicle Driving (EVD)** means the driving of a motor vehicle which is pressing or demanding of prompt action... displaying red and/or blue flashing lights or an alarm...

30. Members will not undertake EVD unless:

...

30.2 they are in the process of moving into a position to check a vehicle's speed or to apprehend a driver/passenger for an offence.

48. The police in Tango 206 considered the 16 seconds amounted to a brief period of EVD which was engaged in to assess: whether Mr Lynch would 'continue his manner of driving', and whether 'he had no intention of stopping'<sup>25</sup>, and to be in position to pursue if he did not stop.<sup>26</sup> However, having formed the view that he would not stop and that it was too risky to pursue, they pulled over. I accepted that those opinions were genuinely held, and they were consistent with their contemporaneous radio communication.<sup>27</sup>

49. Sergeant Sean Rimmer, Officer in Charge of the Driver Training and Road Policing Unit, reviewed the evidence and agreed with that assessment. He explained that Tango 206 was 'moving into position' to conduct a pursuit, and that 'moving into position' was a type of EVD.

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<sup>25</sup> Applying part of the definition of pursuit in *General Order – Emergency Vehicle Driving (EVD) & Pursuit Driving*, 23 February 2017 updated 6 June 2019, [13.15]

<sup>26</sup> Applying part of the *General Order – Emergency Vehicle Driving (EVD) & Pursuit Driving*, 23 February 2017 updated 6 June 2019, [30.2]

<sup>27</sup> Death in Custody Presentation – Operation Grover, 02:00-2:05.

Sgt Rimmer conceded that if the 16 seconds was EVD, it was unclear at what point it would become a pursuit.

50. Assistant Commissioner Wurst also initially thought that the 16 seconds was EVD.<sup>28</sup> However, having listened to the evidence and having reflected on the definition of pursuit, he changed his mind. Ultimately it was his opinion that Tango 206 was engaged in a pursuit.<sup>29</sup> I understood that Assistant Commissioner Wurst was satisfied by the evidence that all the necessary points of the definition of pursuit had been met, namely: by speeding off Mr Lynch had demonstrated he had no intention of stopping; the police in Tango 206 knew that he was aware he was required to stop (because he had initially pulled over); and their immediate activation of lights and sirens combined with a speedy chase was a short but active attempt to apprehend a hostile vehicle.

51. Senior Sergeant Richard Howie, the Watch Commander situated in JESCC, thought the definition of pursuit was clear. It was his opinion that the 16 seconds was a pursuit. Applying common sense, he said that if the Astra had crashed ‘then and there’ it would have been classified as a pursuit.<sup>30</sup>

52. In the *Inquest into the death of Patrick Wayne Bloomfield* the former Coroner, Judge Cavanagh, identified the potential for ambiguity in the definition of pursuit<sup>31</sup> which may explain these differing opinions. Although he did not agree that the definition was ambiguous, Assistant Commissioner Wurst acknowledged that it was “open to interpretation”,<sup>32</sup> Sgt Rimmer said it was a “grey area”,<sup>33</sup> and in the

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<sup>28</sup> Affidavit, Assistant Commissioner Travis Wurst, 2 May 2023, [92]

<sup>29</sup> T 142

<sup>30</sup> T 135

<sup>31</sup> [2021] NTLC 010, [36]

<sup>32</sup> T 141

<sup>33</sup> T 70

Organisational Review the definitions of EVD and pursuit were said to be “somewhat overlapping”.<sup>34</sup>

53. Assistant Commissioner Wurst explained some of the inherent dangers arising from police pursuits. He said that “drivers seeking to evade police are unpredictable and pursuing these drivers is dangerous as it most frequently occurs on public roads, posing a risk to other road users, pedestrians, persons living in houses in the near vicinity, the alleged offender, any passengers in the car and the police.”<sup>35</sup> The General Order is designed to mitigate those risks but it can only effectively do so if it is applied at the time the risks arise. Accordingly, it is important to remove, as much as is possible, ambiguity, room for interpretation and grey areas from the definition of pursuit.

54. In response to Assistant Commissioner Wurst’s evidence that the 16 seconds was a pursuit, I said:<sup>36</sup>

I think that is a sensible position. It’s hard enough to do all the risk assessments without adding a question in an officer’s mind, is this or is this not a pursuit. The risks arise the minute the lights and sirens are activated and you’re putting your foot on the accelerator to catch up or pursue that vehicle. I do think it’s a very sensible position that there be no ambiguity.

55. I found Assistant Commissioner Wurst’s and Watch Commander Howie’s evidence to be persuasive and sensible. In this case, the risks associated with a pursuit arose when Mr Lynch took off and the police took off after him. During those 16 seconds, all the risks associated with pursuits existed and the General Order concerning pursuits should have applied to mitigate those risks. If there is ambiguity in the definition of pursuit, that ambiguity should be removed.

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<sup>34</sup> Coronial Inquest –Thompson – Organisational Review, [28]

<sup>35</sup> Affidavit, Assistant Commissioner Travis Wurst, 2 May 2023, [44].

<sup>36</sup> T 142

***What were the consequences of not identifying the 16 seconds as a pursuit?***

56. The consequences for not identifying the 16 seconds on Smith Street as a pursuit were significant.
57. If the 16 seconds had been identified as a pursuit, the General Order<sup>37</sup> required that: it be called in over the radio, the Watch Commander is notified, and a pursuit controller is to be appointed even if the pursuit is of short duration. Given this was such a short pursuit, although there may not have been time to appoint a pursuit controller, at least the Watch Commander would have been properly alerted to the situation.
58. Of possibly greater importance to this case, the General Order<sup>38</sup> makes it clear that when a pursuit is terminated there is to be no further engagement with the vehicle unless a search phase is authorised by an appointed pursuit or incident controller (incident controller), who may be the Watch Commander, a Superintendent or an Officer in Charge. I understood that, if appointed, an incident controller could co-ordinate responses, establish search parameters and issue instructions as required. The incident controller monitors any engagement with the vehicle through radio communications, is to be consulted on resolution strategies, and must approve any further pursuit.<sup>39</sup>
59. The guideline concerning *Pursuit Prevention and Resolution Strategies* specifically provides:

The instructions of the pursuit controller or incident controller should be clear to all. The instructions may relate to specific police responses units and may include the following:

Observe and report,

Observe and shadow,

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<sup>37</sup> General Order, *Emergency Vehicle Driving (EVD) & Pursuit Driving*, 23 February 2017 updated 6 June 2019, at [35] and [38]

<sup>38</sup> General Order, *Emergency Vehicle Driving (EVD) & Pursuit Driving*, 23 February 2017 updated 6 June 2019, [61-62]

<sup>39</sup> T pp131-133

Observe and engage if safe to do,  
Boxing,  
Tactical collisions,  
Deliberate action,  
Emergency action,  
Deployment of TRG.

60. In this case because the 16 seconds was not identified as a pursuit this extra level of external supervision was not activated. As Watch Commander Howie explained, “as soon as there is a pursuit that triggers another level of oversight” but in this case “nil pursuit had been called...so I sort of continued with what I was doing,” which was dealing with issues concerning a youth in custody. Shortly afterwards, when he became aware of chatter on the radio about units following a vehicle, he did not connect that with the Smith Street TRAP and continued to prioritise the youth matter.<sup>40</sup>
61. The failure to identify the 16 seconds as a pursuit, and the consequential failure to authorise a search phase and appoint an incident controller, was a lost opportunity to properly coordinate any continuing engagement with the Astra and a lost opportunity to monitor and potentially reduce risk.

***Did the police develop an appropriate resolution strategy?***

62. In an effort to escape apprehension, initially Mr Lynch engaged in highly dangerous driving that put himself, his passengers, and other road users, at serious risk of harm or death. In circumstances where the police did not know who was driving the Astra, it was appropriate that they put in place a plan to identify or arrest the driver, when and if that could be done safely. Critically, any plan needed to acknowledge,

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<sup>40</sup> T 126

address and mitigate the risk that the driver would likely re-engage in seriously dangerous driving to evade apprehension.

63. However, after the initial spree of dangerous driving, for about the next 10 minutes Mr Lynch did not break the road rules.<sup>41</sup> Although a search phase had not been authorised, Superintendent Shean was covertly monitoring the Astra and contemporaneously reporting its position and movements to JESCC.
64. While this provided an opportunity to develop a resolution strategy,<sup>42</sup> effective planning was hampered by the lack of an incident controller. In this regard, Superintendent Shean said that he wanted to be at “arm’s length” from “incident control”. He considered that the Duty Superintendent or the Watch Commander in the communications centre were better placed to take on the role of incident controller because they had “oversight of the bigger picture of who is doing what around the Darwin area and can coordinate other resources to come in, if they are available, to assist in any resolution strategies.”<sup>43</sup>
65. Without an incident controller, police on the ground were doing their best. They were communicating with each other over the police radio<sup>44</sup> and available police were moving into position to assist. Superintendent Shean was considering a number of possible outcomes. If the Astra stopped he thought he would have enough vehicles to establish a cordon, and if the driver ran, he thought the police dog could assist with an apprehension. He was also considering the possible use of a TDD.<sup>45</sup>

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<sup>41</sup> Folio 3, Radio Transmission Synopsis

<sup>42</sup> T 133

<sup>43</sup> T 108, 113

<sup>44</sup> Folio 3.1, Radio Transmission Synopsis

<sup>45</sup> Folio 3.1, Radio Transmission Synopsis, TDDs first mentioned at 2.19.52 am

66. Ordinarily the Watch Commander approves the use of a TDD. But the TDD instruction also permits officers of the rank of Senior Sergeant or above to authorise their use, and in exceptional circumstances their use without authorisation is also permitted.<sup>46</sup>
67. Superintendent Shean said that he believed he had requested the use of a TDD and he expected that, if approved, this would trigger external oversight by the Watch Commander. However Superintendent Shean was mistaken. At 2.20am Superintendent Shean radioed, “once red and blues get activated he’ll probably go again so would be good to have spikes ready” but he did not clearly request TDD approval. When the JESCC dispatcher heard mention of a TDD she spoke to the Watch Commander. Exactly what was discussed is unclear but Watch Commander Howie said that he did not recall any request for a TDD being made and he did not engage in any additional active monitoring of the situation.<sup>47</sup>
68. The officers in Tango 206 thought that, because he was above the rank of Senior Sergeant, Superintendent Shean had authorised the use of a TDD and at 2.22am they radioed asking if there were any units further along Trower Road that might be able to set one up.
69. It seems there was some confusion between the police members about whether a TDD had been approved and who was in charge. The various police in the cars on the ground assumed, given his rank, that Superintendent Shean was in charge. Superintendent Shean hoped the Watch Commander would take control when TDD approval was sought. Meanwhile, the Watch Commander was prioritising a youth in custody matter as he had not been “triggered” to take control in circumstances where no pursuit had been called in Smith Street, he had not connected

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<sup>46</sup> Coronial Inquest –Thompson – Organisational Review, p 10

<sup>47</sup> T 127.

the radio chatter to the Smith Street events, and there was no clear request for approval to use a TDD.

70. I accept Superintendent Shean’s concession that in hindsight the confusion could have been avoided if he had clearly requested the Watch Commander to “come on board and start co-ordinating some things.”<sup>48</sup>

71. If there had been incident controller or if Watch Commander Howie had become aware of the developing complexity, it is likely that the formulation and planning of more concrete and less risky resolution strategies would have progressed and been better communicated. For example, Watch Commander Howie said “if we had known that one of the resolution strategies was just to follow the vehicle, a broadcast could have gone out requesting other vehicles stay away or position themselves...to not get involved initially.”<sup>49</sup>

72. Similarly, Assistant Commissioner Wurst said: <sup>50</sup>

In my view the most appropriate way to have managed the [Astra] at this point was to continue to follow the vehicle using the unmarked asset, for the marked vehicles to disengage or follow from a considerable distance, as had already been occurring, and devise an alternate resolution strategy that was well communicated and co-ordinated using available strategies such as TDD or waiting for the driver to stop his vehicle.

73. It is possible that with better planning and communication, the chance meeting between the paddy wagon and the Astra, the subsequent attempted TRAP, and pursuit, might have been avoided.

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<sup>48</sup> T 115

<sup>49</sup> T 135

<sup>50</sup> Affidavit, Assistant Commissioner Travis Wurst, 2 May 2023, [123]



*Should the TRAP on Trower Road been attempted?*

74. I was concerned about the second TRAP being attempted in circumstances where there had been a period of driving with no breach of the road rule, it was likely Mr Lynch would drive dangerously to avoid apprehension, and when there were no further resolution strategies (such as TDD) in place.
75. Although it had been his intention to continue to follow the Astra, when the paddy wagon pulled alongside, Superintendent Shean's years of experience led him to conclude the driver would be "spooked by the presence of police and take off at speed."<sup>51</sup> In circumstances which were described as "fluid and dynamic,"<sup>52</sup> Superintendent Shean attempted a TRAP in the hope that it would prevent any further dangerous driving. In those circumstances, when police are making decisions under pressure, it is difficult to conclude that an attempted TRAP was unjustified or unreasonable. However, there were a number of problems with its execution.
76. Similarly to the Smith Street TRAP, Superintendent Shean failed to notify JESCC of his intention to conduct a TRAP and wait for approval. Consequently, the other police on the ground were unaware of what he was about to attempt.<sup>53</sup> I accept that Superintendent Shean regretted this communication lapse.<sup>54</sup> That this was overlooked in both attempted TRAPs suggests there may be need of further training or reminders about this requirement.
77. The unorthodox method adopted for the attempted TRAP appeared similar to, and was described by several police officers, as a boxing manoeuvre. For example, two police officers parked at the

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<sup>51</sup> T 112

<sup>52</sup> T 111

<sup>53</sup> Coronial Inquest –Thompson – Organisational Review, [19]

<sup>54</sup> T 111.

Ryland/Trower Road intersection observed the TRAP and described it as a “boxing in procedure” with the police vehicles slowing around the Astra in an attempt to stop it.<sup>55</sup>

78. Shortly after the crash Superintendent Shean phoned Superintendent Sandi Lee Mellon, the Territory Duty Superintendent situated in JESCC. He explained to Superintendent Mellon that he had “attempted to box the car in...but the driver of the van didn’t put themselves in quite the right position so they were able to slip past.”<sup>56</sup> However, in his oral evidence Superintendent Shean suggested that he had not “cast his mind to a boxing manoeuvre” and the method adopted was an unorthodox TRAP from the front.<sup>57</sup> Sgt Rimmer expressed a similar opinion.<sup>58</sup>

79. The *Pursuit Prevention and Resolution Strategies* guideline describes “boxing” as a “coordinated response” that “carries risk and must only be completed by trained officers under specific risk thresholds.”<sup>59</sup> Only members of the Territory Response Group (TRG) are currently trained to conduct boxing. None of the police involved in the TRAP were trained to use this technique. The evidence was that this was not a planned or co-ordinated boxing and developed organically. However, the attempted TRAP (which involved three police vehicles surrounding and slowing down around the Astra) was a type of boxing and, even if unplanned, was conducted in breach of police policy and training.

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<sup>55</sup> Folio 5.11 pp 3, 10, and annexed notebook entry “saw 3 police vehicles try box silver Holden Astra”; Folio 5.12 and annexed notebook entry “observed two police sedan and dog unit blocking in offenders vehicle”

<sup>56</sup> Recorded Statement, Superintendent Sandi Lee Mellon, 20 May 2021, p 18; see also Recorded Statement, Superintendent Shean, 16 May 2021, p 21

<sup>57</sup> T 111

<sup>58</sup> T 83

<sup>59</sup> Affidavit, Assistant Commissioner Travis Wurst, 29 May 23, Annexure 3

80. Accepting that there might have been sufficient grounds to conduct a TRAP, the failure to follow police policy and procedure may have contributed to its unsuccessful outcome.

***Should police have engaged in a pursuit? When should it have been terminated?***

81. Before commencing and throughout a pursuit all police are required to conduct continuous risk assessments. Whenever the risk assessment indicates that the risks cannot be effectively managed, the pursuit is to be terminated immediately by any police member who makes that assessment regardless of rank.<sup>60</sup>

82. When the Astra evaded the TRAP police immediately pursued and the Astra crashed approximately 31 seconds later. What occurred during those 31 seconds and whether the police actions were in accordance with policy and procedure was considered in a Police Organisational Review which found: <sup>61</sup>

c) After the failed TRAP on Trower Road, the incident evolved rapidly, noting the time from the second evade to the crash was a total of 31 seconds. During those 31 seconds, members called the pursuit, called the HV [hostile vehicle] breach of red light, breached the red light intersection themselves and the secondary vehicle moved into the primary position as the crash took place.

d) There were significant risks associated with the commencement of the pursuit on Trower Road, noting the following:

(i) the HV had shown no intention to stop or slow down and travel through red stop light intersections; and

(i) The HV was traveling towards a red stoplight Rapid Creek Rd and Trower Road intersection.

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<sup>60</sup> General Order, *Emergency Vehicle Driving (EVD) & Pursuit Driving*, 23 February 2017 updated 6 June 2019, [23-24]

<sup>61</sup> Coronial Inquest - Thompson- Organisational Review, [29]

e) On balance, this review finds that it was appropriate to commence the pursuit and that the actions of the officers involved in the initiation of the pursuit were in accordance with policy and procedures. While there are inherent risks with all pursuits, members in this scenario had considerable supportive points in forming a decision to pursue:

- (i) Trower Road is a 3 lane road which would subject any civilian traffic to a lesser risk;
- (ii) pursuit engaged in the early hours of the morning, therefore significantly less vehicular and pedestrian traffic;
- (iii) Trower Road is well lit with street lighting, road was sealed and dry;
- (iv) adequate and appropriate resources were in position to assist. 206 being a traffic enforcement vehicle which would take over as primary vehicle if required, Canine unit available if offenders stopped and alighted from the vehicle and a caged divisional van to convey arrests; and
- (v) given the extremely dangerous manner of driving committed by the evading driver within Darwin city, members did not want to risk having the vehicle returning back into the city or traveling to any other heavily populated area.

f) There were significant risks associated with continuing the pursuit once the HV had breached the first red light, noting:

- (i) the HV had shown no intention to stop or slow down and travel through red stop light intersections;
- (ii) the HV was traveling towards a red stoplight Rapid Creek Rd and Trower Road intersection; and
- (iii) the HV has previously evaded police at speed in a built up area (Darwin city).

g) On balance, this review finds that it was inappropriate to continue the pursuit. While there remained a number of reasons in support of the pursuit (discussed above), the balance of the risk assessment shifted noting the actions of the evading driver in failing to stop or slow down at the red stop light Trower Road and Rapid Creek Road intersection demonstrated little thought to the safety of the evading vehicle occupants or any member of the public.

83. Assistant Commissioner Wurst came to the same conclusion.<sup>62</sup>

However, Sgt Rimmer expressed a different opinion. He said: <sup>63</sup>

...Having the luxury of looking at it frame by frame, our recommendations would be that, faced with a red light, it would increase your risk assessments somewhat. And perfect world, being able to see the actions super clear in hindsight, we would expect our students more than likely to recommend a termination...before the [first] red light.

84. With all the advantages of hindsight, I am persuaded by Sgt Rimmer's assessment. Firstly, even if the police did catch up to the Astra, I am concerned that there was no resolution strategy. If the goal was to stop the Astra and arrest the driver, how was that going to be achieved? Secondly, just ten minutes earlier, Mr Lynch had demonstrated a willingness to drive in an extremely dangerous fashion to avoid apprehension. He had breached speed limits, driven on the wrong side of the road, breached a red light and cut a corner only narrowly avoiding collision with another vehicle. It was likely he would take the same risks, and the risk was heightened because he was approaching an intersection against a red light. In light of those risks and with no resolution strategy in place, I consider that a pursuit was difficult to justify.

85. Additionally, had the 16 seconds on Smith Street been identified as a pursuit, another pursuit could not be commenced without first obtaining approval.<sup>64</sup> I do not know whether a pursuit would have been approved but in light of the identified risks, I consider it unlikely.

86. None of these comments should be taken to suggest that the actions of the police on the night were anything other than done in good faith under pressing circumstances. Given his previous driving, once Mr

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<sup>62</sup> Affidavit, Assistant Commissioner Travis Wurst, 29 May 23, [135]

<sup>63</sup> T 85

<sup>64</sup> General Order, *Emergency Vehicle Driving (EVD) & Pursuit Driving*, 23 February 2017 updated 6 June 2019, [60]

Lynch evaded the TRAP at speed it is quite likely that he would have continued to speed away in disregard of the road rules, regardless of whether a pursuit had been initiated. I reiterate that it was his decision to drive dangerously and the crash occurred as a direct consequence of his decisions and actions.

***Was Body Worn Video (BWV) used appropriately? Can the recording of road incidents be improved?***

87. The use of BWV by police is considered to be part of a pursuit resolution strategy and police are required to activate their BWV when engaging in a TRAP or pursuit.
88. It is heartening that almost all attending police activated their BWV. Two police officers did not do so. The reason provided by one officer was that he believed it had been turned on and the other could not recall whether he had attempted to turn it on. Both said that their failure to activate their BWV was not intentional. The BWV that was available provided helpful evidence but the quality of the recordings varied, in part depending on where the recording equipment was mounted on an officer's body.
89. To potentially overcome operator error and placement issues, Assistant Commissioner Wurst advised that options for BWV (or similar) to be mounted on police vehicles are under consideration by the Police Force, including the possibility of automatic activation, for example, when lights and sirens are initiated. The possibility of real time review of BWV by, for example, the Watch Commander, is also under consideration.

## ***Member wellbeing***

90. On viewing the BWV, on reading the police statements, and on hearing from police members, it was readily apparent that the police members are exposed to high levels of trauma, which inevitably affects them.
91. A number of officers involved in the pursuit were also engaged in providing first aid and managing the scene over a considerable period of time. While noting logistical difficulties, Assistant Commissioner Wurst acknowledged the need to remove officers involved in a fatal pursuit from the scene as quickly as possible to preserve their evidence and to protect their welfare. I am assured that it is intended to include guidance around this in future policies.
92. Since this incident, Assistant Commissioner Wurst advised that Northern Territory Police have launched the Tri-Services Wellbeing Strategy 2023-2027.<sup>65</sup> This strategy undertakes to strengthen supports to all officers across all facets of the work with particular focus on critical incidents.<sup>66</sup> The strategy makes provision for critical incident debriefs, peer support programs, and psychological supports which are designed to promote and support officer wellbeing and resilience following traumatic work events. This is to be commended.

## **Conclusion**

93. Tragically, Miss Thompson was killed when Mr Lynch evaded police, sped away, proceeded through intersections against red lights and crashed into an innocent civilian vehicle. It was his second instance of seriously dangerous driving that night.

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<sup>65</sup> Exhibit 3.

<sup>66</sup> Affidavit, Assistant Commissioner Travis Wurst, 2 May 2023, at [291].

94. It was appropriate that the police responded to his earlier incident of dangerous driving. They did so in good faith and with the intention of intervening to prevent any loss of life or serious injury.
95. However, the inquest revealed that there were some failures to comply with the police policies and guidelines, the more significant of these arising from a lack of clarity concerning the definition of pursuit. If the initial 16 seconds on Smith Street had been identified as a pursuit, there could not have been any further engagement with the Astra except if approved and overseen by an incident controller. Such oversight would likely have assisted police to better co-ordinate their response and to develop appropriate resolution strategies. In particular, the chance meeting between the paddy wagon and the Astra might have been avoided. Additionally, as the Trower Road TRAP and pursuit could not have occurred without prior approval it is possible that different decisions might have been made that might have resulted in a different outcome.
96. In his role as chair of the Road Safety Steering Committee, Assistant Commissioner Wurst advised that a new *Road Policing General Order* will be promulgated. The new General Order will update and amalgamate existing policies and procedures. The Road Safety Steering Committee is already considering whether additional oversight can be offered by the Watch Commander or an incident controller when TDD is requested or when a co-ordinated resolution strategy needs to be developed. I am pleased that the Road Safety Committee will consider incorporating any recommendations from this inquest in the new General Order.



## Recommendations

97. **I recommend** that the Commissioner of Police make it mandatory that deaths arising from or connected to a police pursuit are investigated in the same way as a death in custody is investigated.
98. **I recommend** that the Commissioner of Police amend the definitions of pursuit and emergency vehicle driving to remove ambiguity and overlap.
99. **I recommend** that the Commissioner of Police give consideration to the circumstances in which it is appropriate to allocate an incident controller (or a person exercising similar oversight) to assist police members carrying out traffic duties, including, for example, when TDD is requested, when police are engaging with a hostile vehicle, or when there is a need for a co-ordinated resolution strategy; and to make any amendment to the General Orders as is necessary to implement any additional oversight.
100. **I recommend** that the Commissioner of Police ensure police members are aware of their obligations to notify JESCC before conducting a TRAP and of their obligations to activate their BWV when conducting a TRAP or pursuit.
101. **I recommend** that the Commissioner of Police continue to explore ways of improving the video capability of police vehicles, including the feasibility of automatic activation.

Dated this 6<sup>th</sup> day of December 2023.

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ELISABETH ARMITAGE  
TERRITORY CORONER