IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

REDACTED VERSION – FOR PUBLICATION

Court Reference: COR 2012 0265

FINDINGS INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Deaths of: [redacted][1]

Delivered On:	24 September 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank, VIC 3006
Hearing Dates:	20, 21, 22, 25, 26, 27, 28 & 29 August and 1, 2, 3 & 4 September 2014
Findings of:	JOHN OLLE, CORONER
Representation:	Mr Leighton Gwynn and Mr Simon Moglia on behalf of the [redacted] family Mr Ron Gipp instructed by the Victorian Government Solicitors Officer for the Chief Commissioner of Police Mr Ben Ihle instructed by Lander and Rogers on behalf of Constable Purcell, Leading Senior Constable Thek and Sergeant Rumble Ms Fiona Ellis instructed by DLA Piper on behalf of La Trobe Regional Health
Counsel Assisting the Coroner	Ms Naomi Hodgson instructed by the Coroners Court In-House Solicitors Service

[1] I also investigated the death of Jason Govan (COR 2012 264), who died in the same incident, as part of this inquest.

I, JOHN OLLE, Coroner having investigated the death of [redacted]

AND having held an inquest in relation to the death on 20, 21, 22, 25, 26, 27, 28 & 29 August and 1, 2, 3 & 4 September 2014

at Coroners Court MELBOURNE

find that the identity of the deceased was [redacted]

born on 11 December 1969

and the death occurred on 21 January 2012

at Princes Freeway, Morwell

from:

1 (a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER)

in the following circumstances:

1. Mr [redacted][2], aged 42 years resided at an address in Morwell at the time of his death. He was the son of [redacted] and [redacted] and was the youngest of siblings [redacted] and [redacted]. The Deceased was survived by two children, [redacted].

2. The Deceased had a long standing mental health history. His history dated back to 1992 and included a diagnosis of schizophrenia (paranoid type in recent years). He also had a concurrent diagnosis of Dissocial Personality Disorder and mental behavioural disturbance due to psychoactive substance use.

3. His father said that the Deceased '*was a strong, healthy baby and young man. It was my hope that he would take over the engineering business from me when I retired.* [The Deceased] *would often work with me in the business. He did this on and off throughout his life. I never gave up on* [the Deceased] *being able to take over the job, even when he came out of prison in 2011. He was full of life, right up to the end of his life.*'

4. His mother said that he excelled in his education and at sport until a '*big drama unfolded*' whilst he was in America in his teens.

5. His family described him as a good kind hearted person who developed a significant mental health history over many years.

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[2] Following application by the family of [redacted], I made a suppression order which suppressed the publication of any information that would identify [redacted] and members of his family including his mother, father, sister and brother as well as where they reside. As such, I will refer to [redacted] in this finding as the Deceased.

6. The Deceased held a full drivers licence. His prior history included criminal charges ranging from aggravated burglary, theft and intentionally cause serious injury to driving related offences including multiple charges of driving whilst suspended.[3]

7. At approximately 9.10am on 21 January 2012, the Deceased was involved in a high speed head-on collision with a vehicle being driven by Mr Jason Govan. Both the Deceased and Jason died at the scene of the accident. Jason's wife, Rhiannon Govan was also seriously injured in the accident. Jason was survived by his son, Aiden who was 18 months of age at the time.

8. Prior to the collision the Deceased, who was driving his blue 1996 Ford Fairlane (registration FORDNF), was involved in a police pursuit which was terminated shortly after he entered the off ramp to the Princes Freeway travelling against the traffic. The Deceased's vehicle travelled west on the eastbound lines of the Princes Freeway for approximately 1.2 kilometres at high speeds, before the collision occurred.

9. In the days and weeks preceding his death, the Deceased had contact with local police as well as mental health services at Latrobe Regional Health (LRH).

Medical Examination

10. A preliminary examination was conducted on the body of the Deceased by Dr Heinrich Bouwer, forensic pathologist of the Victorian Institute of Forensic Medicine. He determined, in the absence of a full post mortem examination, a reasonable cause of death to be 'Multiple Injuries Sustained in a Motor Vehicle Incident (Driver)'.

11. A toxicological examination revealed THC (the active form of cannabis) in the amounts of ~10ng/ml (blood) and ~9ng/mL (urine) as well as 0.1 mg/L of Oxazepam (sedative/hypnotic drug) in the Deceased urine.

Purposes of the Coronial Investigation

12. The primary purpose of the coronial investigation of a reportable death[4] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[5] An investigation is conducted pursuant to the *Coroners Act 2008* (the Act). The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death,

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[3] The coronial brief includes information that the Deceased had been involved in a high speed chase with police in NSW in 1998. It does not appear that this was information known to Victoria Police.
[4] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation.
[5] Section 67 of the Act.

and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

13. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter *connected with the death*, including recommendations relating to public health and safety or the administration of justice.[6] This is generally referred to as the prevention role of the coroner.

14. I was assisted in my investigation by Detective Sergeant (D/S) Mark Amos, Major Collision Investigation Unit (Coroner's Investigator). His investigation was oversighted by Professional Standards Command (PSC) in accordance with the Victoria Police Oversight principles.

Standard of proof

15. Coronial findings must be made on the basis of proof of relevant facts on the balance of probabilities and that in determining whether a matter is proven to that standard, consistent with the principles enunciated in *Briginshaw* v *Briginshaw*[7].

THE EVIDENCE

16. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence[8] compiled by D/S Amos including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest (listed in paragraph 24) and any documents tendered through them, other documents tendered through counsel (including counsel assisting) and written (and oral) submissions (including replies) of Counsel following the conclusion of the inquest.

17. All this material, together with the inquest transcript, will remain on the coronial file and comprise my investigation into the death. I do not purport to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and where otherwise appropriate. [9]

[6] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.
[7] (1938) 60 CLR 336
[8] Which included witness statements, maps, audio recordings and CCTV footage.
[9] The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence, as well as submissions and replies, does not infer that it has not been considered.

18. I was assisted by the Submissions (and Replies) provided by all counsel (including Counsel Assisting) appearing in this matter. I am grateful to Counsel Assisting for her summary of the facts of this case, which I have largely adopted.

SECTION 67 FINDINGS

19. Prior to the commencement of the inquest, it was apparent that most of the facts about the death are known and were not in dispute. This includes his identity, the medical cause of his deaths and most of the circumstances surrounding the death, including mode of death, time and place of death.

20. I consider that, on balance, the circumstances of the death warrant a determination that the death was a death *in care or custody* under section 3 of the Act and an inquest was therefore mandatory under section 52(2)(b). I note that there was no controversy with respect to the conduct of an inquest.

21. A number of discrete matters were sought to be resolved at inquest and its scope was defined as follows:

- Was the clinical decision in relation to the Deceased on 19 January 2012 appropriate and reasonable in the circumstances?;
- Was the care plan proposed following the Deceased's assessment on 19 January 2012 reasonable and appropriate in the circumstances?;
- Did the conduct of the police pursuit comply with Victoria Police policy and procedure at the time of the incident?; and
- Did the production of OC spray comply with Victoria Police policy and procedure at the time of the incident and in the circumstances?

22. I considered these matters to be sufficiently proximate to the death and the circumstances in which they occurred.

23. I also sought information on a number of matters following the Deceased's being released from custody, including how his release was communicated to various bodies and his contact with mental health services. Whilst these matters were not identified as specific issues for the inquest, they were explored to contextualize the Deceased recent history and to determine whether they raised matters warranting further consideration as part of my investigation.

The witnesses

24. The following witnesses gave evidence at the inquest:

a. Sergeant (Sgt) Rikki Maaka

b. Mr James Callaghan

c. Sgt Heath Hogben

d. Mr Barry Davidson

e. Detective (Det.) Daryl Howard

f. Mr Matthew Adetifa

g. Dr Millicent Chikoore

h. Mr Troy Halton

i. Mr Gregory Birrell

j. Mr Nick Diciero

k. Mr Malcolm Ratcliffe

l. Ms Fiona Ratcliffe

m. Mr Blake Hibbins

n. Mr Brian McWalters

o. Ms Julie McWalters

p. Mr Brian Grimes

q. Mr Simon Kelton

r. Ms Anna Hughes

s. Leading Senior Constable (LSC) Malcolm Thek[10]

t. Ms Cathryn Hoppner

u. Associate Professor (A/P) Richard Harvey (Court Expert)

v. Constable (Cons.) Andrew Purcell[11]

w. D/S Alan Rumble[12]

[10] LSC Thek was granted, following application, a certificate of immunity under section 57(5) of the Act.
[11] Cons. Purcell was granted, following application, a certificate of immunity under section 57(5) of the Act.

x. Senior Sergeant (SS) Matthew Hargreaves

y. D/S Amos, Coroner's Investigator.

BACKGROUND CIRCUMSTANCES

Release from Custody

25. The Deceased was released from prison on 15 August 2011 with no parole conditions. He had received 2 years imprisonment (with a non parole period of 12 months) on 18 February 2010 for aggravated burglary, which was reduced by the Court of Appeal to 18 months on 21 July 2012.[13] This meant that by the time he was released, his sentence had been served, and parole conditions were not warranted. During his time in prison, he was admitted to the Thomas Embling Hospital (TEH) as well as the Acute Assessment Unit of the Melbourne Assessment Prison.

26. On 22 July 2011, in anticipation of his release from prison, Mr Max Hume, solicitor from the Office of Public Prosecutions sent a letter to DSC Maaka in relation to the imminent release of the Deceased requesting the matter be brought to the attention of the relevant mental health authorities[14] as he *'may well present a risk to his own safety and the safety of others when he is released from imprisonment.'* A copy of a report from Dr Claire McInerney dated 30 March 2011 and a report of Dr Danny Sullivan dated 10 May 2011 were attached to the letter of Mr Hume. These reports had been considered by the Court of Appeal, when making their decision to reduce the Deceased sentence.

27. Dr Claire McInerney said in her report:

'[The Deceased] *has a diagnosis of Schizophrenia, and is currently being treated for a relapse of his illness in the context of medication non-compliance... His illness is complicated by poly substance abuse, and very poor insight into his illness...* [The Deceased] *has shown some evidence of improvement, however he is not as yet suitable for management in the community....His presentation has been further complicated by numerous threats of violence as well as high level of agitation... As a result of this, it is at present unclear to where* [the Deceased] *should be discharged when he becomes suitable for community management....Useful conditions of any parole being considered may include*

[12] D/S Rumble was granted, following application, a certificate of immunity under section 57(5) of the Act.

[13] [redacted] v Queen [2011] VSCA 209

[14] This complied with Justice Whelan's direction in the Court of Appeal, para [17]

compliance with recommended mental health treatment, abstinence from illicit substances and submission to random drug screening.'

28. Dr Sullivan assessed the Deceased on 8 May 2011 while he was in TEH. The Report was prepared at the request of the Deceased's solicitors for the purpose of his appeal. Dr Sullivan noted in his report that:

- the Deceased had an established diagnosis of psychotic illness, previously described as paranoid schizophrenia and later as schizoaffective disorder due to a significant mood component when unwell;
- the Deceased had been predominately in treatment over the past 20 years and had spent significant periods of time in hospital under involuntary treatment for psychiatric illnesses;
- the Deceased '*has a diagnosis of a mixed personality disorder with antisocial, borderline and narcissistic elements*'; and
- '*it appears that if* [the Deceased] *were to receive parole or at the end of sentence currently, he would continue on [an order under] s12 of the Mental Health Act and discharge planning would proceed. Given his aggressive behaviour in recent months and ongoing delusional beliefs, it is considered that he would require placement in a SECU and I am unaware of any other current discharge plans. Discharge planning generally relies upon a clear release date and this does not exist currently*....[The Deceased] *would currently require continuing treatment as an involuntary patient.....It is clear that his mental illness satisfies all criteria under s8 of the Mental Health Act and thus his continued involuntary status would be upheld at present, whether he was granted parole or his sentence was recalculated and no longer permitted imprisonment.'*

29. In accordance with the request of Mr Hume, DSC Maaka and his officer in charge, Detective Senior Sergeant Dean Thomas meet with Mr Callaghan, LRH, on 29 July 2011 regarding the Deceased's release into the community.

30. On 2 August 2011, prior to the Deceased's release from custody, Dr Clare McInerney, assessed him and was unable to *elicit psychotic symptoms.* She advised Mr Callaghan (by phone and email) of this and that *'Berlinda independently assessed him in the last few days and similarly did not find evidence of relapse.... At present I do not think that involuntary treatment would be justifiable. I would be grateful if he could be assigned a case manager*

though and given a mental health appointment for shortly after the 16th August; I anticipate that he will require admission at some stage in the future if he remains off medications (particularly if he recommences substance use.) We will between now and the 16 August continue to regularly assess mental state, and try to persuade him to re-start some medication at least.'

31. She also observed that the *'grounds for the successful appeal were that incarceration was especially detrimental to his mental health, but unfortunately once the appeal was successful and he became aware of the absence of conditions on his relation from custody [sic], he has ceased medication all together.'*

32. Mr Callaghan provided this information to *'the clinical director, medical director and general managers'* of LRH on 3 August 2011. A meeting subsequently occurred with it being noted that the Deceased *'would be under no legal obligation to attend legal treatment or take medication as he was an informal client with no parole conditions, requiring him to accept mental health treatment and that Forensicare would need to make a referral through our triage department for the Latrobe Regional Hospital Mental Health Services to engage with the Deceased and his family'*.

33. This referral was made formally by Forensicare in a letter from Dr McInerney dated 11 August 2011. In that referral, Dr McInerney requested *'assertive outpatient follow up with case management.'* The referral noted, amongst other things:

- That in prison the Deceased had gradually reduced his antipsychotic medication ceasing it altogether close to his release from prison;
- That the Deceased had consistently failed to develop any therapeutic rapport with Forensic Mental Health Staff, and that his conversations with staff were frequently contradicted by subsequent statements; and
- That the Deceased had refused to engage in any group or individual work despite various attempts at insight/compliance therapy.

34. Mr Callaghan and Mr Shane Collier [La Trobe Community Mental Health Service (LVCMHS)] prepared a plan for the Deceased - *'Client History & Guidelines for the Management of Crisis Contact'* (the Crisis Plan), in consultation with their colleagues. The evidence suggests that there was an initial or temporary plan put in place which developed over time and was probably completed on 21 October 2011.

35. The Crisis Plan, which was developed following a review of his mental health history and in consultation with various mental health practitioners, stated:

- *If the Deceased presents to the Emergency Department either at LRH or other Hospitals clinicians should not see this man unless there is adequate security staff present.*
- *It would be preferable to have police in attendance. (it is unlikely he would self-present and police will have probably brought him to the A&E).*
- *If violently agitated, disturbed and no foreseen medical issues then assessment at police station would be preferable, but only in extenuating high risk/circumstances.*
- *If the Deceased requires admission (due to psychosis, threats and threats of dangerous behaviour) this should be facilitated post haste by hospital personnel taken into consideration his past dangerousness.*
- *Admission in these circumstances should occur directly to the High Dependency and he should remain there until his psychosis has resolved sufficiently and risk of violence had reduced considerably.*
- *A review of past admissions should occur so as to facilitate a coordinated approach to his treatment and care whilst in the inpatient unit.*

36. On 11 August 2011, police were advised by Mr Callaghan that '*mental health practitioners in Melbourne had now assessed [the Deceased] to be fit for release without ongoing mental health treatment*'. DSC Maaka stated that he was *'bewildered and concerned'* and that the *'information contained in the reports concerned me greatly and I had hoped that we could have been able to - well by conveying that information that there would be a mental health authority that could assist further than what the situation was left at, which was voluntary meetings with [the Deceased]. I had hoped there would be more we could do.'*

37. Due to their concerns, the police arranged for the Divisional Intelligence Unit to publish a daily intelligence summary (DIS) with details of the Deceased's release for the information of local members. According to DSC Maaka, *'It's circulated from the Divisional Intelligence Unit via email to all local members... It is released on this day* [17 August 2011] *and then it is stored at the Divisional Intelligence Unit and was available to members via our police Interpose system and I believe the intranet system also.'* When asked if this would come to a member's attention if they were to encounter the Deceased on the street after the day it is published, DSC Maaka said, '*Not without looking for it.*'

Presentations at Latrobe Mental Health Services between release from custody and prior to 19 January 2012

38. The Deceased presented to the La Trobe Hospital ED on four occasions following his release from custody and prior to the incident on 19 January 2012 (which is dealt with separately).

39. On 20 August 2011, he presented at about 9.00pm but left of his own accord prior to any medical assessment. The records state the presenting problem as '*Pt injected Zyprexa wafer 6 times 10mg at approx 1900 hrs now has stiff muscles in legs and slurring words Pt states nil intent to harm self wanted to ger hugh phx Hep C+, morphine addiction, drug induced psychosis. States parent don't want him to use morphine he tries to get theirs.*'

40. The second presentation was on 8 December 2011, when the Deceased attended the ED at 7.50pm and was seen by Dr Amma Jahangir. The records note '*he has been feeling depressed for some time and has feelings of guilt and wants to right the wrong things he has done. As a result of these feelings he says he took an overdose of 50 Valium tablets last night, thinking he should not be getting up in the morning. As he wants to be seen by LV MHS, Dr Jahangir has requested that [the Deceased] be reviewed by the LV MHS tonight. Other collateral information such as precipitators etc has not been obtained and [the Deceased] has declined to have blood tests done. Client has history of aggression. Crisis plan accessed.*'

41. On this occasion the Deceased was admitted to the high dependency unit (sectioned under the Mental Health Act) and discharged the following day (9 December 2011). The plan on discharge by Dr Khan and Dr Ojo was: (1) discharge off the Involuntary Treatment Order and (2) adhere to crisis management plan in case of presentation. The record reflects that the clinicians were aware of the Crisis Plan.

42. The third presentation was on 2 January 2012, where the Deceased presented with complaints of nausea but was not in the waiting room when called.

43. The fourth presentation was on 8 January 2012, where the Deceased presented to the ED and '*stated only wanted to see mental health services, would not elaborate.*' According to the hospital records, he '*wanted to be prescribed morphine. Stated had vague idea to set his bed on fire with himself in it. Made vague threats to do so again if not given the only medication that is of value to him 'morphine'.*' The assessment details reveal that the Deceased, '*stated his mood was low and the only treatment that would help would be opiates. Declined any other treatment options.*' The record states, he had '*no evidence of perceptual disturbance.*

No expression of bizarre idea, no complaints of perceptual disturbance, no expressions indicative of psychotic thought process. No reference to early warning indicators listed in crisis plan.' The '*formulation*' *is recorded as 'appears to be attempting to access opiate based medications. When declined became passively aggressive. Offered outpatient contact/psychiatric review but declined.*' He was not admitted on this occasion. The record reflects that the clinicians were aware of the Crisis Plan.

Incident in Yarragon on 19 January 2012 and presentation at Latrobe Hospital (two days before the deaths)

44. On 19 January 2012, several passers-by noticed the Deceased sitting in his car on the side of the freeway near Yarragon and were so concerned by his behaviour that they contacted police. One witness, Stan Selent said he was concerned for the welfare of the man in the car and did two u-turns to come back and check on him. He approached his car and stood a metre or two away and asked him if he was all right. He said, '*There was slight movement with his head and I saw that his eyes were rolling back and he replied to me in a very strange and unnatural unhuman [sic] voice, 'I'm okay.*" He said '*I didn't think this man was drunk but more under the drugs*'.

45. Another witness, Edith Barker stated that she passed the car twice. On the first occasion, she observed, '*He had his right arm out of the window and was bobbing around outside the window. Because he was jumping around in the driver's seat, I thought the was fighting with someone or excited and yelling at someone...as I drove past him his head was out of the window looking about and he appeared really upset.*' When she again drove past him about 30 minutes later, she observed him '*now hanging out the driver's window to his waist and he was shaking and jerking around it looked to me like he was having a very severe epileptic fit.*'

46. Sgt Howard[15] responded to the call for assistance and arrived at approximately 11.17am. He had previous dealings with the Deceased '*in 2000 we did a search warrant on his house in Monash Street in relation to some stolen goods and apart from that just general stuff around the street.*' He was not stationed in the Latrobe area at the time of the circulation of the DIS and didn't recall ever having seen it. He said that when he first spoke to him on 19 January 2012, he didn't recognise him.

[15] LSC at the time

47. Sgt Howard said the Deceased kept repeating the same words over and over again including '*we are all going to hell, we are going together, I am the devil, your bullets cannot stop us because we are all going to hell together.*' He said that he would put his tongue in and out of his mouth like a snake. Sgt Howard determined that the Deceased was in urgent need of assessment under the Mental Health Act[16], in part because he was talking about the devil and in part because of the LEAP information he obtained that the Deceased had warnings *'and risks for suicide self harm, serious psych condition and threats to police and carries weapons'.*

48. Sgt Howard said, '*I couldn't communicate with him. It was apparent – I've dealt with a few people with psychosis before and could not even communicate with him.... I could only describe him being in another place....he just appeared mentally not to be there.*'

49. Sgt Howard had a second conversation with the Deceased after an ambulance officer had arrived and he had drunk some water. He said the Deceased's demeanour had changed and of the second conversation he observed, '*I could communicate with him. I'd been to the car and I'd spoken to the hospital and I'd actually seen the ambulance give him water so he'd been, I suppose, hydrated.*''

50. Sgt Howard contacted the Hospital *(Psych Triage)* and they informed him that he '*was a frequent visitor'* who had been there as recently as the previous week.

51. Sgt Hogben arrived at the scene at approximately 11.35am. He said that the Deceased was well known to him from his time stationed at the Morwell Police Station. He knew of his mental health issues '*and was concerned about the risk he posed to himself and to the public*'. He had been dealing with the Deceased since the 1990s and also knew he had drug problems. He did not recall ever seeing the DIS.

52. Sgt Hogben said of the Deceased, '*His demeanour was okay towards us but he was very fidgety, ..., he was sweating profusely. He was looking around, a lot of – you know, sudden movements and that, with his head...he was pale as well.*' Sgt Hogben said he also believed the Deceased needed to be apprehended under the Mental Health Act. He noted that the fuel cap on the Deceased's vehicle was open.

53. Sgt Howard said he tried to contact the Deceased's mother, but does not recall how he obtained her phone number, what number he called or if he was able to speak to anyone from his family. Sgt Hogben also stated that he tried to contact the Deceased's mother, but

[16] Section 10 at the time.

couldn't recall how they got the number but thought that they were unsuccessful in making contact.

54. At approximately 11.52am, ambulance officers arrived at the scene. Barry Davidson was the senior member in the ambulance accompanied by Alicia Cook. Mr Davidson had not had any prior dealings with the Deceased and the only information he'd received was '*a police request under s.10 to transport a male having a psychiatric episode*'. He said of his observations of the Deceased, '*To me he appeared just to be a little bit agitated with the events that were happening there at the time but from my perspective he was compliant, he wasn't anything untoward to me.*' Mr Davidson also reported, '*He said he'd run out of petrol, he'd been mucking around with the coppa's head by saying about the devil, and then ...whilst in the back of the ambulance he just tried to stare me down so to break that I just started talking about cars and why he ran out of petrol.*'

55. Upon arrival at the ED at 12.58pm, Mr Davidson conveyed to triage staff that the Deceased was '*talking about the devil and strange things but my understanding was that the hospital staff knew more than what I did.*' He also filled out the Patient Care Record which he anticipated would be read by the treating team and used as part of the triage process.

56. After having been seen by Triage, the Deceased was assessed by Dr Victor au Yeung who described him as co-operative in the assessment, pleasant to talk to however unhappy about being in hospital.

57. Mr Matthew Adetifa, Mental Health Nurse Practitioner, said he obtained external information from ambulance officers and police but did not see the Patient Care Record completed by Ambulance members prior to seeing the Deceased. He said, '*I can recall that I was told he was parked by the roadside and people were concerned he was there for a while and he was acting bizarrely which could be anything from not answering the question or talking about his delusional beliefs.*' He also said, '*I recall being told that he was bizarre, that he was just standing by the roadside for a long time, they couldn't talk to him, but I wasn't told specifically that he was talking about being a devil or going to hell, I can't recall that.*' Sgt Howard believed he conveyed to Mr Adetifa that the Deceased had spoken about going to hell and bullets not stopping him.

58. Sgt Howard completed the Victoria Police Mental Disorder Transfer Form whilst the Deceased was being assessed in order to transfer custody of the Deceased to the Hospital. However, staff would not accept the form as the Deceased had threatened hospital staff in the past, and they wanted the police to remain until his assessment had been completed.

59. Mr Adetifa assessed the Deceased in the ED and subsequently called Dr Chikoore, psychiatrist, and told her that he didn't think the Deceased met the criteria set out in the Mental Health Act for involuntary treatment. [17] Mr Adetifa said that he had read the Crisis Plan before the Deceased had arrived in the ED and that he was also aware that the Deceased was a complex patient of the service. Dr Chikoore agreed with his assessment and said that the Deceased '*had a major mental disorder and was at risk of psychotic relapse. No overt psychosis had been elicited at the time of the index assessment, but there was a requirement for further assessment over a more extended period. Specifically, there was a requirement to obtain additional corroborative information from* [the Deceased's] *sister, as well as from his parents. It was important to attempt to determine if* [the Deceased] *had resumed use of illicit substances as this could be adversely affecting his mental health. Additionally, it was important for the mental health service to attempt to develop a good therapeutic relationship with* [the Deceased] *in an attempt to persuade him to resume antipsychotic medication.*'

60. Sgt Howard observed that the Deceased at the hospital '*was quite lucid and engaged in conversation different to how he was when I first met him that day*'. He said that after he had been seen by Mr Adetifa and had refused to give a urine sample, he told the Deceased he was at the hospital because '*you were talking about death and the devil.*' The Deceased replied, '*I was just talking shit to piss you off and make you go away.*'

61. The Deceased was released from the Hospital at 1.57pm, pending follow up by '*Flynn from the Psych Team*' and was driven by police to his parent's address in Morwell. This journey home appears to have been uneventful.[18]

62. Mr Adetifa immediately sent an email to Mr Collier as the manager of the LVCMHS Adult Team (also copied to Mr Callaghan) *'requesting for ongoing assessment and to establish the need to restart his medications.* [The Deceased] *agreed to engage with the Community Team*

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[17] At the time section 8 of the Mental Health Act 1986 required the following: (1) The criteria for the involuntary treatment of a person under this Act are that-

(a) the person appears to be mentally ill; and
(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order;
(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

[18] Every time the police engage with someone in relation to an apprehension under the Mental Health Act, a form is completed and submitted to update LEAP with the relevant information.

and attend appointments. He was advised to abstain from illicit substances. He was also provided with contact numbers for lifeline and psychiatric triage services to ring when having suicidal or homicidal ideations. A telephone contact and email were sent to the Latrobe Valley Community Mental Health Team to contact him as soon as possible.'

63. The Deceased's sister confirmed that Mr Adetifa contacted her on 19 January 2012, wanting her to pass on a message to their parents. He indicated that they were going '*to monitor him more closely in the community.*'

64. The Deceased's father said around this time:

'His last three words to me were 'Thank you, dad.' This was around Thursday, 19th January 2012. He ran out of petrol and had been taken to the hospital with the police. He came home and went to fill up his Gerry can. I gave him $35 and drove him to his car. He said, 'thank you dad'. His words were full of love and care. He seemed good. While we went to get his car, he was as good as gold.'

Conclusions with respect to the assessment on 19 January 2011

65. A/P Harvey, Clinical Director, Mental Health, Drugs and Alcohol Services, Barwon Health, prepared an expert report for the Court and concluded that the clinical decision to release the Deceased on 19 January 2012 was appropriate and reasonable in the circumstances. He also concluded that the detailed and comprehensive '*guidelines for the management of crisis contact*' (the Crisis Plan) was also carefully developed, reasonable and appropriate in the circumstances. Having considered all the evidence, I am prepared to accept his opinion on these matters.

66. I also heard evidence regarding the history of contact and efforts made by LRH/ LVCMHS to engage the Deceased with the service, in the absence of parole conditions or the Deceased meeting the conditions of the Mental Health Act. It was outside the scope of my investigation to be conducting a broad assessment of the provision of services from LRH to the Deceased following his release from custody. Nor did the family submit that this should be the case.[19]

67. The family did however question the attempts to engage the Deceased and whether those attempts amounted to '*assertive*' follow up and the assignment of a case manager (as stated in the Forensicare referral).

[19] I invited submissions regarding the scope of the inquest at the directions hearing on 13 March 2014.

68. Mr Collier said that a patient at LVCMHS has two pathways for receiving case management, either by referral from another area mental health service, or through an agency such as Forensicare, as was the case with the Deceased. The latter process requires the LVCMHS makes contact with the patient and the patient's consent to accept services. A case manager is then appointed.

69. Mr Callaghan said that a case manager was not assigned to the Deceased as '*we didn't have any contact with him and he declined services. And we attempted to contact him, as I stated in my statement there was a referral completed. We sent a letter, tried to engage with the family to get [the Deceased] to come in to see and to arrange an assessment, medication and possibly a case manager if he chose to accept that.*'

70. LRH submitted that offers of support were made to the Deceased (and/or his parents) as follows:

- 15 and 16 August and 1 September 2011, early January and 12, 19, 20 and 21 January 2012 where attempts were made to contact the Deceased by telephone; and
- 17 August 2011 and 12 January 2012 letters were sent to the deceased and/or his parents.[20]

71. It appears that no attempt to contact the Deceased or his parents were in fact successful and no responses were recorded as ever received.[21]

72. A/P Harvey was of the view that the efforts made were consistent with usual standards, with that of his own service and would be the practice of the majority of health services across the State. He further observed in relation to the Deceased,

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[20] LRH further noted in submission the following summary of activities with respect to the Deceased:
- [the Deceased] being discussed the Emergency Services Liaison Committee Meeting held on 15 September 2011. This meeting was attended by Senior Sergeant Phil den Houtin from Victoria Police;
- [the Deceased] being discussed at the Clinical Risk Management Meetings on 5, 12 & 19 January 2012.
- Ongoing contact with the Office of Chief Psychiatrist;
- Finalisation of the CMP (October 2011)
- The CMP was placed on CMI ensuring that if [the Deceased] presented to any hospital across the State, then that hospital would have access to his CMP;
- The CMP was also placed on the 'W' drive at LRH, which meant that it was available internally across the service
- Victoria Police was sent a copy of the CMP by Mr Callaghan (October 2011)
- LRH completed 'Alert Sheet' (21 October 2011) in respect of [the Deceased]
- [the Deceased's] involuntary admission to LRH on 8 December was raised and discussed by a member of the treating team with Mr Callaghan on 12 December 2011
- Early January 2012, Mr Callaghan tried again to engage [the Deceased] by telephone and by letter. The letter was sent by Mr Callaghan to [the Deceased's] parents on instruction of Ms Hamden on 12 January 2012.

[21] This excludes the contact with AB's sister on 19 January 2011.

'the passion with which [he] really resisted interventions from mental health services and could adjust his mental state to display symptoms that suited what he was attempting to gain from the people that he was working with at that point in time.'

73. A/P Harvey did not think it was appropriate for LVCMHS to make a home visit to the Deceased. He said that staff visiting a person unannounced in the presence of police officers (as would be required with the Deceased) would be highly intrusive and, *'on one view, an invasion of personal rights and freedoms, it fails to grapple with the fact of his known hostility towards those in authority.'*

74. Ms Hoppner, Director of Mental Health, LRH said that they would not home visit the Deceased because of the risk to staff.

75. In relation to the Deceased living close to his family A/P Harvey commented:

... that would have offered a degree of reassurance to the local health service. Because if the family were not expressing concern, that would be evidence that there was nothing to be concerned about. You know, we expect families to let us know if they're concerned about a loved one and that is a trigger for - for a health service to home visit, to be more assertively involved than just writing letters and leaving phone calls.'

76. Dr Chikoore described the role of the family in these terms, *'essentially they would be the eyes and ears of the mental health services in between the periods of assessment.'*

77. The Deceased's sister said,

'That despite our personal circumstances at the time, we were expected to know when he was back on drugs or relapsing, and be the ones to communicate that to mental health authorities. The emphasis felt all back to front, like it was the responsibility of the family, even though we weren't professional carers. The truth is we didn't know how to help [the Deceased] any more, except to offer our love and support. But he needed more than that.'

78. The LRH further submitted,

'Historically [the Deceased] was noted to have difficultly in engaging in therapeutic relationships. In 2005 Dr. Bell observed that [the Deceased's] mental stability was linked to his refractory propensity to abuse substances, his poor compliance with community based care, his refusal to comply with urine drug screens and his adherence to medication. Thus, the synthesis of all the information available makes it plain that it <u>was ambitious, if not overly optimistic</u>, to release [the Deceased] from prison into the community without

condition, without his adherence to antipsychotic medications but with the expectation that he would voluntarily submit himself to follow-up and case management.' [my emphasis]

79. I agree that as the Deceased was released back into the community without conditions (and in the absence of meeting the requirements under the Mental Health Act), this placed health services in a difficult position - unless the Deceased chose to engage with services. This applies equally to the assignment of a case manager and the suggestion of a visit to his parents (in the event that this was considered appropriate). I do however note that by the time he had been released from prison the Deceased had served his sentence (as reduced on appeal), so parole conditions were not an option for corrections authorities.

80. LRH did however concede that they should have made contact with his general practitioner but submitted that on the evidence (medical records) '*it was not possible to conclude that [the Deceased's] relationship with Dr Edwards was such that it would or could have affected his engagement or lack thereof with LVCMHS or been the source of information to LRH about his mental state.*'

Incident on 20 January 2012 – the day before the deaths

81. I note that the Deceased was involved in a minor '*road rage*' incident on 20 January 2012, which police attended. The Deceased and the other driver gave conflicting stories to the police and an exchange of details between the drivers was facilitated. The Deceased was described '*to be quite off hand about the situation and originally smirking....*'.

82. Neither the Deceased nor the other driver were noted to be under the influence of alcohol and police left the scene after the two drivers exchanged details.

83. The attending police members did not document any behaviour from AB which would have warranted the attention of mental health services.

General comments of the Deceased interactions with health services and the police

84. It would be inaccurate to characterise the Deceased's relationship with health services and police as generally hostile, following his release from prison in 2011.

85. I note that shortly following his release from prison, the Deceased saw his GP to get the return of his license[22] and further consulted about fairly routine physical matters. It would

[22] Consultation with GP at the Hazelwood Health Centre on 18 August 2011 (noting, *He has now been fully rehabilitated of all medication'*).

also appear that he considered the LRH ED as accessible when he wanted assistance, even if he didn't stay to receive treatment.

86. In addition, he appears to have had a number of contacts with police without difficulties. In particular, I note that on 30 December 2011, he was driven home by police.[23] He also had interactions with police on the 19 and 20 January 2012, without these interactions appearing to raise any significant concerns for the Deceased.

87. I also note that the Deceased readily gave the telephone numbers of his family members to police and mental health professionals for them to be contacted.

CIRCUMSTACES OF DEATH

Morning of 21 January 2012

88. The Deceased's mother said she saw her son at about 6.30 am on the day of his death. At that time he told her that he had been watching *Rage* for several hours. She said that she sat and talked with him for a while, and described him as '*extremely calm.... His eyes were clear, he was clean.*'

Pursuit on 21 January 2012

Commercial Road

89. On 21 January 2012, LSC Thek was performing divisional duties with Cons. Purcell. LSC Thek was the driver and held a gold class licence. Cons. Purcell was the observer and was a newly appointed police member '*with little to no operational experience*' having graduated on 13 January 2012. They were driving a fully marked divisional van with registration MCM 875. Their call sign was Traralgon 307.

90. At about 9.07.48 am, LSC Thek was travelling west along Commercial Road, Morwell when he observed, in the opposite direction, a '*blue Ford ... travelling at an excessive speed and briefly cross*[ing] *over the centre diving line along Commercial Road.*' He said that he motioned for him to slow down and, whilst unable to hear anything, he could see the driver was '*yelling at us*'. He said, '*he appeared agitated, his face was screwed up and he was moving about in his car erratically.*' LSC Thek activated his emergency lights and performed a u-turn back towards the Ford which then came to a skidding stop outside the Primary School and reversed back into Commercial Road. Smoke was observed coming

[23] On 30 December 2011, DSS Thek encountered the Deceased walking home along Princes Freeway in Traralgon. He gave evidence that they had a short conversation with the Deceased, he got in the back of the van and they drove him home to his parent's house in Morwell.

from the rear tyres of the Ford. LSC Thek said the driver was still behaving erratically jumping about in his seat.

91. LSC Thek said he executed a second u-turn and observed the Ford come to another skidding stop in the entrance to the Commercial Road North car park. The Ford then reversed and headed back past the police car in a direction east along Commercial Road. At this time LSC Thek said he stopped the police van with the lights activated.

92. The Ford travelled through the White Street round and at around that point LSC Thek said he activated the police siren and directed Cons. Purcell to notify police communications that they were in pursuit. Cons. Purcell said he didn't do so, '*because over those few seconds he had reached the top of Commercial Road and I believed that he was going to stop or he was slowing down.*'

93. LSC Thek stated that he then followed the Ford through the roundabout and accelerated out of the roundabout at about 80 kmh.

94. Cons. Purcell made similar observations about first seeing the Ford on Commercial Road but stated that the male driver '*appeared to be smiling at us.*' After the police vehicle completed the first three point turn, and the car past them again, Cons. Purcell said he managed to make a note of the registration number.

95. Observing events on Commercial Road at this time were witnesses including Troy Halton, Brian McWalters and Julie McWalters. Mr McWalters observed that the driver had '*a big grin on his face as he passed me like he was very happy to see the police divvy van.*' Ms McWalters said, '*I noticed he was looking straight at the police divvy van and I noticed that he had the biggest smirk on his face.*' Mr Halton observed that the Deceased '*didn't look angry or worried by anything, in fact he was quite calm like it was an everyday thing'.*

MacDonald Road Bridge

96. The Ford was observed to make a left hand turn from Commercial Road into MacDonald Road with a green arrow onto the bridge over the railway line. LSC Thek said that the police vehicle was about 15 metres behind him. He observed the three lanes of MacDonald Road at the intersection of Princes Drive were blocked by vehicles. LSC Thek said that there was about 5 seconds between the direction to come up in pursuit and turning into MacDonald Road. LSC Thek observed the Ford stop and said, '*Wait here and don't come up in pursuit, as he had stopped, I also said something like, 'I wouldn't be surprised if he takes off again'.*'

Princes Drive Slip Lane

97. LSC Thek said that he stopped the police vehicle about 3 metres behind the Deceased's vehicle. He said that as he approached the Ford, he removed the OC spray from its scabbard and walked towards the driver's door. He said the driver yelled out '*Put your fucking gun down.*'

98. LSC Thek stated that he didn't reply and as he neared the right rear of the Ford, the driver began revving the engine and he took a couple of steps to the right away from the car. He then stated that the Ford reversed back about 2 metres towards the front of the police van. Cons. Purcell gives a similar description of this event but says the Ford reversed back about 3 metres or so and that he thought '*he was going to keep coming and hit us.*'

99. Also observing the scene at the corner of Princes Drive and MacDonald Street were civilian witnesses. Nick Diciero was situated at the petrol station on the diagonally opposite corner from the Ford. Mr Diciero said he saw the police officer standing outside the police vehicle for eight or ten seconds. He said he did not see the car reverse but did see it take off.

100. Sitting in their vehicle at the lights opposite the location of the police vehicle and the Ford were Malcolm Ratcliff and Fiona Ratcliff. Mr Ratcliff said that the police officer was out of his car for thirty seconds to a minute but he couldn't see if he was talking to the driver of the Ford. He also couldn't tell if the police officer was carrying anything. Mr Ratcliff said that he turned right prior to the Ford leaving the slip lane and he did not look in his rear view mirror.

101. Ms Ratcliff said that she saw the police car with lights and sirens come over the railway bridge on MacDonald Street and stop behind a blue Ford. She said when the police van stopped it had no siren but lights activated. She said that she saw the policeman get out and walk towards the Ford and it *'looked like he'd almost got up right beside the driver...And then all of a sudden the blue car took off.*' Ms Ratcliff did not see the Ford reverse.

102. LSC Thek stated that he jumped back into the driver's seat, immediately activated the siren and notified D24 that they were in pursuit which was recorded at 9.09.46 am. He said he felt that he '*had to take over communications* [from Purcell] *in order to ensure concise, accurate and timely information was broadcast.*'

103. According to the D24 recording the first communication by Traralgon 307 was:

'Traralgon 307 in pursuit' and after an acknowledgment by D24, *'Yeah. Traralgon 307. Westbound Princes Way. Just pulled into the train station car park following FORD NV – November Foxtrot.'*

The registration number is repeated again after a request for vehicle description and traffic conditions.

104. Sgt Rumble was stationed at the Moe Police Station and was performing patrol supervision duties in the Latrobe Police Service Area with call sign Moe 251. He said that shortly *'after 9.00 am, while inside the Moe Police Station I heard a slight burst of a police siren transmit over the police communications. This burst went for about one second, no-one spoke....The next transmission was only several seconds later during which I heard ETL307 communicate via the radio that they were in pursuit with a vehicle travelling west bound on Princes Way near the train station. When I initially heard this I believed the location of the pursuit was occurring on the Princes Highway at Traralgon.'*

105. I note that at 9.10.25 am, Sgt Rumble asked via D24 the reason for pursuit and at 9.10.52 am, he nominated himself as the Pursuit Controller. The reason given at 9.11.05 am was: *'He went screaming past us in the opposite direction. I did a uey and he's tried to ram into us and he just taken off.'*

Morwell Station Car Park (Princes Drive)

106. LSC Thek stated that he exited the slip lane and observed the Ford about 100 metres ahead and he accelerated up to 80 kmh. He then observed the Ford make a left hand turn into the railway station car park along the south side of Princes Drive. He followed the car through the car park but the Ford failed to stop instead turning left back onto Princes Drive. He stated that when he turned left onto Princes Drive the Ford was 100 to 120 metres ahead.

107. Cons. Purcell stated that he believed the speed of the Ford in the car park was 50 to 60 kmh and that he believed the vehicle was trying to lose them.

108. Ms Ratcliffe gave evidence that when the Ford was in the car park and her vehicle was travelling along Princes Drive, she could see the driver from a metre or two away and *'I watched the Ford drive through the car park on my left hand side. The car was flying and I got a better look at the driver. He was a big man and he looked like a psycho. He was holding the steering wheel like he was possessed and you could see his knuckles going white holding the wheel.'* She said of the driver's face, *'it was more like a determined - like "I'm not going to stop" and he wasn't exactly happy, it was sort of a very tense - probably the*

best way to say it is probably a tense face - it was all - yeah, as I said, a determined face. He wasn't going to be stopped. He was not.'

109. Mr Ratcliffe said that he slowed down and tried to block the Ford from exiting the car park. He also stated that the Ford accelerated along Princes Drive up to 80 or 90 kmh and estimated the police to have reached 80 kmh when they passed him. Mr Ratcliffe also observed the driver of the Ford to '*put his fist up in the air out of the driver side window shaking it like he was pissed off at me.*'

Morwell-Thorpdale Road/Jane Street Lights (Jane Street Bridge Lights)

110. LSC Thek said that on exiting the roundabout (Latrobe Road and Princes Drive) he observed the Ford drive through the red traffic signal at the Jane Street Bridge Lights (described as the Morwell-Thorpdale Road). This was communicated to D24 as: *'He just crashed red at Thorpdale*'. Cons. Purcell stated that he recalls that no brake lights came on the Ford when it went through these lights. LSC Thek said he was doing 80 to 90 kmh as he approached the lights and the Ford was doing at least 100kmh. He said when he observed the Ford adjacent to the Vic Roads office on Princes Drive, he accelerated heavily and reached 150kmh but did not gain on the Ford at all.

111. When asked by the Pursuit Controller whether the pursuit was elective or imperative, LSC Thek said it was elective.

Left Turn onto Freeway Exit (from Princes Drive)

112. A civilian witness, Brian Grimes, was travelling west along Princes Drive and was passed by the Ford travelling at about 80 to 100 kmh. He watched it enter the freeway via the exit ramp and said he observed the police in pursuit. He stated the police were 300-400 metres or 15 seconds behind the Ford. He said they were doing about 80 kmh and entered the freeway exit a lot slower speed than the Ford.

113. LSC Thek stated that when they were passing the VicRoads entrance and were about 200 metres behind the Ford, he noticed the no entry signs at the end of the road. He stated that he was not aware it was the freeway exit ramp until he saw the signs. He saw the Ford enter onto the ramp against the signs and accelerate under the old railway bridge. This was communicated to D24 at 9.11.30 am: *'He's gone down the wrong way onto the freeway entry ramp on – at the end of Princes Drive. Still westbound.'*

Off-ramp onto Freeway heading west

114. LSC Thek said that he drove to the end of Princes Drive and slowed down and turned left onto the exit ramp and kept to the far left of the road with lights and sirens on and was travelling about 80 to 100kmh at this time. He also admitted that he did up to 150 kmh on the exit ramp where it was safe to do so.

115. Cons. Purcell stated he recalled LSC Thek informing D24 they were doing 150kmh and that the Ford was getting away from them. The D24 recording reflects: *he's just entered the freeway, westbound on the wrong side. I'm doing 150. He's pulling away from me.'*

116. Cons. Purcell said that they started to pull over about the time he could see the freeway up ahead in the distance and that they heard an instruction to terminate the pursuit over the radio. The Pursuit Controller is recorded to say via D24 at 9.12.05am: *He's on the wrong side terminate pursuit. Alright. Terminate pursuit.'*

117. LSC Thek stated that about the time he drove around a sweeping bend, the Pursuit Controller terminated the pursuit and he immediately pulled onto the right hand side of the road and turned the sirens off. He said he left the lights activated to make himself visible to oncoming traffic. About a minute after he stopped, he stated a white four wheel drive pulled up beside them and told them there had been an accident on the freeway.

118. A civilian witness, Simon Kelton, was travelling on the freeway exit ramp approaching the railway bridge when he saw the Ford passing him in the wrong direction and he pulled over and let the car pass. He stated that the police passed some 20 seconds behind the first car and estimated they were doing about 70 kmh.

119. Anna Hughes was also travelling on the exit ramp in an easterly direction when she saw the Ford and the police coming in the opposite direction. She was unable to estimate the speed of the Ford or the police car or the time or distance between the two cars. She was able to say the Ford was going at a fast speed and the police car was going at a slower speed.

120. Sgt Rumble said that when he was informed that the Ford was going the wrong way on the freeway exit, he said, '*at this stage I'm aware obviously it's not in Traralgon. I'm thinking it's potentially Morwell but I'm not exactly sure.*'

121. The pursuit, according to the D24 records, is a total of 2 minutes and 19 seconds in duration.

Observations and Freeway and Collision

122. Gregory Birrell and Blake Hibbens gave evidence of seeing the Ford travelling the wrong way on the Freeway as they were each travelling east bound. Mr Hibbens said he saw that the driver had both hands on the steering wheel up quite high. He also saw the police divvy van stationary on the Morwell side of the exit ramp a short distance off the freeway.

123. Mr Christopher Burke witnessed the accident through his rear vision mirror and said:

'As I was watching him continue up the freeway I saw him still in the right hand lane, I don't recall seeing him swerve. I then saw the vehicle crash into another car that had been travelling in the right hand lane....I saw the black car get air born slightly and roll into the ditch.'

124. Following the accident, a number a bystanders tried to help and emergency assistance, including police, arrived shortly after. Neither the Deceased or Mr Govan could be assisted by ambulance personal. Mrs Govan was airlifted to hospital.

125. Detective Senior Constable Robert Hay, MCIU analysed the accident and gave an opinion that the Deceased's vehicle was travelling in the east bound lane of the freeway at a minimum speed of 154 kmh.

126. The evidence available to me included GPS data which was downloaded from the pursuit vehicle. The manufacturer of the device (Garmin) did however say that the accuracy of the data for any one given point is risky and unsafe. Little reliance was therefore placed on this data for the purpose of my investigation.

Rules and Guidelines concerning police pursuits in Victoria (applicable at the time of the accident)

127. The relevant Victoria Police documents governing pursuits was contained in the Victoria Police Manual (VPM) - Policy Rules *Urgent duty driving and pursuits*[24] (the Rules) and the

[24] Issued 22/2/10 and last updated 7/11/11. The pre-requisites for police pursuits are also set out in the Policy (VPM – Policy Rules Police Vehicles). 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. The rules regarding the authority to drive police vehicles and police vehicles are also set out in the Police Vehicle Rules. There were no issues regarding this aspect of VP policy as part of this investigation.

VPM Procedures and Guidelines *Urgent duty driving and pursuits*[25] (the Guidelines). I note that both documents have been substantially amended since this death (see **Comments**).

128. The Guidelines at the time established two types of pursuits - an *elective* pursuit and an *imperative* pursuit.

129. The Rules made the following overarching statement with respect to police pursuits:

*There are **inherent risks** with urgent duty driving. These risks increase significantly when high speeds are involved, and in areas of high vehicular or pedestrian traffic. ....*

*A **police member's duty to protect life and property** will always have primacy over the need to arrest offender, especially when the offence involved is **relatively minor**, or where there are **safer options** other than immediate arrest. Any decision to cease urgent duty driving or terminate a pursuit on the grounds of avoiding an unacceptable risk will be supported. Any action taken to limit the risks to public, including offenders/s, and police will be viewed as a decision that displays sound professional judgement.*

130. The Rules provided, amongst other things that:

The driver considering initiating a pursuit must assess the risks and reasons for the pursuit, having regarding to [the Procedures]; *if the risks outweigh the result to be achieved, they must terminate the pursuit.*

131. The *Guidelines for an urgent duty driving risk assessment* is set out as follows[26]:

Anything can influence an urgent duty driving risk assessment; however, consider the following before and at all times during the driving. Any action should escalate or de-escalate depending on the risks.

- *What is the outcome you are trying to achieve?*
- *What Approved Driving Authority do I hold, and what are the restrictions?*

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[25] 22/2/10 and last updated 7/11/11

[26] In addition there is a table which provides a 'scale' for 'imperative pursuits' (e.g. a fleeing armed offender, or dangerous driver), Police duty requires a danger to be stopped ('*I believe safety is at serious risk and my duty requires me to act*') →Reasonably belief that pursuit does not further increase the danger ('*My pursuit is not increasing the danger*') →But pursuit must be terminated when the urgent duty driving becomes more dangerous than the original incident ('*I will terminate pursuit because the danger is increasing*'). The table also provides a scale for 'elective pursuits' (e.g. driver fails to stop for a breach of the Road Rules), Lawful reason to intercept vehicle ('*I have a lawful right to stop this driver.*") →Reasonably belief that pursuit does not endanger the public or police ('*My pursuit is not endangering the public or police*') →But pursuit must be terminated when the urgent duty driving poses serious danger ('*I will terminate pursuit because there is a serious danger*').

- *What is likely to happen if you don't stop a pursued driver, or if you arrive at an incident slower than anticipated?*
- *How safe do you feel driving in the manner you are?*
- *What class of police vehicle are you driving?*
- *What types of warning devices are fitted your police vehicle?*
- *What are the road, weather and traffic conditions like and how familiar are you with driving in those conditions or locations?*
- *Do you know the identity of the person you are pursuing?*
- *How competent or experienced a driver do you believe the person you are pursuing to be?*
- *If responding to incident, what type of incident is it and what other police are responding?*

132. The Policy provides that the observer (or the driver if there is not observer) must notify PCC that a pursuit has been initiated and maintain constant radio communications. All communications by the PCC operator is recorded.

133. The PCC operator is to acknowledge the pursuit and notify an operational police supervisor to perform the role of Pursuit Controller.

134. The Rules provides for termination conditions which include that the risks outweigh benefit and the identity of driver of the pursued vehicle is established and there is a likelihood that later apprehension will be possible and there is no immediate threat to public or police safety.

135. The Rules also provide that to effect a termination, police must immediately stop, acknowledge the termination and turn off any flashing blue/red lights and alarm. The termination of a pursuit results in an audible sound, all persons have to acknowledge termination, and pull over, report location.

Comments on police pursuit VPMs

136. I have previously criticised earlier iterations of Victorian police pursuit polices and procedures[27], particularly as they relate to the risk assessment model and the scope of

[27] Investigations into the deaths of Jason Kumar (COR 2009 5767) and Sarah Booth (COR 2006 4974) both published on Coroners Court website.

permissible pursuit[28]. For that reason, I made a number of recommendations for reform (see **Comments**). These criticisms are also relevant to the policies in place at the time of this incident.

137. I have also said that the most difficult factors to *control* in a pursuit environment are the variables associated with the target driver and their vehicle as well as other road users – the *unknown* risks. I have noted in the past that the unknowns in every pursuit are likely to be:

- The age of the driver/driving experience of the driver;
- Whether the driver is suffering the intoxicating effects of alcohol or drugs;
- The emotional state of the driver (including whether the driver has mental health issues);
- The mechanical state of the subject vehicle (that is, in respect of roadworthiness – braking, steering, suspension and tyres);
- Unseen conflicting vehicular or pedestrian traffic; and
- The nature of the unlawful conduct that is suspected to have occurred.

138. In this case, one of the critical *unknowns* appears to have been the emotional state of the driver and the degree to which his behaviour was predictable (or unpredictable).

139. I also make the comment that there is always a danger in a retrospective analysis, which involves the outcome of a pursuit as the determinative feature. This ignores the fact that most pursuits do not result in a fatality (or accident), which in my view is in large part as a result of *probability* rather than necessarily good design (at least at that time).[29]

Evidence regarding the application of the VPMs

140. LSC Thek, Cons. Purcell and Sgt Rumble each gave evidence they were trained in and aware of the applicable VPMs at or prior to 21 January 2012.

141. LSC Thek gave evidence that in Commercial Road he was not in pursuit of the Ford, but was attempting to intercept the vehicle given its behaviour up and down Commercial Road.

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[28] The VPMS do not explain **how** a member is to apply the various risk assessment criteria (posed as a series of questions), what order (if any) and what weight should be given to an individual criteria (positive, negative or neutral). The risk assessment model must be able to be readily applied by members. In my view, a risk assessment model must, on application, produce the same or similar outcome by those who apply it to the same factual scenario.

[29] I have therefore taken the view that to make real changes in this area, the basis for change lies in ethics and risk management principles. That is, as any police pursuit is inherently risky, the risk of pursuing should only be justified in restricted circumstances, which should be clearly articulated. (See **Comment**).

142. At the commencement of the pursuit in the slip lane following the Deceased taking off, LSC Thek made the following observations:

- it was an elective pursuit: '*I guess an imperative pursuit, in my mind at the time, may have been something like an armed robber fleeing a scene or, you know, a murderer fleeing the scene and you've got to get that person and get them no - you know, no matter what. This was still an elective, I felt, at the time.*'
- '*The outcome I was hoping to get the driver of the Ford off the road due to the danger he was posing to other people on the road.*'
- in terms of his risk assessment at that time, '*Well I guess the risk assessment, again, I was taking note of the area we were in, any traffic, other people on the road. It was very quiet down that side of the railway line in Morwell. But I was aware that if he continued west on Princes Drive, sort of heading away from the more populated part of town, but I also felt that judging by this earlier driving, if I was just to let him go, would he continue driving like this without - with or without us there and cause - continue to cause danger to other people on the road.*'
- As to whether he considered finding out the identity of this person without pursuing him based on his number plate, '*Sure we had a numberplate, but did that numberplate belong on that car? We didn't know that and therefore couldn't establish identity.*'

143. At the point at which the Deceased went through the railway station car park and came back onto Princess Drive, LSC Thek said of his risk assessment, '*You always try to minimise risk, but at this stage I felt the risks that were in play were, I guess, in line with the outcome we were hoping to achieve, which was getting him off the road.*'

144. LSC Thek thought it was a possibility that the Deceased might stop because he said, '*as far as my knowledge of the area of Morwell goes, I didn't have intimate knowledge. I knew going west along Princes Drive there was out of town and you could get into bushland, which I believe came to a dead end down there, which would give him nowhere else to go ...So that was in my mind, that there's a possibility of a resolution of the pursuit down there.*'

145. Further, LSC Thek stated of a pursuit through a station railway carpark, '*There were a few parked cars in the car park, there was no pedestrian or traffic movement in the car park, so what he was doing through that car park wasn't - in every day life and a normal, reasonable*

person's perception, yes, it would have been excessive but in taking consideration with what he had done earlier, it wasn't out of control.'

146. At the point at which the Deceased went through a red traffic light at the Jane Street Bridge, LSC Thek made the following observations:

- as to the desired outcome, '*Ideally you'd like them to stop, but then there's also keeping observations on him, so - to give us that opportunity to call in other resources to assist with the resolution of the pursuit.*' He also said, '*I guess also with the observation - if we can get other units, as far as observation goes, whether it be Air Wing, TNU, that gives D24 more time to get information back to us as far as the registration, owner, possible driver goes....*'
- as to finding his identity through the number plate, '*Not at this stage. Unless you can identify an owner of the vehicle and confirm that that plate belongs on that car, you have no idea who the owner is, if the car's registered, the possible identity of driver. You've got nothing just with a rego at that stage.*'
- as to his risk assessment, that the risks had escalated, '*And I was aware that...he was heading out of the populated area of Morwell. I was certain - pretty certain there was no further traffic lights down that end of town, so, you know, that time of the morning very quiet on the roads as well, I still felt that it was safe to continue and get - hopefully get him off the road.*'

147. In respect of the outcome he hoped to achieve at the point of turning onto the freeway exit ramp, LSC Thek said, '*At that point it was just observation. I remember saying to Purcell again that no way knowing – we're going onto the freeway itself, entered the exit ramp...*'.

148. In respect of the risks of turning onto the freeway exit ramp, LSC Thek said that the risk had increased, '*Obviously, the risk is oncoming traffic – the main one...*'

149. LSC Thek gave evidence that his training included observation was a legitimate reason for initiating and maintaining a pursuit. He said, '*I guess the aim of observing in a pursuit rather than trying to actively stop the driver is to allow other resources to come in, like the Air Wing who can observe from the air.*'

Conclusions as to the pursuit

150. I make the following conclusions and observations in relation to the conduct of the pursuit:

- The police were entitled to be concerned about the Deceased's driving in Commercial Road. He appeared to be goading the police (at least in the beginning), engaging in a game of 'cat and mouse' and, by the civilian accounts, was *smirking* about the situation.
- It was appropriate for the police to attempt to intercept a driver engaging in this type of behaviour.
- The police commenced a pursuit in circumstances where the Deceased failed to obey their direction to stop. LSC Thek said of this decision, in contrast to the prospect of not engaging in a pursuit, that '*you're damned if you do and damned if you don't....He has driven the car towards us in Commercial Road, reversed the car back towards us – so it displays he hasn't got a great regard for other road users. Other people have seen this.....– if we're to let him go without taking any further action and he cleaned someone up down the road then we would be here being asked why we didn't do something. Now, we took the decision to pursue and the outcome is that we're here and we're answering questions in relation to that.*'
- Whilst the registration number was obtained by the police prior to the stop in the slip lane, it was not communicated to D24 until after the commencement of the pursuit at 9.10.33 am. The results were not therefore obtained until after the pursuit was terminated. The results of the registration check will give details of the registered owner of the vehicle and therefore details regarding the driver of the vehicle, if they are the same person.[30] The divisional van was not fitted with a Mobile Data Terminal (MDT) to allow the police members to conduct their own search. I have been advised that this has now changed and all divisional vans and patrol vehicles in the country area are fitted with MDTs.
- It appears that an inaccurate description of the location of the pursuit was initially communicated to D24 at the commencement of the pursuit (expressed as *Princes Way* with no suburb rather than Princes Drive, Morwell). This was fairly quickly corrected (although without the suburb). The Pursuit Controller wasn't aware of the actual location of the pursuit until after it was terminated. Whilst it appears that his lack of knowledge wouldn't have resulted in an earlier termination of the pursuit, communicating key facts to D24 remains critical in the conduct of any pursuit.

[30] I note that on 19 January 2012, the police officer recognised the driver as the Deceased ('*Now that you have said that it looks a bit like [the Deceased]...go with his details thanks.*'

- I agree that whether a pursuit is classified as *elective or imperative* (the distinction no longer exists) this bears no impact on the continuation of the pursuit.[31] What is important is that the pursuit should be terminated when risks outweigh the outcome to be achieved, regardless of the classification.

- The most confounding feature of this pursuit was the Deceased's inexplicable behaviour (as noted above, the *unknown*). Unlike other pursuit related deaths which often involve *accidental* collisions at speed into cross traffic and/or street fixtures, these circumstances involve the Deceased driving on the wrong side of the road for over a kilometre at high speeds and into the path of oncoming traffic. In fact, in order to enter onto the exit ramp, the Deceased had to have made '*close to 180 degree*' left hand turn.

- We can only speculate about the Deceased's mental state at the time, and indeed whether it changed over time. I agree with Counsel Assisting that it is not possible to discern the reason why the Deceased engaged in the pursuit and travelled the wrong way on the freeway, whether it be due to fear of police, misadventure, deliberate self harm or psychosis (a combination) or for some other reason.

- A/P Harvey was asked to comment on the Deceased's mental health condition at the time of the incident and, whilst noting that there was limited information on his mental state at the time, he said, '*I am of the opinion, based on the longitudinal history that the Deceased's mental state adversely affected his decision making and behaviour, and significantly contributed to the incident that resulted in both his and Jason Govan's deaths.*'

- There were a number of key decision making points in the pursuit. They were:

  a. the commencement;

  b. the travel through the train carpark;

  c. *crashing* the red lights at the Jane Street Bridge; and

  d. exiting the freeway entrance in the wrong direction using the off ramp.

- I have been critical of the pursuit VPMs applicable at the time (paragraph 136) which, in my view, seem to permit a wide range of decision making options for those commencing

[31] As noted in submissions on behalf of the police members: *Insofar as there was a notional and perhaps definitional distinction between the two there seems, upon analysis, not to be any relevant difference to the way in which the classification of a pursuit as one or the other would effect the decision to terminate. Essentially each pursuit should be terminated when the risks outweigh the intended rewards or aims.*

or conducting a pursuit. This makes it difficult to form any meaningful conclusions (or assessments) with respect to the decision making on that day. That being said, it does appear that the VPMs would have permitted the commencement of the pursuit and its travel through the train carpark.

- In my view however, a more prudent and cautious approach would have been to terminate the pursuit when the Deceased crashed the Jane Street Bridge lights. I say this in part because the Deceased was becoming increasingly more likely to engage in risk taking behaviour. Sgt Rumble said of crashing these lights: *'No doubt there's an element of luck in it, absolutely no doubt, you know, there is, and like I've acknowledged there is a big risk in it.'* He said that in his mind, the pursuit was close to termination at that point but he wanted to know more. Ultimately however, I am unable to say that the continuation of the pursuit at that stage would not have been permitted under the applicable VPMs.

- As to the stage of the pursuit where the Deceased entered the exit ramp to the Princes Freeway, I am of the view that the pursuit should have been immediately terminated by the Traralgon 307. The overall balance of risks in relation to the pursuit had tipped in favour of termination. It would have been abundantly clear that he was not going to stop, which was the key objective.

- The evidence does not allow for any firm conclusions as to what the Deceased would have done, had the police not commenced the pursuit at the slip lane. He could have continued to try and engage with the police, taken the same course down the Princess Freeway or removed himself from the area without incident or something entirely different. This is something we will never know.

- Traralgon 307 entered the exit ramp with a view to observing where the Deceased had travelled. I understand that it was tempting to do this, but in my view it was not appropriate in circumstances where the pursuit should have been terminated.

- I was not drawn to any provision in the Rules or Polices which permitted the continuation of a pursuit for the purpose of 'observations', once the risks outweighed the result to be achieved – even where the police vehicle was slowing down[32]. As already stated however, termination at that point would have made no difference to the outcome.

[32] Although I don't doubt that there will be a rare scenario where this might be an appropriate option.

Production of OC Spray

151. As noted above, DSC Thek approached the Deceased's vehicle with the OC spray in his hand.

152. Senior Sergeant Matthews Hargreaves, Centre of Operational Safety, Victoria Police, gave evidence that in his opinion, '*It was appropriate and in accordance with Leading Senior Constable Thek's training and instruction from Victoria Police to determine that a an appropriate tactical technique in this situation was to remove his OC spray from his scabbard and to ensure his own safety, the safety of Constable Purcell, the safety of the public, and the safety of* [the Deceased]. *Leading Senior Constable Thek's conduct was proportionate and a reasonable option available to him, and was in line with his safety first philosophy and the relevant VPMP and VPMG.*'

153. The Deceased's family say that *'Officer Howard who just two days prior had attempted to secrete the spray from* [the Deceased] *so as to avoid escalation. Officer Howard also took this non-confrontational approach in his dealings with [the Deceased] so as to avoid escalation. ...Thek took no corrective action to dissuade [AB] from his misapprehension that he was holding a gun.'*

154. The scenario faced by Sgt Howard was very different to that facing police on 21 January 2011. I note that the vehicle was stationary and had been so for hours, the Deceased was not revving his engine and there had not been any interaction (as described above) with police immediately beforehand.

155. It is odd that the Deceased referred to the OC spray as being a 'gun', but it will never be clear whether this was his actual belief or whether he said this for another reason. I agree that it would have been appropriate for LSC Thek to have responded to dispel any belief that it was a gun, but I note that he said; '*I didn't really get a chance to communicate with him at all.*'

156. On the basis of the material before me, I am unable to conclude that the tactical option employed by LSC Thek fell outside the options reasonably available to a police officer in the same circumstances.

FINDINGS

157. Having considered all the evidence, I find that [redacted] born on 11 December 1969, died on 21 January 2012 of Multiple Injuries Sustained in a Motor Vehicle Incident (Driver), in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

158. I conducted a policy hearing which examined Victoria Police pursuit policy as part of my investigation into the death of Sarah Booth, aged 17, who was the passenger in a vehicle involved in a police pursuit on 31 December 2006.

159. As a result of that investigation I made the following recommendations (amongst others) on 14 July 2014:

Recommendation 1

Police should never pursue a vehicle simply because it is fleeing. A pursuit should only be undertaken where police hold a pre-existing belief on reasonable grounds that intercepting the vehicle is necessary:

- to prevent a serious risk to public health and safety; or
- in response to a serious criminal offence that has been committed, or is about to be committed, which involves serious harm to a person or persons.

Recommendation 2

The current Victoria Police risk assessment model for police pursuits should be redeveloped and an alternative more appropriate model be adopted, such as the 'traffic light model', so as to guide police members as to what weight should given to one particular risk factor over another. Any risk assessment model should be commensurate with appropriate industry practice in other safety critical environments.

160. The CCP responded to these recommendations in October 2014 indicating that they would be implemented.

161. On 13 July 2015, a range of changes were introduced. In particular, I note the CCP's advice that the changes include the introduction of (amongst other things):

- additional clear criteria that must be met before a pursuit can be conducted;
- a clear requirement that a pursuit must not be initiated in ordinary circumstances for any property or minor traffic offence;
- a clearer decision making tool and risk assessment guide in the form of a flow chart for members to follow in relation to a pursuit; and

- a 'traffic light model' which guides members as to the weight that should be given to particular risk factors in relation to a pursuit.

162. If my earlier recommendations had not been implemented, I would have made them again as part of this investigation.

163. I note that if these changes had been in place at the time of this incident, a pursuit **would not** have been conducted.

164. Whilst these changes will not serve to take away the grief suffered by families, it is my view that each death has been instrumental in the changes having been made.

Separation of police members

165. Immediately after the incident, LSC Thek and Cons. Purcell returned alone together, by vehicle, to the Morwell Police Station. The journey only took a couple of minutes.

166. Where a death or deaths involve police contact, the initial part of an investigation is crucial, and it is important for the members to be separated prior to their statements being taken.

167. I accept that immediately after the accident the scene was chaotic and required resources to be garnered from numerous places.

168. Sgt Rumble said:

'we had a major incident on the freeway. Ah, a lot of people in that area; had very limited police resources that early on, and it was in my opinion the best option....[and we] needed to get the Traralgon members free of the area.'

169. Despite this, I agree with the Deceased's family that the police members involved in the pursuit should not have been allowed to travel together in the manner that it occurred. There is however no evidence to suggest that this impaired my investigation.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that a **redacted** version of the finding be published on the internet.

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

- The Senior Next of Kin on behalf of the family
- Flemington and Kensington Community Legal Centre
- The Victorian Government Solicitors Office
- Landers and Rogers
- Detective Sergeant Mark Amos, Coroner's Investigator

Signature:

JOHN OLLE
CORONER
Date: 24 September 2015