IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 0858

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of:	GREGORY ANDERSON
Delivered On:	6 October 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Date:	10 December 2014
Findings of:	Judge Ian L. Gray, State Coroner
Representation:	Dr Ian Freckelton QC with Mr Ben Ihle, Counsel, instructed by Ms Rose Singleton, Victorian Government Solicitors' Office, on behalf of the Chief Commissioner of Police.
Counsel Assisting the Coroner	Ms Rachel Ellyard, Counsel, instructed by Ms Jodie Burns, Senior Legal Counsel, Coroners Court of Victoria.

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

AND having held an inquest in relation to this death on 10 December 2014
at Melbourne
find that the identity of the deceased was Gregory Anderson
born on 3 November 1959
and the death occurred 13 February 2014
at the Alfred Hospital, 55 Commercial Rd, Melbourne
from:

1(a) GUNSHOT WOUND TO CHEST

in the following circumstances:

1. On 12 February 2014, Gregory Anderson (**Mr Anderson**) was fatally shot by Constable Anthony Hester (**Constable Hester**) at Bunguyan Reserve[1], 1475 Frankston-Flinders Road, Tyabb, Victoria.
2. Constable Hester shot Mr Anderson after he formed the belief that Mr Anderson was going to run at him and stab him.
3. Mr Anderson was pronounced deceased at 1.25 am on 13 February 2014 at the Alfred Hospital, after unsuccessful emergency surgery.

BACKGROUND

4. Mr Anderson was born 3 November 1959, in Bendigo. He attended a number of schools in various States of Australia. Mr Anderson grew up in a Presbyterian home, attending church and Sunday school with his mother and brothers.[2] In his adult life, he explored a diverse variety of religious beliefs. Mr Anderson had interest in numerous religions including the Hare Krishnas, the Mormons and the Russian Orthodox Church. In the Luke Batty inquest, Ms Batty's evidence was that Mr Anderson often talked about hearing voices and referred to rituals of cleansing and diet. He had "obsessive" views about some food groups and Western medicine, preferring Chinese herbal medicine.[3]
5. While Mr Anderson from time to time held down various jobs, he did not maintain stable employment. His younger brother described Mr Anderson as "*quite an entrepreneur*" and "*clever enough to do whatever he wanted.*"[4] In the years prior to Mr Anderson's death, he did not have stable accommodation and at times lived in his car.
6. In 1984, Mr Anderson married, however the marriage ended without children.
7. In 1990, Mr Anderson had a brief romance with which resulted in a son being born in 1991 after the relationship ended. Mr Anderson had very limited contact with that son after his birth.

[1] The Bunguyan Reserve is the home ground of the Tyabb Cricket and Football clubs.
[2] Suppression Order dated 20 October 2014 prohibits the publication of any information that would identify or tend to identify any residential address, email address or phone number of Mr Anderson's parents.
[3] Coronial brief, p. 1483 and Transcript, p. 225.
[4] Coronial brief, p. 756.

8. In 1992, Ms Batty commenced a relationship with Mr Anderson, which lasted intermittently for approximately two years.
9. Ms Batty and Mr Anderson recommenced their relationship in 2001 and Luke was born on 20 June 2002, in Clayton. At the time of Luke's birth, Ms Batty and Mr Anderson did not have any relationship, other than Mr Anderson being Luke's father. Ms Batty's evidence was that one of the reasons the relationship ended was because Mr Anderson was verbally abusive toward her. Ms Batty and Mr Anderson also had conflicting and incompatible views, including how to raise Luke..
10. Ms Batty was Luke's primary care giver and provider during the entirety of his life.
11. To manage Mr Anderson's contact with Luke, consent orders made by the Family Court of Australia, allowed Mr Anderson to have weekly access to Luke. These orders remained in place from 2006 to 24 April 2014. However, during this period, Mr Anderson's access to Luke became more and more restricted through the involvement of the Victoria Police, the Department of Human Services[5] and the Courts.
12. On his own account, Luke loved his father "*to bits*."[6] Mr Anderson was devoted to Luke; he took him to museums and art shows to broaden his education, taught him maths and purchased educational gifts to help him academically. Mr Anderson regularly took Luke to the beach and parks and taught him how to sail. Luke described his father to others as always having a smile on his face and as always being prepared to lend things to people.[7] According to Ms Batty, Luke was never afraid of his father.[8]
13. In November 2010, Mr Anderson's wrist was badly broken, resulting in approximately two weeks hospitalisation. During hospitalisation, on 10 November 2010, Mr Anderson, unrelated to his wrist injury, was reviewed for mental health issues due to aggressive and hostile outbursts. A mental health assessment that appears to have taken approximately 34 minutes took place. It was noted that Mr Anderson was co-operative, that his mood was 'Ok' but his affect was mildly elevated and his thought stream 'pressured and voluminous'. However, Mr Anderson was not assessed as being delusional, with the assessor expressing the tentative view that Mr Anderson was "*sub-clinical bipolar illness exacerbated by cessation of cannabis with mild hyper-mania.*"[9] A further note from the Liaison Psychiatry Service dated 11 November 2010 stated that Mr Anderson "*did not display any psychotic thinking.*"[10] No formal mental illness was diagnosed and the hospital's treatment plan was to maintain a regular dose of diazepam.[11]
14. Mr Anderson had a history of over-bearing and violent conduct towards Ms Batty. She believed he had mental health problems, including paranoia and religious fixations, something also observed by other persons including police officers who encountered him. However, there is no evidence of any formal psychiatric diagnosis during Mr Anderson's life.

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[5] At the time of the Inquest the Department was known as the Department of Human Services. On 1 January 2015, the Department of Heath and the Department of Human Services joined to form the Department of Health and Human Services.
[6] Coronial brief, p. 629-630.
[7] Coronial brief, p. 639.
[8] Coronial brief, p. 1497.
[9] Clinical notes from Frankston hospital dated 11 November 2010, coronial brief p. 2413.
[10] Clinical notes from Frankston hospital dated 11 November 2010, coronial brief p. 2416.
[11] Coronial brief, p. 2410. Diazepam is an oral medication that is used to treat anxiety. It belongs to the benzodiazepine family of drugs.

15. On 16 May 2012, after being arrested by police officers on allegations of being violent towards Ms Batty, Mr Anderson was admitted pursuant to section 10 of the *Mental Health Act 1986*. The hospital records state that Mr Anderson was "*rational, discursive, articulate, completely normal, essentially in behaviour and presentation.*"[12] Under mental state examination Mr Anderson was assessed to be "*discursive, neat, rational articulate*" and that, he had full insight, his cognition was intact and he denied suicidal ideation.[13] Mr Anderson was found to have no psychiatric symptoms and discharged by the hospital without any recommendation for follow-up or referral to a mental health specialist for further assessment. On the face of it, this non referral for any follow-up revealed a surprisingly superficial approach in my view.
16. During the Luke Batty inquest, a psychiatric autopsy/desk top review[14] was performed by Emeritus Professor Paul Mullen, Centre for Forensic Behavioural Science (**Professor Mullen**) and he expressed the opinion that Mr Anderson likely suffered from a delusional disorder,[15] a form of psychosis which is exhibited by individuals who are able to present as normal and 'pull themselves together'. Professor Mullen noted that recognition and diagnosis of such disorders is not easy, but they are treatable.[16] Professor Mullen reasoned that had Mr Anderson been diagnosed and treated with medication to control his delusions, his abnormal ideas and delusions might not have driven him to criminal and violent behaviour.[17] Professor James Ogloff expressed the view that even if a period of time in prison may have ameliorated the risks flowing from this condition, there is no guarantee that it would not recur later or, even have been exacerbated.[18]
17. Mr Anderson appeared to be able to exercise a level of control over his own conduct and switch between irrational and rational behaviours and presentations. One of the most important issues to emerge in Luke Batty's coronial investigation was the inability, or failure of the system to bring people like Mr Anderson inside the framework of the system and begin processes of change.
18. At the time of Mr Anderson's death, there were four unexecuted warrants for his arrest. These related to 11 criminal charges laid by police officers which included unlawful assault, assault by kicking, assault with an instrument, making threats to kill, threatening to inflict serious injury, contravening an intervention order, driving an unregistered motor vehicle, accessing child pornography, possessing child pornography, failing to answer bail and contravening an interim intervention order.
19. As at the date of his death, 12 February 2014, Mr Anderson was the Respondent to a current family violence intervention order (**FVIO**) in which Luke and Ms Batty were named as protected persons.
20. The FVIO was intended to prevent Mr Anderson from seeing Luke other than at weekend sporting events. This prohibited Mr Anderson's attendance at Luke's sporting events during the week and at activities such as scouts. The Order had number of conditions, the most critical one being:

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[12] Coronial brief, p. 2254.
[13] Coronial brief, p. 2256.
[14] Without any clinical interaction.
[15] Exhibit 104 – Professor Mullen Expert report, p. 54-57.
[16] Transcript, p 1717-1736.
[17] Transcript, p. 1738.
[18] Transcript, p. 1790.

On the weekends [Luke] plays football, cricket or engages in Little Athletics, the Respondent [Mr Anderson] is free to attend these events, and speak to [Luke] when he is there in the company of others.[19]

21. The order was specified to last until 31 December 2019.

JURISDICTION

22. Mr Anderson's death was a reportable death pursuant to section 4 of the *Coroners Act 2008* (**The Act**) because it occurred in Victoria and he died from injuries sustained when police officers attempted to take him into custody.

THE PURPOSE OF A CORONIAL INVESTIGATION

23. The Coroners Court of Victoria is an inquisitorial jurisdiction.[20] The purpose of a coronial investigation is to independently investigate a reportable death[21] to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[22] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances to the death, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[23]

24. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the investigation findings and the making of recommendations by coroners, generally referred to as the 'prevention' role. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[24] These are effectively the vehicles by which the prevention role may be advanced.[25]

25. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[26] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

26. Detective Sergeant Allan Birch (**DSS Birch**) and Detective Senior Constable Paul Bubb (**DSC Bubb**) from the Homicide Squad were the coroner's investigators and prepared the coronial brief. I thank them for their tireless work in the investigation and for preparing a comprehensive coronial brief in a professional and expeditious manner.

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[19] Coronial brief (Luke Batty), p.1543.

[20] Section 89(4) *Coroners Act 2009.*

[21] Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear to have been unexpected, unnatural or violent.

[22] Section 67(1) of the Act.

[23] *Harmsworth v The State Coroner* [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[24] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[25] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[26] *Keown v Kahn* (1999) 1 VR 69.

27. This finding draws on the totality of the material produced for the coronial investigation into Mr Anderson's death. That is, the investigation and coronial brief in this matter,[27] the coronial brief prepared in relation to Luke's death,[28] the statements, reports and testimony of those witnesses who testified at the Inquest and any exhibits[29] tendered through them. All this material, together with the inquest transcript,[30] will remain on the coronial file. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

STANDARD OF PROOF

28. All coronial findings must be made based on proof of relevant facts on the balance of probabilities and, in determining this; I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[31] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

   - the nature and consequence of the facts to be proved;
   - the seriousness of an allegations made;
   - the inherent unlikelihood of the occurrence alleged;
   - the gravity of the consequences flowing from an adverse finding; and
   - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

29. The effect of the authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

IDENTITY OF THE DECEASED

30. Mr Anderson was identified by way of fingerprint comparison. There is no dispute about Mr Anderson's identity and it required no further investigation.

31. I formally find the deceased to be Gregory Anderson, born 3 November 1959.

MEDICAL CAUSE OF DEATH

32. On 14 February 2014, Dr Lee, forensic pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on Mr Anderson's body and provided me with a written autopsy report, dated 6 June 2014, stating the cause of death to be from a gunshot wound to the chest.

THE CIRCUMSTANCES OF MR ANDERSON'S DEATH

33. On 12 February 2014, Mr Anderson left the shared-accommodation house at 19 Culcairn Drive, Frankston South where he had been renting a room for the previous three weeks. Prior to leaving this address, Mr Anderson packed almost all of his belongings into a backpack. When Mr Anderson left,

[27]. The coronial brief comprises approximately 2625 pages.
[28] The coronial brief comprises approximately 3776 pages.
[29] 110 exhibits were tendered at the Inquest.
[30] Inquest transcript comprises 1833 pages spanning 13 days of evidence.
[31] (1938) 60 CLR 336.

he was wearing the backpack and had taken a large knife from the kitchen of the house. Mr Anderson walked[32] to a bus stop in Wells Street, Frankston, boarded a bus and travelled to the Bunguyan Reserve.

34. On the same day, at about 4.37 pm, Ms Batty drove Luke to the Bunguyan Reserve for cricket training.[33] When they arrived, Mr Anderson was already present. Ms Batty asked Luke whether he was all right and whether he wanted her to stay, as she usually did not stay for practice. Luke said he would be all right. Ms Batty left Luke with the training staff, parents and other children from the cricket team and returned home. Ms Batty's Inquest evidence in relation to seeing Mr Anderson at the Bunguyan Reserve that night and why she did not ring the police to try and get him arrested on unexecuted warrants was:[34]

> *His dad stood up looking very happy to see Luke, very affable, he didn't look agitated or problematic, it was a really nice sunny night. We hadn't seen Greg at cricket practice all season. I - we didn't know he was going to be there, but we weren't surprised that he was there, in fact, I was quite - and Greg - Luke on the way to the um, practice had kind of, you know, probably was wishing he wasn't there and I said, "Are you going to be all right?" And he said, "Yeah, I'm all right, mum." I said, "Your dad will be happy to see you. You'll be all right, buddy." And seeing Greg there looking happy to see Luke, I'd had some really unpleasant situations trying to - involving the police at the oval. It was traumatic, stressful, unpredictable. I hadn't got - I didn't trust, I didn't trust the situation and I thought of Luke and thought, this will be the third time I've tried to get this man arrested in front of Luke and his friends at that bloody oval.*[35]

35. On this night there was an active FVIO, in place that named Mr Anderson as the Respondent and Ms Batty and Luke as the Affected Family Members. While the FVIO, as amended on 9 September 2013, did not permit Mr Anderson to be at Luke's sporting events mid week, Ms Batty's evidence was that she was unaware of this and believed that Mr Anderson was permitted to be at Luke's cricket training on this night. Ms Batty's rationale of why she did not call the police to prevent Mr Anderson from remaining at training is understandable when seen in this context.

36. Shortly before 6.00 pm Ms Batty returned to collect Luke, as the cricket training was due to finish at 6.00 pm.[36] On the completion of the cricket training session, Mr Anderson was in the cricket practice nets with Luke, bowling balls to him. Luke was batting with his Gray Nichols cricket bat.[37] Children, parents and training staff were still packing up.

37. Luke approached Ms Batty and asked if he could continue practising with his father. Ms Batty agreed and Luke returned to the nets where he continued practising cricket with Mr Anderson.[38] At the inquest, Ms Batty spoke of her acceptance that allowing Luke to practice in the nets with his father was, a tragic misjudgement made in the moment:

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[32] CCTV McDonalds Restaurant and Civic Video Store.
[33] Significant Witness Interview – Rosemary Batty.
[34] A Warrant to Arrest is an official Court document which provides a police officer with the power to arrest a person or place them in custody.
[35] Transcript, p. 62.
[36] Significant Witness Interview – Rosemary Batty.
[37] Significant Witness Interviews of Rosemary Batty and The Cricket Coach.
[38] Significant Witness Interview – Rosemary Batty.

Ms Ellyard:	*Ms Goldsbrough seems to have wanted there to always be other people close by when Greg and Luke spoke to each other and my question is - that's my reading of what she meant - is that your reading?*
Ms Batty:	*That's my reading - - -*
Ms Ellyard:	*Is that what you understood at the time?*
Ms Batty:	*That's my reading and that's pretty much what happened. I mean basically when you're at footy training or footy matches, there are opportunities for him to hug his son or have a quick chat, but the rest of the time, they're playing or they're being coached by the coach, there's parents there, there's the team's other parents there, they're on the pitch. He never got in a car, he never removed himself. He was on the pitch and if his dad went up and gave him a hug and had a quick chat with him, I saw there was nothing wrong with that because he was in my line of sight, in the public forum, on the oval, where everybody else was. On the night he died, lapse of judgment on my behalf because within five minutes, everyone had gone home and clearly that was a staged situation that I hadn't seen coming.*[39] (emphasis added).

38. While waiting for Luke, Ms Batty continued to talk with other parents and children. The under-12 team cricket coach[40] (**the Cricket Coach**), was in the car park organising his three sons into his car, preparing to leave. The Cricket Coach's 8-year-old son[41] (**the 8-year-old boy**), realised that his cricket bag had been left near the practice nets and ran back to collect it. As the 8-year-old boy was picking his bag up, he heard a noise from inside the practice nets and turned to see Mr Anderson gripping the handle of a cricket bat that was raised over his right shoulder.[42] Mr Anderson brought the cricket bat down in a strong chopping action. The 8-year-old boy, did not see the cricket bat connect but saw Luke laying on the ground inside the practice nets. The Cricket Coach observed his son return to the car visibly distressed. The 8-year-old boy described to his father that Mr Anderson had hit Luke with a cricket bat.[43] The Cricket Coach, relying on information given to him by his distressed son, believed that Luke had been accidentally injured while practising with his father in the cricket nets. No one else was present at the practice nets and no one witnessed exactly what had happened to Luke.

39. At the same time, just prior to 6.29 pm. Ms Batty heard a "*distressed sound*", a "*noise of anguish*"[44] emanating from the cricket practice nets. Ms Batty observed Luke lying on the ground in the cricket nets, with Mr Anderson kneeling over him.[45]

40. Ms Batty became hysterical, believing that Mr Anderson had accidentally, but seriously, injured Luke whilst playing cricket with him. Ms Batty could see blood on Luke's head and saw Mr Anderson kneeling over Luke. She ran toward the clubrooms and asked for the ambulance to be called. Ms Batty did not approach the cricket nets, terrified that if she did so she might witness a tragedy involving Luke.

41. The Cricket Coach approached Mr Anderson and Luke, getting within about four metres, and asked if Luke was alright. Mr Anderson charged at him and he retreated. After a few minutes, the Cricket

[39] Transcript, p. 110.
[40] Name suppressed pursuant to the *Open Courts Act 2013*.
[41] Name suppressed pursuant to the *Open Courts Act 2013*.
[42] VARE Interview – The 8-year-old boy.
[43] VARE Interview - The 8-year-old boy.
[44] Recorded witness interview with Rosemary Batty, Batty Inquest Brief, at p. 115.
[45] Significant Witness Interview – Rosemary Batty.

Coach approached the nets again, although not as close as before, and asked Mr Anderson if Luke was alright and whether he was breathing. Mr Anderson responded:

> *Yeah, he's - he's OK. He's OK now, he's gone to heaven*[46]

42. The Emergency Services Telecommunications Authority (**ESTA**) recorded a call at 6.29 pm from the Cricket Coach.[47] At about 6.33 pm, Hastings-based ambulance paramedics, Sheldon Carr and Camilla Glasby, were dispatched to the Bunguyan Reserve. The information provided to the paramedics at this point in time was:

> *A patient with a traumatic injury, serious haemorrhage in Tyabb. At the Tyabb Cricket Ground, an 11 year old there has been hit by a cricket ball.*[48]

43. A further update was then provided by ESTA:

> *Query arrest. Query stabbing.*[49]

44. Upon arrival, the paramedics observed a woman waving and yelling and screaming, telling them

> *He's killed him!*[50]

45. The paramedics drove to behind the cricket rooms and parked the ambulance near the playground. They observed a male standing in the nets, about 50 metres away,[51] who said to them:

> *It's too late. Get the police. It's too late. He's gone. Don't come near me.*[52]

46. The male, later identified as Mr Anderson, was brandishing a knife and stated:

> *He's gone. There is nothing you can do for him. You better get the cops.*[53]

47. The ambulance officers believed Mr Anderson had blood on his clothing and hands. Paramedic Carr's evidence was that Mr Anderson had a knife, which he *"slightly lifted his arm away from his body to make it visible. It felt like it was escalating as his voice began to get louder and he moved out of the nets more."*[54] Due to the unacceptable risk posed by Mr Anderson, the ambulance was driven about 100 metres away from Luke and paramedic Carr communicated to ESTA that there may be a deceased person, a male had a knife and that the police were needed as soon as possible.

48. The police mobile patrol supervision unit with the designated call sign 'Mornington 251'[55] requested ESTA to send the mobile patrol units Mornington 303[56] and 304 to respond. At 6.39 pm, Mornington 303, crewed by Constables Anthony Hester and Richard Postlewaite advised ESTA that they were en-route to the incident. At 6.42pm, Mornington 304[57] crewed by Senior Constables Benjamin Swift and Bradley Carroll, advised ESTA that they were available to assist and were told

> *Mornington 304 to Tyabb please and for all units information, the further information from the ambulance was, it was a call saying that a serious haemorrhage, that's regarding the child. The child's not moving. When asked if the child was still conscious the father implied that the child*

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[46] Significant Witness Interview with The Cricket Coach. Coronial brief pp174, 176.
[47] This call lasted 8 minutes and 20 seconds.
[48] Anderson coronial brief, p. 896.
[49] Statement of Sheldon Carr, Anderson Inquest Brief, at p. 474.
[50] Coronial brief, p. 475.
[51] Anderson coronial brief, p. 481.
[52] Anderson coronial brief, p. 481.
[53] Anderson coronial brief, p. 475.
[54] Anderson coronial brief, p. 476.
[55] 251 is the Victoria Police code for a sergeant supervisor shift for a police service area.
[56] 303 is the Victoria Police code for the afternoon divisional van shift that commenced duty at 3:00pm.
[57] 304 is the Victoria Police code for the afternoon divisional van shift that commenced duty at 4:00pm.

had gone to heaven. Was fitting and serious haemorrhage. I don't have any further info regarding the knife and the stabbing but safety principles obviously apply.[58]

49. At 6.46 pm, the Hastings paramedics advised ESTA that they were unable to get near the patient as the offender had a knife. At 6.50 pm, Mornington 303 advised ESTA:

    Mornington 303 urgent. 303, we have a male with a knife. It would appear that he's stabbed his son. His son would appear to be deceased. He's agitated. He's got a knife in his hand.[59]

50. On arrival at Bunguyan Reserve, Constables Hester and Postlewaite were directed towards the cricket practice nets. They moved on foot towards the practice cricket nets where[60] they observed what appeared to be a child laying on the ground in the practice nets, with Mr Anderson crouching or kneeling over him. Constables Hester and Postlewaite ran towards the practice nets and as they did, Mr Anderson walked out of the nets toward them. Mr Anderson was holding a knife and appeared to be covered in blood. Constables Hester and Postlewaite immediately stopped and began retreating from the advancing Mr Anderson. They continually yelled at Mr Anderson to '*stop, drop the knife and get on the ground*'. Both police officers drew their police issued Smith and Wesson .40 calibre semi-automatic pistols. Constable Postlewaite's evidence was that he heard Mr Anderson saying words to the effect "*Are you going to shoot me from there?*"[61] Constables Hester and Postlewaite retreated to the loose gravel area not far from the clubhouse.

51. At 6.50 pm, all police units were advised:

    Mornington 304, Mornington 701 and all units that can head to Tyabb Football Club on Frankston Flinders Road at the back of the tennis courts. Male armed with a knife.[62]

52. At 6.51 pm, Mornington 303 requested urgent backup, including the assistance of the Victoria Police Critical Incident Response Team, a negotiator, the Victoria Police canine unit, the divisional supervising Senior Sergeant and all Major Crime Units.

53. By 6.52 pm, both Senior Constables Swift and Carroll had arrived and took up positions to form a line of four police officers between Mr Anderson and the civilians and ambulance paramedics behind them. Mr Anderson's positioning and actions prevented the police officers and paramedics from accessing the practice nets to provide medical aid to Luke.

54. All four police officers were retreating from Mr Anderson, walking backwards whilst calling on him to 'stop, drop the knife and get down on the ground'. Mr Anderson continued to advance on the police officers with the knife in his hand. Mr Anderson briefly stopped moving forward and Senior Constable Swift deployed Oleoresin Capsicum Spray (**OC Spray**).[63] It appeared to the police officers that the OC spray did not reach Mr Anderson due to the prevailing wind. Subsequent investigation reveals that it did contact Mr Anderson on his face, upper body and surface of his prescription spectacles that he was wearing. Senior Constable Carroll's evidence was that Mr Anderson said words to the effect of:

[58] Anderson coronial brief, p. 915.
[59] Anderson coronial brief, p. 916.
[60] Statements of Constables Hester and Postlethwaite and SCs Swift and Carroll.
[61] Coronial brief, p. 509.
[62] Anderson, coronial brief, p. 916.
[63] Statement of SC Swift and Graeme Pollard.

Come on shoot me, fucken' kill me[64]

55. Senior Constable Carroll addressed Mr Anderson by his first name; however, it did not result in a de-escalation of Mr Anderson's threatening behaviour. The police officers did not surround Mr Anderson so as to avoid agitating him further, offering him multiple exit points. Mr Anderson continued to advance towards the police officers as they continued to move backwards.

56. At the same time OC foam was deployed, Senior Constable Carroll recalls Mr Anderson was screaming "*Fucken' shoot me, fucken' kill me.*"[65] Senior Constable Carroll believed that Mr Anderson was going to spring at the police officers so he shouted at him "*Greg, don't do it.*"[66]

57. Mr Anderson suddenly moved directly at Constable Hester who discharged one round from his police issue firearm. At the same time, Senior Constable Carroll began to squeezing the trigger on his firearm, only stopping when he heard the sound of Constable Hester's firearm discharge.[67] Constable Postlewaite's evidence was consistent with Constable Hester's evidence that Mr Anderson was approximately three to five metres from Constable Hester at the time of the shooting.

58. Constable Hester's statement details the critical facts in his mind prior to discharging his firearm as follows:

    a. his serious concerns for the condition of Luke in the cricket nets;
    b. his observation that Mr Anderson was holding a knife;
    c. Mr Anderson was ignoring his repeated demands to 'drop the knife' and 'get down to the ground';
    d. his observation that Mr Anderson did not seem to be afraid of police, in spite of their firearms being pointed at him;
    e. the attempted use of OC spray by Senior Constable Swift being unsuccessful;
    f. Mr Anderson's continuing and quickening approach towards the police officers despite warnings to stop;
    g. Mr Anderson drawing closer to him, despite him (Constable Hester) retreating from Mr Anderson;
    h. Mr Anderson's action in raising the knife to chest height as he continued to approach him;
    i. his observation that Mr Anderson appeared to be focusing his attention on him more than the other police officers as he quickened his approached with the knife; and
    j. his belief that Mr Anderson "*was going to run at me and try to stab me with the knife. I was scared for my welfare and that I was going to get injured.*"[68]

59. The bullet struck Mr Anderson in the upper chest and did not exit his body. Mr Anderson immediately fell to the ground, with the knife still in his right hand.[69] Mr Anderson resisted paramedics' efforts to

[64] Coronial brief, p. 520.
[65] Coronial brief, p. 521.
[66] Coronial brief, p. 521.
[67] Coronial brief, p. 521.
[68] Coronial brief, p. 501.
[69] Statements of Graeme Pollard, Lisa Powell, Sheldon Carr, Camilla Glasby, Constables Hester and Postlethwaite and SCs Swift, Carroll and Pringle.

attend to the bullet injury. The police officers helped restrain Mr Anderson so that he could be treated. Mr Anderson repeatedly said "*let me die.*"[70]

60. Immediately after Mr Anderson was shot, at 6.55 pm, the attending paramedics pronounced Luke deceased. The medical evidence is that it was unlikely Luke was alive at the time the police officers attended the Bunguyan Reserve.

61. Mr Anderson was flown by Victoria Police Airwing air ambulance to the Alfred Hospital. Despite emergency surgery, Mr Anderson was pronounced deceased at 1.25 am on 13 February 2014.

THE REQUIREMENT FOR AN INQUEST

62. Section 52(2) of the Act mandates that I must hold an inquest into a reportable death if the death or cause of death occurred in Victoria and the death is suspected to be a result of homicide,[71] or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

63. Mr Anderson's death was clearly a result of homicide in the circumstances where a police officer was attempting to take him into custody. That is, the uncontentious fact is that Constable Hester caused the death of Mr Anderson while attempting to take Mr Anderson into custody and therefore it was mandatory to hold an inquest into his death.

64. It is important to be clear that it is not my role to apportion blame and section 69 of the Act expressly prohibits a coroner from including in a finding or a comment of any statement that a person is, or may be, guilty of an offence.

65. The Act allows a coroner to notify the Director of Public Prosecutions (**DPP**) if they form the belief that an indictable offence has been committed in connection with a death. In this case I am entirely satisfied on the evidence that Constable Hester was acting in self defence when he shot and killed Mr Anderson. Accordingly there will be no referral to the DPP.

THE INQUEST

66. On 10 December 2015, I conducted an inquest into Mr Anderson's death. The following witnesses gave evidence:

    a. DSS Birch; and

    b. Superintendent David Clayton, Operational Safety Division of the Police Academy.

67. I did not call any of the police officers involved with Mr Anderson immediately prior to his death, as their accounts of the circumstances that led to the death were consistent with each other, and corroborated by independent witnesses.

68. The focus of the Inquest was to determine if there were any prevention opportunities arising out of Mr Anderson's death. Superintendent Clayton's evidence was that he reviewed the conduct of Constable Hester, Constable Richard Postlethwaite, Senior Constable Benjamin Swift and Senior Constable Brad

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[70] Coronial brief (Luke Batty), p.472, 489, 516.

[71] Homicide is defined as the killing of one person by another.

Carroll and formed the view that the actions of all four police officer were in accordance with the relevant Victoria Police policies, procedures and training at the time.

69. Superintendent Clayton's evidence in relation to Constable Hester's decision to discharge his firearm, was that it was a reasonable and appropriate use of force in the circumstances and in accordance with his training and instruction from Victoria Police. Superintendent Clayton's reasons, with which I agree, were based on the conclusion that Constable Hester held a reasonable belief that Mr Anderson posed an imminent risk to his safety and that discharging his firearm was necessary to protect his life or prevent serious injury to himself.

70. Superintendent Clayton's evidence was that all four police officers involved with Mr Anderson were, as at 12 February 2014, appropriately trained. This included training in the Tactical Options Model that is to be applied by police officers when responding to incidents or planning operations where there is a potential that force may be used. The purpose of the Tactical Options Model is to assist police officers to select the most appropriate tactical option available to them to resolve an incident successfully, taking into account all the circumstances. The centre of the Model focuses on 'safety first', 'assess and reassess' and 'communications'. Superintendent Clayton's evidence explained that there are a number of tactical options available to a police officer to assist them in resolving a situation, including 'negotiation', 'tactical disengagement', 'cordon and contain' and a range of defensive police equipment such as the use of a baton, a firearm, OC Spray and other tactics and weapons.

71. Superintendent Clayton's evidence also detailed the Operational Safety Principles[72] that all police officers are required to apply in the course of their duties. They are:

    a. Safety First: The safety of police, the public and offenders or suspects is paramount.
    b. Risk Assessment: A risk assessment is to be applied to all incidents and operations.
    c. Take Charge: Exercise effective command and control.
    d. Planned Response: Take every opportunity to convert an unplanned response into a planned operation.
    e. Cordon and manage: Unless impractical, adopt a 'cordon and containment' approach.
    f. Avoid confrontation: A violent confrontation is to be avoided.
    g. Avoid force: The use of force is to be avoided.
    h. Minimum Force: Where use of force cannot be avoided, only use the minimum amount reasonably necessary.

72. I note that the Victoria Police adopts the HIARRC (Hazard Identification, Assess Risk and Risk Control) process when conducting a risk assessment which focuses on three distinct steps of identifying the hazard, assessing the risk associated with each hazard, and controlling the risk (through elimination, minimisation or use of tactical options).

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[72] These Operational Safety Principles underpin all training that recruits and OTST police officers receive. These Operational Safety Principles are set out in the VPM Policy Rules **(VPMP)** titled 'Operational Safety and Equipment'.

73. The Operational Safety Principles are designed to be remembered more readily by police officers and to be applied in an urgent situation (such as in the context of a critical incident). This approach, known as the 'S.A.F.E.' approach, dictates that, upon encountering such a situation, a police officer should:

   a. **Slow down.** 'Step back.' (Apply the 'Safety First' and 'Take Charge' Operational Safety Principles).
   b. **Assess the risks.** (Apply the 'Risk Assessment' Operational Safety Principle).
   c. **Formulate a plan.** (Turn an unplanned reaction into a planned response).
   d. **Evaluate the options.** (Apply the 'Cordon and Manage' Operational Safety Principle and assess other planned arrest options).

74. I agree with Superintendent Clayton's evidence that it was reasonable for Constable Hester to believe that Mr Anderson posed an imminent threat of danger to his life based on his own perceptions and observations of his conduct. Considering the unsuccessful attempts to de-escalate, it was appropriate, and consistent with Constable Hester's training, that he decided that an appropriate tactical response was to discharge his firearm to ensure his own safety.

75. I agree with Dr Freckelton QC and Mr Ihle's submissions that the four police officers, in the short period of time in which they interacted with Mr Anderson, acted in accordance with Victoria Police policies and protocols. I also agree with the submissions that the police officers impressed upon Mr Anderson the need to put down his weapon, did nothing to inflame the situation despite the extremely difficult circumstances of being confronted by a man covered in blood, wielding a knife, and with good reason to believe he had used that knife to kill a child. The police officers retreated from Mr Anderson, attempted to use OC spray to subdue him, and allowed him several means of egress in an attempt to de-escalate the situation.[73]

THE POLICE INVESTIGATION

76. I also note the evidence of DSS Birch relating to the Victoria Police Manual Guidelines for 'Inquests' which requires:

> *Inquest briefs where there is police involvement in the death. Where there is a police involvement component in the victim's death, for example, police shooting, police pursuit, death in police presence or custody the Homicide Squad are to prepare and distribute inquest briefs in the following order. One copy to the Coroner's Office. One copy to professional Standards Command. One copy for Office of Public Prosecutions. One copy for the investigator. One office copy.*[74]

77. I note DSS Birch's evidence that the purpose of sending a brief of evidence to the Director of Public Prosecutions is not necessarily to confirm the Homicide Squad's view that there is no reasonable prospect of conviction for any criminal offences in relation to a police contact related death, but to:

> *have an independent statutory body that prosecutes both police, and civilians on behalf of the State, make an assessment of all the evidence and come to a - whatever conclusion they do. I'm just confident that will be the same as that achieved by the Homicide Squad, but I wouldn't*

[73] Victoria Police submissions prepared by Dr Freckelton QC and Mr Ihle dated 10 December 2014, p. 16.
[74] Victoria Police Manual, Procedures and Guidelines 'Inquests'. Transcript p. 22-23.

send it there for confirmation. I'd send it there with a strong belief, but looking for an impartial independent assessment of all the evidence.[75]

78. I fully agree with DSS Birch's emphasis on the need for an independent and impartial assessment of the evidence in these matters.

79. It is always important in these cases to ensure that police officers investigating the actions of other police officers, and police officers assisting coroners, are experienced, competent and that their investigations are comprehensive and completely objective. This promotes public confidence in the administration of justice. For the purposes of this coronial investigation, coroner's investigators DSS Birch and DSC Bubb received all of their instructions from me. I am satisfied that they were sufficiently competent and experienced to perform the tasks requested of them, and that they in fact did so objectively and comprehensively. I thank them for their assiduous and detailed focus on the task of preparing and submitting the coronial brief and in their assistance to me.

COMMENTS

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

80. After an extensive coronial investigation, it is not known why Mr Anderson acted in the manner in which he did on 12 February 2014.

81. While Professor Mullen's psychiatric autopsy provided a diagnosis of a delusional disorder, it is not possible to properly understand Mr Anderson's thought processes on 12 February 2014 and the extent to which a pathology of a delusional disorder may have affected him.

82. The situation confronting the police officers involved with Mr Anderson on this day was complex, and placed extraordinary demands on their decision making skills. Despite the difficult circumstances, I consider the incident was managed in accordance with the Victoria Police's Tactical Options Model and the Operational Safety Principles.

83. Police officers are entrusted with upholding the rule of law and protecting the Victorian public's safety. In fulfilling this important responsibility, police officers have been given extensive powers including the power to use coercive force, if necessary. Police officers are frequently confronted with a situation where the safety of the public, themselves and their fellow officers depends upon their ability and preparedness to use force.

84. I note that any force used by a police officer must be consistent with legal requirements and the principles of section 462A of the *Crimes Act 1958* (Vic), which states:

    A person may use such force not disproportionate to the objective as he believes on reasonable grounds to be necessary to prevent the commission, continuance or completion of an indictable offence or to effect or assist in effecting the lawful arrest of a person committing or suspected of committing any offence.

85. In protecting public safety and upholding the law it is expected that police officers will act instinctively, decisively and often making split second life changing decisions. This is made all the

[75] Transcript, p. 27-28.

more complex where police officers are required to confront an individual behaving as Mr Anderson was.

86. I agree with Superintendent Clayton, and DSS Birch's inquest evidence that Constable Hester's response to Mr Anderson threatening him with the knife was justified in all the circumstances.[76]

FINDINGS

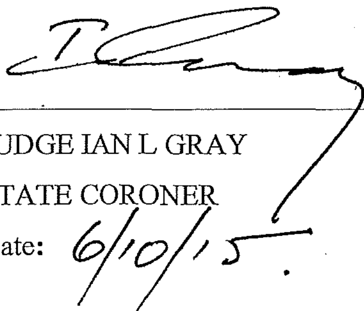
Pursuant to section 67(3) of the Coroners Act 2008, I make the following findings connected with the death:

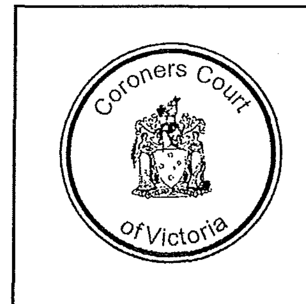
87. I find the deceased's identity to be Gregory Anderson, born 3 November 1959.
88. I accept and adopt the conclusions of Dr Lee and I find that Gregory Anderson died from a gunshot wound to the chest.
89. I find that Victoria Police training in relation to the use of force, as at 12 February 2014, was appropriate.
90. I find that Constable Hester, Constable Richard Postlethwaite, Senior Constable Benjamin Swift and Senior Constable Brad Carroll were appropriately trained in the use of force in accordance with the Victoria Police's Tactical Options Model and the Operational Safety Principles.
91. I find that Constable Hester, Constable Richard Postlethwaite, Senior Constable Benjamin Swift and Senior Constable Brad Carroll's individual, and collective, responses to Mr Anderson on 12 February 2014 were consistent with the Victoria Police's Tactical Options Model and the Operational Safety Principles.
92. I find that Constable Hester used lethal force only after unsuccessful attempts to de-escalate the confrontation with Mr Anderson.
93. I find that Constable Hester's use of force in using his firearm to shoot Mr Anderson was justified and necessary in the circumstances.

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

- **Gregory Anderson's family.**
- **Graham Ashton, Chief Commissioner of Police.**
- **Detective Senior Sergeant, Allan Birch (Homicide Squad), coroner's investigator.**
- **Detective Senior Constable Paul Bubb (Homicide Squad), coroner's investigator.**

Signature:





JUDGE IAN L GRAY
STATE CORONER
Date: 6/10/15

[76] Transcript, p. 18.