IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 / 1554

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: CRAIG DOUGLAS[1]

Delivered On:	8 December 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Melbourne
Hearing Dates:	4 – 7 February and 10 - 14 February 2014
Findings of:	CORONER PHILLIP BYRNE
Representation:	Ms J Dixon QC and Ms Fiona Spencer for Ms Douglas Mr B Ihle for Chief Commissioner of Police (CCP) Mr R Gipp for Constables Cross and O'Donnell
Counsel Assisting the Coroner	Ms R Ellyard

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, PHILLIP BYRNE, Coroner, having investigated the death of CRAIG DOUGLAS

AND having held an inquest in relation to this death on 4-7 February and 10-14 February 2014
at Coroners Court, MELBOURNE
find that the identity of the deceased was CRAIG DOUGLAS
born on 19 February 1980
and the death occurred on 2 May 2011
at Grey Street near the intersection with Dalgety Street, St Kilda 3182
from:

1 (a) GUNSHOT WOUNDS TO CHEST

in the following circumstances:

BACKGROUND

1. Craig Douglas was born in Prahran, Victoria on 19 February 1980 to Ms Tana Douglas. For the first few years of his life Craig lived with his grandmother in Melbourne while his mother supported them, working in London.

2. In 1987 Ms Douglas and Craig left Australia, eventually settling in Los Angeles. According to his mother, Craig adjusted to his new environment very well initially. When Craig was almost 13 his school environment changed significantly and he started acting out and became distant from his Mother.

3. In 1997, after some involvement with police, Craig moved back to Australia for a fresh start. He lived with his Godmother and started an apprenticeship. Ms Douglas informed the court how Craig was very happy during this time, however, something changed and in 2000 Craig left his Godmother's home. Ms Douglas lost touch with Craig for a period of time.

4. Over the next few years Craig was convicted of a number of offences and spent time in prison.

5. At the time of his death Craig Douglas was living at 60 Church Street, Geelong North. A friend of Craig's, Lucas Watson was living with him. Lucas Watson had shifted from Coffs Harbour, NSW and was an acquaintance of Craig Douglas' from prison.

6. Craig Douglas was in a relationship with another resident, Ms Tahlia Tuck who resided at unit 7, 60 Church Street and friends with another resident of the apartment block, Ms Kelly Berg.

BROADBRUSH CIRCUMSTANCES OF EVENTS OF 1st MAY 2011

7. On 1 May 2011 at approximately 6:30pm Craig Douglas along with Mr Lucas Watson, Ms Kelly Berg and Ms Tahlia Tuck arrived at the Gatwick Hotel, Fitzroy Street, St Kilda. They had been in Melbourne since 29 April 2011, staying the previous two nights in a hotel on Peel Street, North Melbourne.

8. According to the coronial brief of evidence the four friends checked into Room F3 on the third floor of the Gatwick Hotel.

9. CCTV footage at the Gatwick Hotel shows Craig Douglas and Lucas Watson leave Room F3 at 7:17pm and walk to the first floor where they entered Room 219 at 7:18pm.

10. Mr Luatasi Scanlan and Ms Amanda Threllfall were the residents living in Room 219. Ms Threllfall and Mr Scanlan both provided statements tendered to the court describing how two men, unknown to them, knocked on their door then pushed their way into the room.

11. It is clear that there was a confrontation between the two parties. In the course of that confrontation Ms Threllfall was stabbed in the back three times and once in the face. A quantity of cannabis and a set of scales belonging to Ms Threllfall was stolen.

12. According to the statement of Ms Threllfall a man in a brown top struck her on the back twice. She did not see a knife but when she put her hand against her back it was covered in blood.

13. Mr Scanlan's statement describes how the first man through the door was holding "what might be a gun."[2] He also describes seeing the other man holding a knife in his right hand and Ms Threllfall screaming out.

14. Once Craig Douglas and Lucas Watson left Room 219 Mr Scanlan rang an ambulance which resulted in the attendance of both paramedics and the police.

15. CCTV footage shows Craig Douglas and Lucas Watson returning to Room F3 at 7:23pm. At 7:25pm footage shows Craig Douglas, Lucas Watson, Ms Tuck and Ms Berg leaving room F3 with their luggage and then leaving the Gatwick Hotel through a rear door.

16. When Police attended they spoke to Mr Scanlan and reviewed the CCTV footage. A copy of the CCTV footage was also copied onto a disc and handed to police. While still at the Gatwick Hotel the footage was viewed by a number of police officers including Detective

[2] Statement of Luatasi Scanlan, p54 of the brief.

Senior Sergeant Philip Hubbard, Sergeant David Eadie, Senior Constable Leanne Cox and Constable Jason O'Donnell. It was noted that one of the females in the footage was pulling a distinctive pink suitcase on wheels. For the purposes of this finding and for clarity, I propose to refer to Mr Jason O'Donnell as Constable O'Donnell, his position at the time of the incident under investigation, although I am aware he resigned from the Victorian Police shortly prior to the conclusion of the formal inquest.

17. Due to the use of a firearm and a knife in the incident police requested the attendance of Critical Incident Response Team (CIRT).

18. At approximately 9:45pm, prior to leaving, Detective Senior Sergeant Hubbard and Sergeant Eadie spoke to the police officers present and discussed returning to St Kilda Police Station for a debrief.

19. At approximately 9:55pm St Kilda 313, a divisional van staffed by Senior Constable Leanne Cox (driving), and Constable Jacob Bowman (observer) left the Gatwick Hotel. They turned from Fitzroy Street and headed south up Grey Street.

20. St Kilda 303, a second divisional van staffed by Constables Ryan Cross and Jason O'Donnell, also travelled the same route on their way back to St Kilda Police Station.

21. Having observed a group they suspected were the suspects from the Gatwick incident St Kilda 313 pulled over at the intersection of Grey Street and Burnett Street. Shortly thereafter St Kilda 303 pulled up next to them. A short conversation took place confirming that they had seen the group and that they were pulling 'wheelie' suitcases similar to the suitcases the suspects from the Gatwick incident left with.

22. At the suggestion of Constable O'Donnell, Senior Constable Cox then requested the attendance of the CIRT unit by police radio. Constable Bowman was dispatched by Senior Constable Cox to take the details of a further bystander wearing a white hoodie in the event that he was part of the group as well.

23. By this stage Craig Douglas, Lucas Watson, Ms Tuck and Ms Berg had turned around and were heading north back towards Fitzroy Street.

24. Constable Cross left the St Kilda 303 divisional van and proceeded on foot north following the group that had been identified as suspects.

25. Constable O'Donnell performed a "U-turn" in the St Kilda 303 divisional van and travelled north on Grey Street. When he reached a position adjacent to the suspect group, by the intersection of Grey Street and Dalgety Street, he came to a sudden stop in the median strip.

26. A confrontation occurred where Craig Douglas, who was on the southern side of the intersection, produced a knife and advanced towards Constable Cross who had arrived on foot near the Grey Street – Dalgety Street intersection. Constable Cross retreated seeking to create distance between himself and Craig Douglas. Craig Douglas continued to advance with the knife extended towards Constable Cross. When Craig Douglas was in very close proximity to Constable Cross both Constable Cross and Constable O'Donnell, who had earlier exited the van, discharged their service revolvers at Craig Douglas at close range. Constable Cross fired twice, Constable O'Donnell once.

27. Craig Douglas was struck by two bullets, one in the chest, the other in the posterolateral aspect of the right shoulder. Dr Matthew Lynch, Senior Forensic Pathologist, who upon coronial direction, performed an autopsy, opined in evidence that either wound would be fatal.

28. First aid assistance was administered by police initially and then paramedics once they arrived. Despite their efforts Mr Douglas passed away and he was formally pronounced deceased at the scene.

CORONIAL INVESTIGATION HISTORY

29. Coroner Spooner had original carriage of this matter and held a directions hearing on 13 May 2013. Prior to Coroner Spooner retiring and shortly before the proposed inquest dates the matter was assigned to me. A further directions hearing was held on 28 November 2013. Subsequently the formal inquest was held on 4 – 7 and 10 – 14 February 2014.

30. The following witnesses were called to give evidence at the Inquest:

- Sergeant David Eadie;
- Detective Senior Sergeant Philip Hubbard;
- Detective Constable Robin Hedin (Acting Detective Sergeant at the time);
- Sergeant Brian Howard;
- Senior Constable Siem Ling Chy;
- Leading Senior Constable Shannon Hickson;

- Inspector Graeme Sprague;
- Inspector Glenn Owen;
- Leading Senior Constable Alan Pringle;
- Mr Harald Wrobel;
- Ms Laura Meese;
- Mr Daniel Armstrong;
- Mr David Pink;
- Dr Dimitri Gerostamoulos;
- Senior Constable Leanne Cox;
- First Constable Jacob Bowman;
- Constable Ryan Cross;
- Constable Jason O'Donnell
- Mr Mandeep Bogal
- Senior Sergeant Timothy Hoban
- Dr Matthew Lynch
- Detective Senior Sergeant Ian Snare

RELEVANT LAW – ROLE/FUNCTION OF THE CORONER

31. I believe it is incumbent upon me, for several reasons, to include in my finding aspects of the law which impact upon the exercise of my powers under the Coroners Act 2008 (the Act) because that finding forms the crucial conclusion to the coronial investigation. It is primarily directed to the parties directly impacted by the findings made; often families of the deceased person, lay persons, not their legal representatives. Furthermore, the finding constitutes the formal public record of the conclusions reached in the coronial proceeding. Very often parties leave with an unfulfilled expectation because those adversely affected by an act or omission alleged to have occurred look to the coroner to lay or apportion blame for the death being investigated; indeed some want their "pound of flesh". While what is generally referred to as

an "adverse finding" is made, it should as a matter of law, in my view, be couched in more subtle terms.

32. Often the implied attribution of fault is lost on the lay party who expected more direct strident denouncement of the party against whom the adverse finding is made.

33. Keown v Kahn,[3] a decision of the Victorian Court of Appeal, represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway adopting a statement contained in the report of the Brodrick Committee (UK) Report[4] said:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame."*[5]

34. Again quoting the Brodrick Committee (UK) Report, His Honour noted:

> *"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."*[6]

35. So while not laying or apportioning blame a Coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Callaway J.A. described it in Keown v Kahn:

> *"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial; the*

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[3] (1999) 1VR 69

[4] Report of the Committee on Death Certification And Coroners (1971) (UK) ("The Brodrick Report" Cmnd. 4810)

[5] (1999) 1 VR 69, 75

[6] (1999) 1VR 69, 75

conclusion would be more indeterminate than a conclusion about legal responsibility; and there would be no prospect of a trial at which the person blamed might ultimately be vindicated by an acquittal."[7]

36. I have found the dichotomy between finding cause of death on one hand and finding or apportioning fault, blame or culpability on the other difficult to articulate. Quite recently, in a judgement of the New Zealand Court of Appeal, I saw as good an explanation of the conundrum as I have seen. In the Coroners Court v Susan Newton & Fairfax New Zealand Ltd[8] reference is made to *Laws NZ*, Coroners. At paragraph 28 under the heading of "blame", the following statement appears:

> *"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause." (my emphasis)*[9]

37. In his judgement in Keown v Kahn, Callaway J.A. referred to the Norris Report, upon which the 1985 Coroners Act was largely founded, and observed in relation to whether the action of the police was an act of self defence:

> *"A coroner is not concerned with questions of law of that kind. Instead the coroner is to find the facts from which others may, if necessary, draw legal conclusions."*[10]

38. Importantly in the context of this case His Honour, on the next page, continued:

> *"It follows that a person who kills necessarily contributes to the cause of death and that is none the less true where the killing is in lawful self defence. A coroner is not concerned with the latter question but will ordinarily set out the relevant facts in the course of finding how death occurred and the cause of death. The facts will then speak*

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[7] (1999) 1VR 69, 76

[8] [2006] NZAR 312

[9] [2006] NZAR 312, 320

[10] (1999) 1VR 69, 75

for themselves, leaving readers of the record of investigation to make up their own minds about lawful self defence or any similar issue."[11]

Therefore it is not for me to say whether the shots fired by the two Constables were acts of self defence, or in defence of a colleague (justifiable homicide); that would be a legal conclusion. Suffice to say I do have to consider, as a matter of pure fact, whether the shots fired (two by Cross and one by O'Donnell) were discharged when Cross was in immediate peril of life and limb.

39. In the same case His Honour Mr Justice Ormiston observed:

"The findings of coroners ought to eschew use of language which connotes legal conclusions as opposed to factual findings."[12]

40. Once the facts are elucidated the parties (and others) can do with them what they will. I have heard it contended that if there is no determination of criminal or civil liability what is the point of the exercise. That contention is, in my view, not only cynical, but ill founded.

41. Leaving aside the ability to make recommendations (the preventative role) the inquest provides a forum where the facts surrounding a death can be drawn out and examined. By its very nature it is inquisitorial. The coroner has an obligation, to quote His Honour Mr Justice Callaway, "to seek out and record as many of the facts as the public interest requires". Unlike some other proceedings which may flow from the same death "interested parties", who often do not have the resources, knowledge or experience to pursue the facts, are entitled to be legally represented at inquest. That, of course, was not the case here where Ms Douglas was extremely well legally represented with a team headed up by Queens Counsel.

42. Causation goes to the heart of the matter. It has been the subject of considerable judicial attention and discussion in the coronial context.

43. In Chief Commissioner of Police v Hallenstein, Hedigan J observed:

"The issues of causation and contribution have bedevilled philosophers for centuries and have attracted consideration by superior courts in all jurisdictions and places for more than a century. The inclination to expound, in an authoritative way, the connection between human behaviour and consequences has proved seductive. The estimation of the nature and extent of this connection may be described as the evaluation

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[11] (1999) 1VR 69, 76

[12] (1999) 1VR 69, 70

of "contribution". The law has also espoused minimalism in attempting definition of the causative or contributing effect of conduct. Nearly 50 years ago, a powerful High Court (Dixon CJ, Fullagar and Kitto JJ) described causation as "all ultimately a matter of common sense" adding for good measure that "in truth the conception in question is not susceptible of reduction to a satisfactory formula." Fitzgerald v Penn (1954) 91 CLR 268, 278.

In E and MH March v Stramare, (1991) 171 CLR 506 the High Court of Australia considered the fundamentals of causation in the negligence context. The statements of principle in relation to causation are, in my view, applicable to the concept of contribution within the Act, is concerned with the causes of death and who contributed to it."[13]

44. In March v Stramare (supra) Chief Justice Mason observed:

"What was the cause of a particular occurrence is a question of fact "which must be determined by applying common sense to the facts of each particular case"."[14]

45. For an act or omission to be the cause, or one of several causes, of a death the connection between the act and/or the omission and death must be logical, proximate, and readily understandable; not illogical, strained or artificial. In theory it is a difficult and complex concept but one which, in my view, is manageable in practice.

46. I make one further comment on the relevant law. While it may be obiter, in a short judgement in Keown v Kahn, Justice Batt, in a timely reminder to coroners, made the following observation:

"Finally, I desire to make some comments with regard to the record of investigation. There is no doubt that coroners may discuss the evidence and explain their findings. But I have the impression that at any rate more contentious inquests coroner's reports have of late tended to be prolix. At least as a general rule, that is unnecessary."[15]

47. Prolix is defined in the Shorter Oxford Dictionary variously as "of long duration", "protracted", "verbose" and "long winded". I suspect His Honour was concerned that there was a tendency developing in our court where some findings were unnecessarily lengthy,

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[13] (1996) 2 VR 1

[14] (1991) 171 CLR 506, paragraph 17

[15] (1999) 1 VR 69, 79

sometimes convoluted, where critical findings of fact were difficult to discover, enmeshed in minutia and other basically irrelevant background circumstances that were far removed from the causal factors that warranted attention. I always seek to heed His Honour's advice.

48. I turn to the scope/parameters of the investigation including the formal inquest. A coroner is a creature of statute; whatever Common Law powers existed were abrogated by the Coroners Act 1985 which fundamentally changed the function. It was truly a quantum leap from the 'old' quasi-criminal proceedings under the 1958 Act to the new fully inquisitorial role. It seems to me it took some time for those fundamental changes to be fully comprehended and applied.

49. The Coroners Act 2008 provides that a coroner must, if possible, find the cause of a death (see section 67(1)(b) and (c) of the Coroners Act 2008). Furthermore, a coroner may comment on any matter connected with the death, including public health or safety, or the administration of justice (see Coroners Act 2008, Section 67(3)). Furthermore, a coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with the death (see Coroners Act 2008 Section 72(2)).

50. The Coroners Act does not provide a general mechanism for an open ended enquiry into the merits or otherwise of the performance of government agencies, private institutions or individuals. In Harmsworth v The State Coroner[16], Justice Nathan broached the subject of the limits of a coroner's power and observed that the power of investigation is not "free ranging", commenting that unless restricted to pertinent issues an inquest could become wide, prolix and indeterminate. Significantly he added:

> *"Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for such comment. Such discursive investigations are not envisaged nor empowered by the Act they are not within jurisdictional power."*[17]

[16] (1989) VR 989

[17] (1989) VR 989

51. The relevant principle was recently re-stated in the Full Court of the Supreme Court of the Australian Capital Territory. R v Coroner Maria Doogan; ex-parte Peter Lucas - Smith and ors.[18]

52. I accept that the Coroners Act 2008 contains provisions that indicate a coroner may undertake broader enquiries that the 1985 Coroners Act envisaged. As Judge Coate, adopting Mr Justice Beach's comment in Thales Australia v Coroners Court of Victoria,[19] stated in the inquest into the death of Tyler Cassidy (COR 2008 5542) that in considering the scope/breadth of "circumstances in which the death occurred" one considers the scheme of the Act as a whole together with the preamble and purposes provisions.

53. The scope/parameters of a coronial investigation, including formal inquest, is still in my view dependant on whether there is sufficient nexus to conclude an issue is "connected with the death". I do not believe Thales Australia Ltd v Coroners Court of Victoria significantly alters the fundamental principle stated in Harmsworth.

54. In Doomadgee & Anor v Deputy State Coroner Clements[20] Mr Justice Muir commented that coroners are not "roving Royal Commissioners". He added:

> *"It is significant also that the rules of evidence do not bind a coroners court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The evidence relied on by the Coroner must be relevant to the matters within the scope of the coronial inquiry"*[21].

55. I suggest that principle equally applies to the evidence received at inquest.

56. Having said that, I conclude the issue of what in broad terms I will refer to as "police training" falls well within the scope of the investigation and inquest. The issue was canvassed at length during the hearing. Several witnesses were called to address that issue. Once again in broad terms, it was contended by counsel for Ms Douglas that aspects of the police training were deficient to the extent that those claimed deficiencies represent causal factors in the death of Craig Douglas.

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[18] (2005) ACTSC 74 (8 August 2005)

[19] 2011 VSC 13

[20] (2005) QSC 357

[21] (2005) QSC 357, paragraph 35

CORE ISSUES THAT REQUIRE CLOSE ATTENTION

57. I proceed to an examination, discussion and analysis of the issues that I have identified as requiring further attention, those which I consider to be the principle, controversial core issues which must be addressed in this finding;

- The adequacy of the debriefing at the Gatwick Hotel
- Whether the approach to the suspect group was a co-ordinated, planned response in accordance with police training and operational safety principles
- Specifically, whether Constable O'Donnell's approach was in furtherance of a planned response/objective and in accordance with operational police training principles
- Deployment of CIRT
- Whether there have been, as claimed, systemic deficiencies in the Operational Safety Training Tactics (OSTT) and/or the Hazard Identification, Assess the Risk, Risk Control (HIARRC) model or the SAFE principles identified during the inquest.
- Consider the question of the integrity, adequacy of the internal reviews, were they sufficiently questioning, objective and robust.

DEBRIEFING AT THE GATWICK

58. I turn to address the first contentious issue – in his submission Counsel for the Chief Commissioner of Police conceded there was:

> *"no specific briefing or instruction prior to the police clearing the Gatwick... ".*[22]

59. Members were advised to return to the St Kilda police station for a briefing. The consensus, including the views of the senior members at the scene, Detective Senior Sergeant Hubbard, officer in charge of St Kilda CIU and Sergeant Eadie, Port Phillip Divisional Patrol Supervisor, was that the offenders were "long gone" from the St Kilda area. Counsel for Ms Douglas contend that there was a failure by senior members at the Gatwick to conduct any

[22] Submission CCP, paragraph 20

form of briefing, provide instruction and direction to the uniformed members should they come upon the offenders en route back to the St Kilda police station.

60. In considering this issue, I have taken into account several matters including:

- The relative inexperience of the general duties uniformed members
- Although the identity of those involved in the violent incident at the Gatwick was not known, it was abundantly clear that the males at least were in all likelihood armed and had a propensity for violence.

61. I note that although it was thought the group had left the area there was discussion between Sergeant Eadie and Sergeant Howard, team leader in charge of both Critical Incident Response Team ("CIRT") units who attended the Gatwick, concerning the CIRT units patrolling the area keeping a look out for the suspects and the general duties members were advised by Sergeant Eadie to "keep their eyes open".

62. As we now know the group (including the two males Watson and Douglas) had not left the St Kilda area but were encountered by the members in St Kilda 303 (O'Donnell & Cross) and St Kilda 313 (Cox & Bowman) who had no instruction/direction or advice on what to do if they encountered the suspect group.

63. Senior Constable Cox in her evidence stated that there was no discussion about what to do if the offenders were found, nor was there any discussion that they may still be in the St Kilda area.[23] That recollection accords with the evidence of First Constable Bowman, and Constable Cross. There was also no discussion that CIRT should be called if the offenders were located.

64. Detective Senior Sergeant Hubbard, the most senior member in attendance at the Gatwick maintained that direction/guidance as to tactics to be adopted should the general duties members come upon the suspects was not necessary as he had confidence in the capabilities of the members. It could be contended that subsequent events suggest that this level of confidence was at best optimistic, perhaps even ill founded.

65. Senior Sergeant Hoban suggested the discussions that took place at the Gatwick prior to clearing the scene were reasonable and informed. He maintained that "instructions" given prior to leaving would have been speculative, hypothetical and potentially dangerous. I do not accept that contention. I suggest general instruction rather than absolute tactics would have

[23] Transcript, Cox p. 576

been prudent and appropriate. In my view, too much reliance was placed on the incorrect consensus conclusion that the suspects were "long gone". Specifically, the real prospect of a chance encounter should have been factored into discussions.

66. In my view a contingency plan should have been provided to at least the general duties members prior to them clearing the Gatwick should they encounter the suspects.

67. Having reached this view I hasten to add that I am unable, with any degree of certainty, to say that had some general advice and direction been provided the outcome would have been different.

68. The submission made by Ms Dixon on behalf of Ms Douglas relating to what occurred at the Gatwick which resulted in police attendance demands some attention. It is submitted that the:

> *"...events at the Gatwick Hotel generally have too tenuous connection to the cause and circumstances of Craig's death to properly be the subject of findings in this inquest."*[24]

69. The submission goes on to claim:

> *"...the allegations about Craig's conduct at the Gatwick Hotel, which have never been the subject of a criminal trial, properly remain allegations and in Ms Douglas' submission should not be the subject of conclusory findings, even by way of background."*[25]

70. That contention is just too convenient; on the contrary the actions of Craig Douglas and Lucas Watson at room 219 were the genesis of the events that occurred in Grey Street some two and a half hours later. The same submission demonstrates a contradiction; under the heading "Knowledge of the potential risks involved with apprehending the suspects" it is stated:

> *"In addition to the identity of the suspects, all four officers were aware that the suspects had been involved in an alleged robbery, during which a firearm and a knife had been used."*[26]

71. The investigation of the incident at the Gatwick involving significant violence resulted in police, including those directly involved in the subsequent incident in Grey Street, being acutely aware that the suspects were in all likelihood armed and potentially dangerous; to

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[24] Douglas Submission, paragraph 4.6

[25] Douglas Submission, paragraph 4.7

[26] Douglas Submission, paragraph 4.10

suggest that I am not entitled to form that view because Craig Douglas was never tried over the Gatwick incident is trite and, with respect, bordering on fanciful.

72. On the other hand, while it could reasonably be thought that the male members of the group were potentially dangerous, to conclude (prior to the confrontation in Grey Street) that Craig Douglas was "prone to extreme and gratuitous violence and prepared to cause significant injury to anyone who was in the way of what it was he wanted" is likely to be founded on hindsight and is "one bridge too far".

GREY STREET – THE ENGAGEMENT

73. I turn to the second contentious issue which I see as perhaps the most significant issue for determination; what occurred in Grey Street at the intersection with Dalgety Street when the group, who the police members observed and suspected them to be those involved in the Gatwick incident, were, to use a neutral term for the moment, "engaged".

74. On their way back to the police station for a debriefing St Kilda 313, manned by Senior Constable Cox and Constable Bowman, and St Kilda 303, manned by Constables O'Donnell and Cross, proceeded up Grey Street from Fitzroy Street. The suspect group was observed by Senior Constable Cox who immediately suspected they were the people involved in the incident at the Gatwick. A very short distance behind St Kilda 313, Constables Cross and O'Donnell, initially Cross, also observed the group and suspected them to be the group they sought. I am satisfied all four members had a strong suspicion the group observed were those they were interested in. The distinctive wheelie suitcases were the key to the suspicions added to by the fact the group who had obviously seen the police vans immediately turned and headed back down Grey Street towards Fitzroy Street. In the event, Senior Constable Cox stopped the van further up Grey Street near Burnett Street where she was joined very shortly after by SK 303 with Constables O'Donnell and Cross. All members agreed that it was very likely that the group contained the suspects. Here the controversy arises, in broad terms counsel for Constables O'Donnell and Cross maintain that, in accordance with their training, specifically the SAFE principles, the uniformed members in St Kilda 313 and St Kilda 303, formulated a plan during the brief discussion that occurred when the vans stopped at Burnett Street.

75. It was further suggested that there was no other option but to immediately engage and attempt to arrest the suspects and eventually fire their weapons at Craig Douglas.

76. That contention may well apply at the time when Craig Douglas, armed with a knife, was bearing down on Constable Cross with an obvious intent to do him bodily harm. I suggest by then the die was cast. It is the earlier initial approach upon which I am required to focus.

77. In the submission on behalf of the Chief Commissioner no issue is taken with the submission by Counsel Assisting that:

> *"It is open to the Coroner to find that in fact there was no planned approach to Craig and that what occurred was precipitated by O'Donnell's independent decision..."*[27]

78. However, having a little "each way" the submission goes on to suggest:

> *"However, a distinction must be drawn between what "is open" by way of finding (in a strict legal sense) and that which the Coroner* ***ought*** *to find in the context of this case."*[28]

79. On the other hand submissions made on behalf of Ms Douglas maintain there was a failure to apply basic training guidelines with "no cohesive plan in place". The Douglas submission contends that although there was a short conversation between Constable O'Donnell and Senior Constable Cox[29] where Constable O'Donnell suggested CIRT be contacted to establish where they were:

> *"There was no discussion of or team planning about what the officers should collectively do about what they had observed, or about what each officer was individually planning to do."*[30]

80. In considering the efficiency of that claim I have looked to what occurred immediately after the short conversation between Cox & O'Donnell. In my view it is beyond contention that the actions taken, particularly by Constable O'Donnell, demonstrate there was no cohesive plan, not even a rudimentary one. In fact I conclude there was no arrangement whatsoever that could be viewed as a formulated plan prior to the confrontation at Grey & Dalgety Streets. It is clear none of the officers knew what the others intended.

81. The situation that prevailed is encapsulated in the following submission of Counsel Assisting where Ms Ellyard stated:

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[27] Submission Counsel Assisting, paragraph 15

[28] Submissions in reply for CCP, paragraph 6.

[29] Transcript, Cox p. 570, 580, O'Donnell p. 782, 795

[30] Douglas Submission, paragraph 4.22

"At the time of the conversation between Cox and O'Donnell, Cross was already out of the van and Bowman was shortly to leave his van to follow another male down Grey St. It is apparent that once O'Donnell drove back down Grey Street, none of his police colleagues knew what he was intending to do or had any sense of the role they should be playing to support his proposed course of action. Rather, it appears that it became necessary for the other members to improvise as the situation unfolded. Cross approached on foot without knowledge of what O'Donnell was doing. Cox was also required to approach on foot after she heard gunshots."[31]

82. The response from the CIRT to Cox's transmission (suggested by O'Donnell) came only 25 seconds later advising they were "about a minute off". Of course that response was not heard by or communicated to O'Donnell or Cross due to O'Donnell's unilateral decision to immediately confront the suspect group. As it turned out CIRT 385 arrived at the scene some 10 seconds after shots were fired and CIRT 350 arrived within a minute.

83. I turn to what Constable O'Donnell proposed. After having had a short discussion with Senior Constable Cox, he executed a "U-turn" and headed back down Grey Street toward where the group of suspects had been sighted. Constable O'Donnell claimed it was his intention to travel back down Grey Street to observe and/or seek to confirm the identity of the group as the suspects from the Gatwick. He further claimed he proposed to park where available on the western side of Grey Street to facilitate that intention. Constable O'Donnell claimed the fact that he pulled up adjacent to the group was "unexpected".

84. In his submissions Mr Gipp, counsel for Constables Cross and O'Donnell, reminded me that in assessing the performance of his clients I have to be careful not to do so with the benefit of hindsight. One has to constantly reflect upon that prospect. Furthermore, in reaching factual conclusions I further remind myself that the incidents for consideration/examination, especially the principle issue, the confrontation in Grey Street, has to be considered in the circumstances of the actual incident as it unfolded, not in the clinical, somewhat sterile artificial atmosphere of the courtroom years after the event.

85. The position was indeed eloquently stated by Lord Denning in Wiltshire v Barrett:[32]

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[31] Submission Counsel Assisting, paragraph 13

[32] [1965] 2 All E.R. 271

"The police have to act at once, on the facts as they appear on the spot: and they should be justified by the facts as they appear to them at the time and not on any ex post facto analysis of the situation."[33]

86. I turn to consider what were the causal factors in the death. It is noteworthy that at no stage in evidence, cross examination or submission was it conceded by those representing Craig Douglas that his actions represented causal factors in his own death. In the submission made on behalf of Ms Douglas it was suggested I find Constable O'Donnell acted "precipitously and dangerously". In submission in reply Mr Gipp, counsel for Constable O'Donnell, maintained that it was Craig Douglas who acted "precipitously and dangerously". That conclusion is in my view inescapable. There can of course be more than one causal factor in a death. I turn to consider whether the actions of others, particularly those of Constable O'Donnell, in Grey Street represent causal factors in the death.

87. Mr Gipp further submitted the initial approach was consistent with police training and operational safety principles. His submission does not separate or distinguish between the actions of Constables Cross and O'Donnell.

88. Constable O'Donnell claimed his initial approach was non-confrontational; claiming he adopted a "toned down" approach after he got out of the van saying "G'day mate" to Watson. It is to be noted that his initial approach was to Lucas Watson, not Craig Douglas, who at that stage he had not observed. Constable O'Donnell's claim is not supported by any other evidence; either that of his colleagues, who were some distance away, or the observations of the civilian eye witnesses who gave evidence. Constable Cross, in his evidence, recollects hearing O'Donnell say to Mr Watson "Police, don't move".[34] That phrase would not follow a "toned down" approach. It sounds like an initial comment. I conclude Constable O'Donnell's actual actions, established by the evidence, would strongly suggest his initial approach was not "toned down" and tend to the view he intended to immediately engage with the group, and if satisfied as to their identity, he envisaged arresting the male suspects. After executing the three point turn he proceeded north with the flashing lights on the van activated, he came to a sudden stop immediately adjacent to the majority of the group not in an available spot on the western side of Grey Street, but in the gap in the medium strip where he was observed by

[33] [1965] 2 All E.R. 271, 273

[34] Transcript p.685 (the transcript on occasion records the phrase as "please don't move" but my notes record "Police, don't move").

civilian witnesses to virtually immediately confront the group, other than Craig Douglas who was not immediately observed by Constable O'Donnell.

89. Much of the evidence of the various civilian eyewitnesses led at the hearing, resulted in a conundrum for me. There were glaring inconsistencies in the versions of events. I am in no way critical of those witnesses; most of them viewed the incident unfold from a distance, it was quite dark, the incident occurred over a very short period of time and furthermore it was likely to have been a dramatic experience, indeed somewhat traumatic, to observe the confrontation and subsequent shooting death of a citizen.

90. One particular issue that required attention was the evidence of the witnesses Ms Meese and Mr Armstrong that they did not hear the so called "toned down" approach taken by Constable O'Donnell; the "G'day mate", "we've been looking for you" greeting. If those words were indeed spoken by Constable O'Donnell and if they were delivered in a quiet voice it is likely they would not have been heard by the witnesses who were some distance away on the other side of the road further north down Grey Street. I make no firm finding as to whether the claimed words were used, although as stated that approach is entirely inconsistent with his unilateral, unplanned actions. In the event, I have concluded that his initial approach, irrespective of what language was adopted, was not "toned down" by virtue of his approach under flashing lights and screeching stop.

91. Mr Ihle, on behalf of the Chief Commissioner of Police submitted that Constable O'Donnell's engagement with the suspects was:

> *"...directly in line with the Safety Principles and OSTT training".* [35]

92. With respect, I disagree; that conclusion was reached primarily on the basis of Constable O'Donnell's version of events not the comprehensive body of evidence led at this inquest which leads me to a contrary view.

93. What is clear is that very shortly after the initial confrontation the situation dramatically changed complexion with the appearance of the knife wielding Craig Douglas menacingly bearing down on Constable Cross who had proceeded on foot back down Grey Street in support of his colleague.

94. I note that in the submission in reply it is not submitted by Ms Douglas that a different approach by Constable O'Donnell would "definitely have resulted in a different outcome". It

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[35] CCP submission, paragraph 28

is merely maintained the risk of a violent confrontation was materially increased by his approach. That may or may not have been so.

95. It was further contended that the Williams Review[36] concluded that aggressive confrontation with armed suspects can readily lead to unpredictable behaviour. While I take no issue with that contention one can only speculate as to whether the outcome would have been different if indeed a more non-confrontational approach had been adopted.

96. I am prepared to indicate at this time that there is, in my opinion, no basis for an adverse finding or comment against Constable Cross; he was literally a victim (or more correctly, almost a victim) of circumstances due to the unplanned, independent and unilateral actions of his colleague Constable O'Donnell who, I regret to say, put him in an invidious position.

97. Having found Constable O'Donnell's engagement with the suspects was not directly in line with safety principles and OSTT training I turn to consider whether his approach was a causal factor in the death of Craig Douglas. I revert to the Australian vernacular to best describe Constable O'Donnell's unilateral actions; they were, in my view "gung-ho" and represent, although not the principle cause, a causal factor in the death. As a matter of logic there can be more than one causal factor in a death.

98. The claim that the death of Craig Douglas was avoidable and preventable is of course true. The engagement between police and the suspects could and indeed should have been resolved peacefully. Leaving aside for the moment the actions/performance of Constable O'Donnell in failing to adopt SAFE, OSP principles and OSTT training, it was primarily Craig Douglas' actions that were patently dangerous and precipitous and were the principle causal factor in his death.

CRITICAL INCIDENT RESPONSE TEAM INVOLVEMENT

99. Another area of contention relates to the CIRT, two units of which attended the Gatwick and were in the vicinity at the time of the incident. The question is, if it had been a CIRT that engaged with Craig Douglas at the outset would the outcome have been different. It is true that since its creation as a specialist resource within Victoria Police a CIRT unit has not been directly involved in a fatal police shooting. Whether CIRT had been charged with the onerous responsibility of apprehending the suspects there would have been a different outcome I

[36] Michael Williams examination of Police Shootings 2005-2008, Feb 2009 (Williams Report No 1.)

cannot with any certainty say; that would very much have depended on the response of Craig Douglas. As Mr Ihle correctly submitted the question of whether Craig Douglas would have responded differently is obviously speculative. I do not propose to make a firm finding on that contentious issue, but some discussion on the broad issue is warranted in light of Ms Dixon's comprehensive submission on the topic. It is clear that one of the CIRT were very close by, only a few metres from the Fitzroy Street Grey Street intersection.

100. It was claimed the circumstances warranted that the suspects be confronted and apprehended immediately without awaiting CIRT involvement. I accept there was urgency about that course of action, as was conceded on behalf of Ms Douglas, but it could be argued that immediacy is a relative term. I suggest the endeavour to apprehend should have been a planned response, preferably with the input of the specialist units of CIRT, one unit of which arrived at the scene some 10 seconds after the shots were fired, the second unit within a minute. As to the necessity of immediately apprehending the male suspects; although they had been involved in a violent incident at the Gatwick Hotel and it was likely they are still armed, it would seem that they had not been involved in any further incident in the intervening three hours.

As to whether the circumstances prevailing in Grey Street represented a "critical incident" warranting a CIRT "call out" it should be noted CIRT had already been "called out" and deployed following the Gatwick incident. They were already in the area keeping an eye out for the suspects. It was not as if the criteria for CIRT involvement had to be met, it had already been met as in a sense they were already deployed.

It should also be noted that the CIRT unit closest was very near the Grey Street intersection of Fitzroy Street, the direction in which the group were heading, obviously having seen the police vans pass them proceeding south up Grey Street. Their involvement would, in my view, have satisfied the required level of urgency; an appropriate and reasonable "immediacy."

Senior Sergeant Hoban stated in evidence it was "a given" that, if appropriate, having requested CIRT involvement and in light of their proximity, awaiting their deployment would have been justified. I suggest the short period of time in getting to the scene would not have resulted in an unacceptable delay.

101. Sergeant Howard, in charge of the two CIRT units gave evidence, which I accept, that in a street environment, it was not feasible to initiate an "inner cordon" to contain the suspects and

even difficult to implement a "roving cordon" in the circumstances that prevailed in Grey Street.

OPERATIONAL POLICE TRAINING

102. Again, not surprisingly, as to this issue there is a divergence of views. On behalf of the Chief Commissioner of Police it was submitted that the training provided to all members is underpinned and informed by years of significant reflection, refinement and development. I was told "safety first" is the paramount consideration; the "overarching", "all encompassing" principle upon which operational training is delivered. Furthermore, it is claimed that no systemic deficiencies were demonstrated by this hearing.

103. On the other hand the position put on behalf of Ms Douglas is that police training was so deficient that I should find those claimed deficiencies represent causal factors in the death.

104. The bulk of the evidence led at the inquest on this issue was given by Senior Sergeant Hoban. He gave comprehensive evidence concerning the various principles which underpin the training provided together with evidence as to the genesis and content of the training regime.

105. At the outset I note that those members directly involved in the incident in Grey Street were Operational Safety Tactics Training (OSTT) trained. The nub of the issue is - were the members appropriately trained under a comprehensive, robust, efficacious training regime; or was there a failure by the members involved to apply the principles and procedures taught.

106. The policies developed are obviously not static, from time to time modifications and refinements are made. An example of that is the additional component of the OSTT training referred to in the Douglas submission, Cordon and Manage, apparently adopted in response to the Williams Report No 2.[37]

107. I accept the concept that training should not be too prescriptive, but flexible where tactical options are provided to account for the precise circumstances encountered "at the coalface".

108. I do not believe issue can be taken with the SAFE principles which "underpin" the training regime (to use a generic term); they are sound and appear to me to be based fundamentally on common sense.

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[37] Meeting Operational Safety and Tactics Training and Critical Incident Management Training Standards – Progress Report – July 2009 or Douglas Submission, paragraph 5.39

109. In spite of the contention to the contrary, I am not persuaded that systemic deficiencies in the training regime were demonstrated at the hearing. From time to time experiences will dictate that improvements/refinements will occur. I find that the training regime is comprehensive and quite sophisticated, taking on various forms of delivery and is fundamentally adequate.

110. Having said that I am sure it would be accepted that there is always room for improvement. I suggest the circumstances surrounding the death of Craig Douglas would provide a perfect scenario based component of the OSTT training program and propose to make a recommendation to that effect.

INTERNAL REVIEWS

111. In the Douglas submission it is claimed that there was a failure by Victoria Police to critically analyse and assess the circumstances surrounding the death of Craig Douglas. It is further claimed the reviews that were undertaken to "provide advice on the training delivered through OSTT" failed their objectives. [38]

112. On the other hand, in the submission on behalf of the Chief Commissioner of Police it was maintained that after incidents such as that here Victoria Police implement "rigorous internal review processes and analyses."

113. There were in fact several internal reviews undertaken; a CIRT review, the Critical Incident Management Review by Superintendent Kostiuk[39] and the Post Incident Review – Fatal Police Shooting of Craig Douglas in St Kilda (1 May 2011) by Senior Sergeant Hoban.[40]

114. In broad terms none of these reviews saw or identified deficiencies in the performance of the members involved. I accept that in reaching those conclusions none of these reviews had the benefit of, in effect, hearing both sides. They did not have the benefit of the considerable body of evidence that was led at the inquest. Those reviews, for all intents and purposes, only considered the versions of events claimed by the members involved, particularly Constable O'Donnell. As Senior Sergeant Hoban conceded these reviews have limitations and are based on a limited range of materials.

115. It was suggested the Kostiuk Report was the vehicle for critical evaluation of the incident. The Douglas submission alleged that report involved:

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[38] Paragraph 5.18

[39] Critical Incident Review report, December 2011

[40] Exhibit 22A

"very little critical evaluation and simply restated the conclusions of the PIRT Report."[41]

116. I do not propose to comment on the level of evaluation the reports achieved, save to say that fundamentally they came to the same conclusions. Perhaps that is not surprising when one considers the reviews proceeded on the basis of the same limited materials referred to earlier. That must surely impact upon their value as a tool for review and improvement.

117. In answer to a question I put to him, Senior Sergeant Hoban advised that an additional review involving an "in depth" analysis of my findings will be undertaken. That planned review will have the benefit of having had the initial version of events tested at the inquest. Whether that review would reach different conclusions I, of course, cannot say.

118. Unfortunately, as was the case here, the formal coronial proceedings usually do not occur for several years after the event. When all the evidence is examined if there are important lessons to be learnt and refinements to training are warranted it is imperative that the earlier internal reviews be fulsome, rigorous and entirely objective.

POLICE INVESTIGATING POLICE

119. The perennial issue in matters of this nature, a "police shooting", relate to police investigating police was, not surprisingly, raised.

120. Submissions made on behalf of Ms Douglas ask that I acknowledge that:

"...there will always be disquiet for family affected by police shootings inquests during the inquest process where police members investigate police."[42]

In my experience that is almost always so.

121. I do not propose to canvas that contentious issue in general terms, but will consider the adequacy, efficacy and objectivity of the investigations undertaken in this matter by Detective Senior Sergeant David Snare, a experienced detective attached to the Homicide Squad.

122. The Douglas submission continues:

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[41] Paragraph 5.20

[42] Douglas Submission, paragraph 5.36

"...The evidence of the civilian witnesses, and a number of inadequacies in the police investigation of the shooting which were highlighted during the cross-examination of Detective Senior Sergeant Snare, have left Ms Douglas concerned that she will never know whether, had a thorough and rigorous investigation been carried out by an independent body, a different picture might have emerged."[43]

123. Three particular alleged deficiencies were referred to:

"(a) the scene was not immediately secured and the police officers involved in the shooting were not immediately separated;

(b) potential witnesses were directed to leave the scene without providing statements or their contact information; and

(c) a number of relevant inquiries were not made, or were not made promptly, in the immediate aftermath of the shooting."[44]

I do not accept those claimed deficiencies, even if true, compromised my investigation.

124. I conclude the criticism of Detective Senior Sergeant Snare is unwarranted; furthermore I am satisfied Detective Senior Sergeant Snare's investigations were thorough and objective. The Coronial Brief (which forms part of the public record of the proceedings) is sufficiently comprehensive to satisfy public expectation.

125. The vexed issue was to some extent discussed by the then State Coroner Judge Jennifer Coate, in her finding into the death of Tyler Cassidy. Judge Coate referred to the review commissioned by the Office of Police Integrity in November 2009 concerning police investigating police in deaths associated with police contact. The report following that review titled: Review of the Investigating Process Following a Death Associated with Police Contact, was subsequently published in June 2011.[45] In that review a variety of views were expressed as to the appropriateness of the current model. The review concluded, having examined other models here in Australia and overseas, that the current legislative framework for the investigation and oversight of deaths associated with police contact is not optimal. However it

[43] Douglas Submission, paragraph 5.36

[44] Douglas Submission, paragraph 5.36

[45] Office of Police Integrity, 1 June 2011

also concluded that the Homicide Squad are "the best placed experts"[46] to continue in the short to medium term to conduct the primary investigation; I concur.

126. The Homicide Squad investigation, directed by the coroner with carriage of the matter, is oversighted by the Professional Standards Command (PSC). It is the coroners investigation and the scope of the investigation and parameters are matters for the coroner, an independent judicial officer. I do not believe I can, in this forum, add anything of substance/value to the discussion as Judge Coate observed the issue received comprehensive attention in the OPI review. I add the recent review undertaken by Robert McClellen in New South Wales titled Oversight of Police Critical Incidents (29 November 2013) also addressed the issue in some detail. For more analysis and discussion on this topic paragraphs 566-581 and 658-675 of Tyler Cassidy Finding provide further insight.

127. I only add that recent refinements/enhancements to our coronial processes have been introduced; perhaps the most significant being utilisation of experienced "in house" solicitors who liaise with the Coroners Investigator, communicate coronial directions and instruct counsel assisting prior to and during the formal forensic judicial process.

128. Also introduced was an initial Mention/Directions Hearing scheduled not more than one month after the event being investigated where the primary investigator is identified where the coroner who has carriage of the matter can provide further direction and where interested parties can have input into the issues to be examined.

129. I only add that the suggestion that if Ms Douglas had not been involved in the inquest process the only evidence presented would have exonerated police actions. The implied suggestion that the court would not, of its own motion, have critically evaluated the conduct of the police involved is I suggest highly regrettable. If criticism by way of adverse finding is warranted on a consideration of the evidence it will and indeed has been made. In the final analysis thorough and rigorous investigation has been undertaken by an independent entity – the Coroner.

MEDIA COMMENT

130. The OPI Review considered the issue of senior police officers engaging in what I will describe as "kerbside presentations" in the media, particularly television, shortly after a police shooting

[46] OPI Review, p.47

incident generally supporting, condoning, exonerating their junior colleagues. The OPI Review concluded:

> *"Irrespective of a legitimate need to show public support, statements made in support of members that pre-empt the investigative process undermine the integrity of the investigation into the death. Far from helping the police involved, statements exonerating police reduce public confidence in the investigative process. They remove the legitimacy of the investigative process, and with it, any chance of a public acceptance that police associated with the incident have been legitimately exonerated."*[47]

131. The review provided what I believe are eminently reasonable topics to be included in any police response for interview; they include:

- Acknowledge the tragedy
- Reassure the community as to public safety
- Express concern about the welfare of the family of the deceased
- Express concern as to the welfare of any police involved
- Stress that the matter will be subject to a Coroner's inquest
- State that there will be a thorough police investigation and police investigators will forward a Coronial Brief to the Coroner to assist with the inquest
- State that the police investigation will be subject to active oversight by the Ethical Standards Department who may also report to the Coroner
- State that OPI will also independently oversee the investigation
- Advise that neither the police investigation nor the oversight will pre-judge the outcome of the Coroner's inquest.

I believe those suggestions provide an appropriate compromise, however I accept these are matters for police command.

132. I formally find Craig Douglas died on 2 May 2011 at the intersection of Grey and Dalgety Streets, St Kilda from two gunshot wounds to the chest, one fired by Constable Ryan Cross,

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[47] OPI Review, p. 53

the other by Constable Jason O'Donnell, when armed with a knife, he bore down on Constable Cross with obvious intent to do him harm.

COMMENTS

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

1. Operational uniformed members of Victoria Police are armed; such is obvious. There is an understanding in the community that unfortunately from time to time, hopefully very rarely, the use of a firearm will be warranted. There is, however, a further important expectation; it is that such use should be as a last resort.

2. Dr Dimiteri Gerostamoulos, Head of Toxicology at VIFM gave evidence about the levels of various drugs found upon post mortem toxicological analysis:
   - Methadone – a "very small amount" was detected.
   - Alprazolam (a benzodiazapam) was also detected.
   - Tetrahydrocannabinol, indicating recent use of cannabis, was detected – but Dr Gerostamoulos could not say with any degree of certainty how much had been taken.
   - Amphetamine (speed) – a stimulant, was detected in a urine sample, but not in a blood sample.
   - Diazepam (a sedative) was also detected.

   Dr Gerostamoulos advised that in combination the drugs detected could have had the effect of altered judgements and perception, but could not say that the amphetamine alone impacted on Craig Douglas' judgement. The toxicology results were somewhat surprising to me in light of the suggestion that Craig Douglas was "pilled off his brain"[48] or words to that effect.

[48] Quote attributed to Mr Lucas Watson in a report provided by a Clinical and Forensic Psychologist, appendix RRR to the police brief of evidence, p.5.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. That the Chief Commissioner of Police consider utilising the circumstances surrounding the death of Craig Douglas as a basis for a OSTT training scenario to further reinforce and focus the importance of planning at the operational level.

2. Bereaved family members and the community are entitled to expect that the investigation conducted in relation to 'police contact deaths' will be transparent, accountable and thorough.

   In this case, the account given by Constable O'Donnell in his written statement lacked critical details which were only revealed during the inquest. There is no doubt that assumptions were made regarding what occurred at the Grey Street engagement based on his written statement.

   The OPI suggested in the *Review of the investigative process following a death associated with police contact* (June 2011):

   In the absence of any suspicion as to possible criminal conduct and where practicable investigators should audio and visually record a 'free narrative' account of what happened by police involved in any incident involving a death associated with police contact as soon as possible after the incident has occurred.

   I am of the view that this approach would have strengthened the investigative process in this case and consequently I recommend its adoption.

3. In addition, in the finding into the Death with Inquest of Samir Ograzden (COR 2008 2028), Coroner Audrey Jamieson adopted a recommendation made by Judge Coate (then State Coroner) in the Finding into the Death of Tyler Cassidy:

   "To allay perceptions regarding collusion and bias, without compromising the coherence of the account given by Victoria Police members following a police contact related death, I recommend that the Secretary to the Victorian Department of Justice provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in the incident."

   I note that this recommendation has not been implemented at the date of this finding.

I add my voice to Coroner Jamieson's proposal and the suggestion of the OPI and adopt both these as recommendations.

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

Ms Tana Douglas

Ms Lizette Robertson

Lander and Rogers, Solicitors

The Chief Commissioner of Police

Senior Sergeant Gillard, Victoria Police

Ms Jessica Morris, VGSO

Signature:

PHILLIP BYRNE
CORONER
Date: **8 December 2014**