STATE
CORONER
VICTORIA

CORONERS REGULATIONS 1996

Form 1

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23 October 2009
Case No: 1798/04

RECORD OF INVESTIGATION INTO DEATH[1]

I, AUDREY JAMIESON, Coroner,

having investigated the death of GREGORY RAM BIGGS[2] with Inquest held at Coronial Services Centre, Southbank on 24 - 25 May 2007, and 28 - 31 May 2007,

find that the identity of the deceased was **GREGORY RAM BIGGS**

and that death occurred on 22 May 2004, at Carlton North[3] in parkland off Park Street, from:

I(a) EXTERNAL BLOOD LOSS
I(b) LACERATION OF RIGHT AXILLARY ARTERY
I(c) SINGLE GUNSHOT WOUND TO UPPER RIGHT BACK AREA

in the following summary of circumstances:

On 22 May 2004, at approximately 6.30pm, Gregory Ram Biggs was observed near the intersection of Lygon Street and Park Street in Carlton North by Victoria Police members, Sergeant Samuel Cahir and Leading Senior Constable John Hawkins. Gregory Biggs was wielding two samurai-like swords and causing property damage. Sergeant Cahir alighted from the Victoria Police vehicle and confronted Gregory Biggs. Sergeant Cahir subsequently fired one shot, critically injuring Gregory Biggs who ran off into the surrounding parkland. At approximately 7.38pm, Gregory Biggs was found deceased under

[1] The Record of Investigation/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.

[2] Gregory Ram Biggs was also known as Gregory Ram Cooper-Biggs, Rama Cooper, Greg Biggs and has been referred to in some documentation as Gregory Rama Biggs and Rama G Cooper.

[3] The suburb where Mr Bigg's death occurred has been referred to in various documents to as Brunswick, East Brunswick and Carlton North. The *Melways* indicates that the area may also be known as Princes Hill. I have adopted Carlton North as the place of death.

a footbridge approximately 200 metres from where Sergeant Chair had discharged his firearm.

The death of Gregory Ram Biggs constitutes a *reportable*[4] death as defined in section 3 *Coroners Act 1985* (the Act).

The investigation into Gregory Biggs' death raised issues regarding Victoria Police training and communication techniques including dealing with people with mental illness and/or drug affected, and the use of firearms. The trajectory of the bullet from Sergeant Cahir's firearm and some witness accounts also raised concern that Gregory Biggs was running away and not advancing, when Sergeant Cahir discharged his firearm. The role and position of Leading Senior Constable Hawkins during the unfolding of the events lacked certainty and raised issues about Police operational procedures. Another identified issue was whether Gregory Biggs would have survived his injury if Sergeant Cahir and Leading Senior Constable Hawkins had pursued him into the parkland.

Other identified issues included the involvement of Corrections Victoria with Gregory Biggs 10 days prior to his death and the involvement of members of the Transport Management Unit of Victoria Police with Gregory Biggs 1 day prior to the Carlton North incident.

An Inquest was held pursuant to section 17(1)[5] of the Act.

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[4] "reportable death" means a death-

(a) where the body is in Victoria; or

(b) that occurred in Victoria; or

(c) the cause of which occurred in Victoria; or

(d) of a person who ordinarily resided in Victoria at the time of death-

being a death-

(e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or

(f) that occurs during an anaesthetic; or

(g) that occurs as a result of an anaesthetic and is not due to natural causes; or

(h) that occurs in prescribed circumstances; or

(i) of a person who immediately before death was a person held in care; or.....

[5] s17. **Jurisdiction of coroner to hold inquest into a death**

(1) A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and-

(a) the coroner suspects homicide; or

(b) the deceased was immediately before death a person held in care; or

(c) the identity of the deceased is not known; or

(d) the death occurred in prescribed circumstances; or

(e) the Attorney-General directs; or

(f) the State Coroner directs.

(2) A coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable.

THE ROLE OF THE CORONER - SECTION 19(1) *CORONERS ACT 1985*

A Coroner is required to find, if possible, the identity of the deceased, how death occurred, the cause of the death and the particulars required to register the death - the place and date of death. For the purposes of distinquishing 'how death occurred'[6] from the 'cause of death'[7], the practice is to refer to the latter as the *medical* cause of death and the former as the *context* in which death occurred or the *background circumstances* and *surrounding circumstances*.

A Coroner's investigation and findings of fact in respect of the circumstances of the death must however, be contained so as to be sufficiently proximate to, and connected to, the death.[8]

A Coroner may also comment on any matter connected with the death including public health or safety,[9] report to the Attorney-General on the death and 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.[10]

In addition, a Coroner must report to the Director of Public Prosecutions if the Coroner believes that an indictable offence has been committed in connection with the death under investigation.[11]

Mr Biggs' identity, date and place of death required no formal coronial investigation.

BACKGROUND CIRCUMSTANCES:

Mr Gregory Ram Biggs was born in Melbourne on 7 September 1976. He spent a considerable part of his youth in Albury. He was 27 years old at the time of his death. He lived alone in rented premises at 140 Barkly Street, Brunswick. Mr Biggs also rented a warehouse/factory at 81-83 Argyle Street, Fitzroy.

Mr Biggs was unemployed. He collected a range of items from markets, garage sales and Opportunity Shops with the aim of opening his own shop. The items included collectable tin

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6 Section 19(1)(b) *Coroners Act 1985*

7 Section 19(1)(c) *Coroners Act 1985*

8 *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, *Clancy v West* [1996] 2 VR 647, *Harmsworth v The State Coroner* [1989] VR 989

9 Section 19(2) *Coroners Act 1985*

10 Section 21(1) and (2) *Coroners Act 1985*

11 Section 21(3) *Coroners Act 1985*

toys, pinball machines and a number of antique swords. He stored most of these items in his warehouse.

Mr Biggs has no formal history of mental illness or of any psychiatric condition.

Criminal history:

Mr Biggs had a history of illicit drug use dating back to the age of 10 years when he commenced using cannabis. He had a criminal history dating from the age of 14 years when he committed an aggravated burglary. From the age of approximately 16 years he commenced using amphetamines and cocaine. In 1992 he spent 3 months in a Youth Detention Centre in New South Wales for property and drug related offences. In November 1995, he was committed to stand trial in New South Wales (NSW) on a number of charges including Possession Firearm, Shoot with Intent to Murder, Maliciously Inflict GBH, Use of Weapon to Resist Arrest and Possession Prohibited Drug. On 30 August 1996, he was indicted in the Sydney District Court on the charges of Maliciously Wound with Intent to do GBH, Malicious Wounding and Possession Firearm for a period of 10 years imprisonment, with a non-parole period of 6 years. He lodged an appeal which was refused by the Court of Criminal Appeal of NSW on 5 March 1997.

On 6 May 2001, Mr Biggs was released on a New South Wales Parole Order[12]. The Order carried with it a number of conditions, however, none of the conditions related to mandatory drug or alcohol counselling or testing or psychological or psychiatric counselling.

The parole period was due to expire on 6 May 2005.

Initially Mr Biggs was supervised by Albury Corrections in New South Wales. In March 2003, his Parole Order was transferred to Victoria under the supervision of Carlton Community Correctional Services (CCS). On 25 March 2003, he was assessed by COATS[13] and on 9 April 2003, by Odyssey House. No drug or alcohol issues were identified and treatment was deemed unnecessary. He was compliant with his Order conditions and attended for supervision on a weekly basis. Due to compliance with his conditions and with no evidence of re-offending, he was directed to report on a six weekly basis from 16 July 2003.

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[12] See Inquest Brief @ pp441-443

[13] Community Offenders Advice and Treatment Service (COATS) is part of the Australian Community Support Organization (ACSO), a non-government community based agency.

COATS are funded by the Victorian Department of Human Services (DHS) to co-ordinate drug and alcohol services for all treatment for community based offenders.

On 10 October 2003, Mr Biggs was transferred to Non Intensive Supervision (NIS)[14] and directed to report on a bi-monthly basis until the completion of the order. **Ms Sarina Papa** became Mr Biggs' Community Correctional Officer around this time. She first met with him on 8 October 2003, and subsequently on 3 December 2003, 4 February 2004 and 31 March 2004. His next supervision appointment at Carlton CCS was scheduled for 26 May 2004.

Personal relationships:

Soon after Mr Biggs returned to Melbourne, he commenced a relationship with **Ms Erin Blackett**. From August 2003, the couple co-habitated for a number of months at 283 Fitzroy Street, Fitzroy. Ms Blackett stated that Mr Biggs smoked cannabis on a daily basis and for a period was also using "ice" on a daily basis. In or around February 2004[15], Ms Blackett observed a change in Mr Biggs' personality. She stated that he had become angry, verbally aggressive and paranoid and she attributed this change to his increased use of drugs and in particular, a new shipment of "ice". Ms Blackett stated that Mr Biggs loved swords and knives and that she had seen him fling his swords around in an uncoordinated manner and smash his belongings up when he was angry. She was aware that he hated the Police because he held the view that he had been set-up by them in NSW. Their relationship ended before Mr Biggs moved to Barkly Street.

Ms Megan Hughes[16] met Mr Biggs in Albury when she was studying there. When Mr Biggs first moved to Melbourne he stayed with Ms Hughes intermittently for a few months in her rented premises in Fitzroy. Ms Hughes had regular contact with Mr Biggs - every 1 - 3 days. In the two weeks prior to his death, Ms Hughes noticed a change in Mr Biggs' behaviour stating that *he was becoming more paranoid over things going on his life.* She was aware of his drug use, however, she never saw him violent or angry and never heard him express any anger towards police.

Mr Justin Garde had known Mr Biggs for approximately 2 years. They had been close friends, both enjoying collecting. They had seen less of each other in the 6 months prior to Mr Biggs' death. Approximately 1 month earlier, they had an argument during which Mr Biggs had offended Mr Garde. They had not seen each other since.

SURROUNDING CIRCUMSTANCES

On 12 May 2004, Mr Biggs attended at Carlton CCS without an appointment requesting to speak to his supervising officer, Ms Sarina Papa[17]. His usual presentation was of a quiet

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[14] According to Corrections Victoria, the reporting frequency will be reduced in circumstances where there has been a reduction in an offender's assessed risk level. The NIS program monitors the offender's compliance against the core conditions attached to an Order with the minimum reporting frequency being bi-monthly.

[15] Ms Blackett acknowledged in her viva voce evidence that her memory of the time frame she spent with Mr Biggs was affected by her own use of drugs at the time. She was in rehabilitation at the time she made her statement - see Exhibit 4 - Statement of Erin Blackett dated 25 May 2004

[16] see Exhibit 14 - Statement of Megan Hughes dated 23 May 2004

[17] See Exhibit 7 - Statement of Sarina Papa dated 5 October 2004

person, never with a raised voice and always on time for his appointments. Ms Papa had never seen Mr Biggs drug affected. On this occasion, his behaviour was out of character - he was noted to be incoherent to the extent that Ms Papa could not make sense of his story, he continually changed the topic of conversation and became increasingly agitated during the course of the 45 minute interview with Ms Papa. He claimed he was being set-up by Police with respect to drug related offences. Ms Papa questioned him regarding his use of illicit substances. Mr Biggs responded that he had not taken any drugs voluntarily - believing that he had been drugged at a nightclub by a Police informant. At no time was he threatening towards Ms Pappa or others and made no threats to harm himself. The location psychologist was not available.

At the conclusion of the interview, Mr Biggs agreed to attend for his scheduled appointment on 26 May 2004. Ms Papa later discussed Mr Biggs' presentation with her superior.

On 19 and 20 May 2004, Mr Justin Garde received a number of telephone text messages from Mr Biggs. The messages were unintelligible. Mr Garde described them as *pretty weird.*[18]

On Friday 21 May 2004, at approximately 7.45pm, Mr Biggs attended at the Victoria Police Transport Branch in Dawson Street, Brunswick. He left behind at the security gate a backpack containing a ceremonial type sword and scabbard and a crossbow fitted with a laser light. At approximately 7.45pm, **Senior Constable (S/C) Darren Bugelly**[19] and **Constable Timothy Carlin** were returning to the Branch in their police vehicle when they were requested to try to locate the male that had left the backpack.

The Officers located Mr Biggs in Dawson Street. Mr Biggs confirmed that the bag and swords were his and that he no longer wanted the items. He gave his name as "Rama Cooper". A routine check of this name with Intergraph was requested. Mr Biggs responded in the affirmative to S/C Bugelly that he had used drugs that afternoon. He signed an indemnity in Constable Carlin's notebook, in the name "Gregory Rama Cooper-Biggs", to confirm forfeiture and disposal of the property (Notice of Abandonment). S/C Bugelly assessed Mr Biggs' orientation as to time and place and formed the view that Mr Biggs was slightly affected by drugs but not mentally impaired.

S/C Matthew Ross[20] was also present during some of this interview, having stopped on his return to the Dawson Street complex when he noticed his colleagues with Mr Biggs. S/C Ross did not speak directly to Mr Biggs. He heard most of the conversation S/C Bugelly had with him. S/C Ross considered Mr Biggs *"a little odd"* , *" like he'd had a couple of bongs"* but not "*impaired to the extent to call a CATT*".

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[18] See p.87 - Brief of Evidence - Statement of Justin John Garde dated 27 May 2004

[19] See Exhibit 20 - Statement of S/C Darren Bugelly dated 23 May 2004

[20] See Exhibit 24 - Statement of S/C Matthew Ross dated 23 May 2004

Mr Biggs was permitted to continue on his way. No charges were laid.

On Saturday 22 May 2004, at 3.00pm, **Sergeant Samuel Cahir**[21] and **Leading Senior Constable (L/S/C) John Hawkins**[22] commenced duty at Avondale Heights Police Station. Sergeant Cahir's duties for the shift incorporated patrol and supervision of the Moreland and Moonee Valley Municipalities. L/S/C Hawkins was the designated driver for their police vehicle - Avondale Heights 252.

At approximately 4.15pm, Ms Hughes visited Mr Biggs at his Barkly Street home. He smoked a bong while she was there. Ms Hughes left Mr Biggs at approximately 6.00pm.

At approximately 6.30pm, Officers Cahir and Hawkins were travelling on the western side of Lygon Street, Carlton North, when they observed Mr Biggs on the eastern side of the road, approximately 20 metres north of the intersection of Park Street. He was attacking a pedestrian crossing with what they initially thought to be a metal bar or pole. L/S/C Hawkins commenced a U-turn towards the eastern side of the road. Prior to completing the turn, Sergeant Cahir exited the front passenger seat of the Police vehicle. He drew his Police issued firearm. As he got closer to Mr Biggs, Sergeant Cahir identified the weapons as a samurai type swords.

Sergeant Cahir called out to Mr Biggs:

POLICE, DON'T MOVE. DROP THE WEAPON.

Mr Biggs moved towards Sergeant Cahir who had positioned himself next to the police vehicle so it was between them. L/S/C Hawkins was still inside the vehicle. Mr Biggs advanced, swinging the swords, raised one above his head and struck the rear window of the police vehicle, smashing the glass. L/S/C Hawkins drove the vehicle forward, removing Sergeant Cahir's cover and turned the vehicle into Park Street. He did not call the Police Communications Centre - D24 - for assistance.

Sergeant Cahir continued to yell the command to Mr Biggs to drop his weapons. Mr Biggs continued to advance on Sergeant Cahir with a sword raised and another held in a thrusting manner. Sergeant Cahir discharged one shot from his firearm, striking Mr Biggs in the upper torso.

Mr Biggs stopped momentarily then ran off in an easterly direction into the parkland situated adjacent to the pedestrian-lights on Lygon Street and ran in an east/west direction along the north side of Park Street.

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[21] Sergeant Cahir has been a member of Victoria Police since 1991. He was fully operational having completed his last training in OSTT on 4 February 2004 - See pp164-173 Inquest Brief.

[22] L/S/C Hawkins qualified from the Police Academy in February 1989. He was fully operational having qualified in OSTT training on 28 January 2004 - see Exhibit 32

Sergeant Cahir notified the Police Communications Centre that he had discharged his firearm. He commenced securing the scene and locating witnesses. He requested a police dog.

L/S/C Hawkins remained unaware that his partner had discharged his weapon until he heard the broadcast over the police vehicle radio.

The Officers did not pursue Mr Biggs into the parkland.

Other Police Units were on the scene soon after including the Police Helicopter which commenced an air search of the surrounding area.

At approximately 6.40pm **Acting Sergeant (A/S) Paul Tymms** of Flemington Police Station arrived at the scene and after speaking briefly to Sergeant Cahir, took control of the crime scene and removed Sergeant Cahir's police issued equipment belt incorporating his firearm. A/S Tymms placed Sergeant Cahir in his vehicle, effectively removing him from duties.

At approximately 7.10pm a Police K9 Unit attended at the scene and commenced in the search for Mr Biggs.

At approximately 7.38pm, Police with the assistance of the K9 Unit, located Mr Biggs lying under a footbridge in the parkland on the north side of Park Street, approximately 200 metres from where Sergeant Cahir had discharged his firearm. There was a significant amount of blood loss where he lay. Gregory Ram Biggs was deceased. Two swords, one measuring 870mm in length, were located with Mr Biggs.

INVESTIGATIONS[23]:

The medical investigation into the cause of death:

Dr Malcolm Dodd, Forensic Pathologist, at the Victorian Institute of Forensic Medicine, attended the scene of the fatality.

On 23 May 2004, at 1.00am, Dr Dodd performed an autopsy[24]. The examination disclosed a bullet entry wound to the upper right back area and an exit wound below the mid of the right clavicle (collarbone). The projectile severed the right axillary artery which resides below the mid part of the right collarbone as it maintained a more or less horizontal trajectory. Dr Dodd commented:

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[23] Investigation includes Inquest - Section 3 *Coroners Act 1985*

[24] See Exhibit 8 - Statement/Pathology Report of Dr Malcolm Dodd dated 29 June 2004

A reasonable explanation for the trajectory in this case is suggested if it is given that the deceased has approached the police officer with sword in hand and with body rotated in an attack like stance.
If this posture is considered then the bullet would have followed exactly this path and exited in an extreme and tangential fashion as is demonstrated on external examination. The bullet has passed through the body; several small metallic fragments were identified on X-ray.

Dr Dodd attributed the cause of death to one of external blood loss secondary to laceration of the right axillary artery from a single gunshot wound to the upper back area.

Toxicological analysis[25] of body fluids disclosed the presence of Methylenedioxymethamphetamine (MDMA)[26], Methamphetamine, Amphetamine[27] and Cannabis at ~54ng/mL.[28]

Dr Dodd reported on the toxicological analysis and relying on the circumstances known at the time, expressed the opinion that:

Use of Amphetamine may induce a state of agitation, excitability and hallucination and may in part explain the behaviour of the deceased on this occasion.

The Police Investigation:

Victoria Police Homicide Squad and Ethical Standards Department (ESD) attended the scene of the incident. The Homicide Squad conducted the investigation. Matters related to the Police involvement were overseen by ESD.

A search of Mr Biggs' Barkly Street premises on 23 May 2004, located a number of weapons including 20 swords of various types and descriptions. A search of his warehouse/factory premises in Argyle Street, Fitzroy on 25 May 2004, located a small Ecstasy manufacturing laboratory, a range of drugs and more weapons including 12 swords.

The Inquest brief was prepared by **Detective Senior Sergeant Jeffrey Maher** of the Homicide Squad.

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[25] See Exhibit 13

[26] Is a designer amphetamine also known as "ecstasy".

[27] Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. Toxicity associated with amphetamine use include agitation, hyperthermia, hallucinations leading to convilsions, unconsciousness, and respiratory and/or cardiac failure. (Source: Victorian Institute of Forensic Medicine)

[28] One of the main active psycho-active ingredient in cannabis is Δ9- tetrahydrocannabinol (THC). The presence of THC in blood at concentrations in excess of 2 ng/mL strongly suggests recent use of cannabis (within a few hours). (Source: Victorian Institute of Forensic Medicine)

The Office of Police Integrity (OPI) - Victoria, investigated the circumstances. In November 2005, the OPI published a *Review of Fatal Shootings by Victoria Police* which included the shooting of Gregory Biggs. The OPI investigation concluded that several Operational Safety Principles were not applied by the police involved in the incident.

Police Training:

In 1994 Victoria Police implemented Operational Safety & Tactics Training (OSTT) through Project Beacon. The course is intended to reinforce the 10 Operational Safety Principles and the use of an assessment tool[29] designed to assist members in converting an unplanned response into a planned response or operation. According to a Victoria Police 2007 Strategic Directions Paper[30], *the overarching philosophy of OSTT is that: the success of an operation will be primarily judged by the extent to which the use of force is avoided or minimised.*

All Victoria Police Officers permitted to carry operational and safety equipment must undergo post-recruitment OSTT[31] for two days, twice a year. OSTT devotes a quarter of these sessions to issues to do with conflict resolution inclusive of defensive tactics and dealing with members of the public with mental health issues. Part of this component seeks to reinforce general principals through scenario training. The OSTT requirements include training in the use of operational safety equipment including oleoresin capsicum spray ('OC spray').

Sergeant Cahir complied with and completed the periodic training requirements of OSTT on 4 February 2004, at the Victoria Police OSTT training facility in Essendon. On that day he also trained and qualified in the use of oleoresin capsicum foam ('OC foam').

L/S/C Hawkins complied with and completed the periodic training requirements of OSTT on 28 January 2004.

The evidence of witnesses in the Lygon/Park Street vicinity:

There was some variation in the witness accounts of the unfolding scenario. This is not unexpected and not a reflection on the *bona fides* of the witnesses. It was night time, perception of distance is effected, estimation of distance varies greatly between individuals and recollection can be influenced by external factors such as another person's recollection or the media's portrayal of the circumstances.

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29 The assessment tool is referred to as *HIARCC* (Hazard Identification, Assess Risk, Risk Controls).

30 See Exhibit 22 @ p40

31 See Exhibit 23 - Operational Safety & Tactics Training Syllabus, July - December 2001 throught to January - June 2004.

Ms Josephine Pratore's account[32] of the sequence of events is difficult to reconcile with that of other witneses. She was credible and consistent about what she witnessed from her flat where she had a relatively unimpeded southerly view of the parkland on the corner of Park and Lygon Streets. Nevertheless, the weight of the evidence leads me to conclude that Ms Pratore has not observed two policemen following a man but has observed the police car, a police officer and possibly Mr Biggs in positons within the darkened parkland after Sergeant Cahir had discharged his weapon.

Similarly the statement of **Christopher Oliver**[33] was at odds with the other 3 occupants of their car. He stated that he saw two police officers out of their vehicle when the man was shot.

The weight of the evidence is to the contrary.

FINDINGS and COMMENTS

Corrections Victoria

On 12 May 2004, Ms Papa made an assessment that Mr Biggs *did not appear to be in crisis.* She did not refer Mr Biggs for a mental health assessment or for drug testing. **Mr Georgiou**, on behalf of the family, submitted that this was a failure to take positive action in response to Mr Biggs' presentation and was equivalent to Corrections ignoring its' supervisory responsibilities. The submission proposed that if Corrections had adopted a more proactive course of action, instead of simply leaving Mr Biggs until the next appointment, the events of 22 May 2004, *may* have been altered.

To accept this proposition I would also have to accept that a referral for a mental health assessment or drug analysis would have happened immediately and would have resulted in Mr Biggs' immediate incarceration for treatment and/or removal from access to illicit drugs. A "comfortable satisfaction" must be reached to conclude that the management of Mr Biggs by Corrections, was deficient to the extent it could be considered a causal factor in his death. In addition, the connection between acts and/or omissions alleged to have been causal factors in his death must be proximate and logical, not illogical or strained.

I do not accept this proposition as it lacks cogent, persuasive proofs.[34]

I accept the evidence of Ms Papa and **find** that she adopted an appropriate and reasonable course of action in response to Mr Biggs' presentation on 12 May 2004. She spent time listening to Mr Biggs' concerns on the day despite having no appointment and emphasised that he return again on 25 May 2004, when he had a scheduled appointment. She had no

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[32] See Exhibit 3 and Transcript of Proceedings pp1-42

[33] See statement of Christopher Oliver @ p.162 of the Inquest Brief

[34] See *Briginshaw v Briginshaw* (1938) 60 CLR 336, *Anderson v Blashki* (1993) 2 VR 89; *Secretary to the Department of Health and Community Services v Gurvich* (1995) 2 VR 69 and *Chief Commissioner of Police v Hallenstein* (1996) 2 VR 1.

benchmark or parameters on which to assess whether Mr Biggs was drug affected or suffering a mental illness as there was no history of the latter and he denied use of the former.

I make no adverse finding against Ms Papa or Corrections Victoria in this instance.

Transport Management Unit Officers

Similarly, I accept the evidence of the TMU Officers that on 21 May 2004, they had no grounds to detain Mr Biggs or to call a CATT or invoke section 10 *Mental Health Act* 1986. Although Mr Biggs' presentation was unusual, he was not using the weapons but surrendering them. He was not violent but compliant with their questioning and search. He did not demonstrate an intense dislike for Police. He was not overtly demonstrating signs of acute mental illness and the behavioural oddities that he did demonstrate appeared explainable by his admission to having smoked cannabis.

I find that the response of TMU officers, Constable Timothy Carlin, S/C Darren Bugelly and S/C Matthew Ross, to Mr Biggs' presentation on 21 May 2004, was reasonable and appropriate in the circumstances and that there was nothing in Mr Biggs' presentation that could have alerted them to the events that unfolded approximately 24 hours later.

Sergeant Samuel Cahir and L/S/C John Hawkins

Both Officers made application to be excused from giving evidence on the grounds that he may incriminate himself as to the commission of an indictable offence, namely murder, manslaughter or breach of s25(1) of the *Occupational Health and Safety Act* 2004. A witness is entitled to invoke the privilege against self-incrimination if there are reasonable grounds for the witness' belief that the witness may be in peril of incriminating himself as to the commission of an indictable offence if an answer to a question(s) is given. In *R v The Coroner; ex parte Alexander*[35], Justice Gray ruled that the privilege against self-incrimination applies in proceedings in a Coroners Court[36].

Sergeant Cahir's application was accepted and he was excused from giving evidence. L/S/C Hawkins' application was refused.[37]

I have previously commented on the diminished fact finding ability of the coronial process in matters where critical witnesses to an incident invoke the privilege[38]. The balance

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[35] [1982] VR 731

[36] Justice Gray followed Madden CJ in *Re O'Callaghan* 91899) 24 VLR 957

[37] See Transcript of Proceedings @ pp 495-496

[38] See for example, *Record of Investigation into Death* of Lee Andrew Kennedy - Case No: 1318/05

between ensuring the protection of the witness from potential criminal or civil proceedings arising from the giving of evidence at an Inquest and enabling a rigorous inquiry into the facts, may soon to be resolved with the introduction on 1 November 2009, of the *Coroners Act* 2008. In particular, section 57 of the new Act enables the Coroner to issue a certificate of protection to the witness if the Coroner determines there are reasonable grounds for the witness' objection. This provision provides uniformity with a number of other Australian jurisdictions[39].

I accept that Officers Cahir and Hawkins were suddenly and unexpectantly confronted with a dangerous situation. I also accept that it was a situation that required intervention by the Police.

I find that only Sergeant Cahir was out of the Police vehicle at the time of the incident that is, only one Officer confronted Mr Biggs.

The circumstances of Gregory Biggs' death are a perturbing reminder of the acutely difficult and violent situations Police are confronted with in the course of their duties that do require some form of immediate response. But the circumstances of Gregory Biggs' death is also a poignant example of the tragic consequences when the Police rely too heavily on bravado and spontaniety at the expense of policy and procedure and their actual training in relation to dealing with mental illness and/or drug affected persons. The Police have an obligation to the public to implement strategies for preventing violence not creating it or inflamming an already violent situation. While I accept **Sergeant Miles'** evidence that a risk assessment of a critical incident is fluid, Sergeant Cahir's deviation from Operational Safety Principles put himself and his junior officer at risk. I agree with Mr Georgiou of Counsel, that containment of the situation should have been the predominant response. Sergeant Cahir created the scenario which led to Mr Bigg's death when he single handedly confronted Mr Biggs, a man armed with weapons in a busy residential area, acting in a dangerous, violent and irrational manner. L/S/C Hawkins was not there to back him up, or help dilute the immediacy of the threat because he had been left behind in charge of the police vehicle - and there he remained.

I find that L/S/C Hawkins did not have an appreciation of the additional risk to Sergeant Cahir when he moved the police vehicle forward and into Park Street. He was in fear of his own safety. Nevertheless or perhaps because of his fear, he did not call for backup.

I do not however equate and have not formed a belief, that these acts and/or omissions of L/S/C Hawkins amount to those intended to be covered by Section 25 of the *Occupational Health and Safety Act* 2004.

Once Sergeant Cahir adopted this approach on Mr Biggs, in the absence of his partner, he took away the opportunity to discuss and implement a plan with his more junior colleague. He took away the opportunity that time allows - the time to invoke Operational Safety Principals, to call for backup. By removing the benefits that time would have availed the Officers, Sergeant Cahir was left with only enough time to defend his own life. This was not

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[39] See for example, Freckleton I. & Ranson D. *Death Investigation and the Coroner's Inquest,* Oxford University press, 2006 @ pp 578-585, for a summary of the various jurisdictional statutory provisions.

the time to consider the use of OC spray - there was now no time for the deployment of OC spray - the immediacy of the threat was advancing all too rapidly and Sergeant Cahir had already excluded the viability for its' use by his immediate actions. At this critical point in the scenario, I accept that Sergeant Cahir feared for his life. I accept that he no longer had a choice but to use his firearm - he had already removed all other possible choices.

The discussion about the possibility and/or practicality of using OC spray to disable Mr Biggs is rendered academic in the absence of the implementation of a plan in the first instance. In the circumstances, it becomes unnecessary to make any findings on whether the situation rendered the use of OC spray safe and practical. I accept the evidence about the limitations of OC spray. Controversy over its' use include:

- whether its' use should ever be considered when the person confronting Police has a weapon,

- whether Police should put themselves at risk by getting within the approximate 3 metre limited range to use the OC spray if the person has a weapon, or

- whether or not the weather conditions render its' use unsuitable.

Given the manner and speed in which the whole tragic scenario unfolded, any reference of consideration of the use of OC spray has been done only with the benefit of hindsight. The desirability or suitablity of the use of OC foam is even more academic than the use of OC spray. Although trained in its' use, I am advised and accept that it was simply not available in Region 3 at the time.[40]

I find that Sergeant Cahir precipitated the shooting of Gregory Biggs but I accept that he did continue to yell out a warning to Mr Biggs to drop his weapons before discharging his police firearm. I also accept the forensic evidence that the trejectory of the bullet from Sergeant Cahir's firearm is consistent with it being discharged as Mr Biggs was brandishing his swords in a rotational attack like action, exposing the right upper back area to the bullet.

I find that Sergeant Cahir discharged his firearm as Mr Biggs was advancing upon him, not retreating or running away.

The consequence of not immediately pursuing Mr Biggs may have inevitably contributed to a delay in locating him. Had he been discovered earlier and received medical intervention effective at curtailing the blood loss from the bullet wound, the outcome may have been different - Mr Biggs may have survived. However, this proposition could only be accepted as logical if there was certainity about whether Sergeant Cahir and L/S/C Hawkins would have in fact been able to locate Mr Biggs on their own.

I find that the actions of Sergeant Cahir and L/S/C Hawkins after Mr Biggs fled into the parkland was appropriate. At this point within the scenario, I am satisfied that they

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[40] I am mindful of the current controversy surrounding the issuing of Tasers to members of Victoria Police however, they were not the subject of discussion in this Inquest as an alternative means of disabling Mr Biggs.

converted their unplanned response into a planned response. Sergent Cahir was not sure that he had actually shot Mr Biggs. The parkland was dark. Mr Biggs had weapons and had been violent. The Officers would have put themselves at additional risk if they had pursued him.

At this stage of the scenario, it was appropriate to await assistance before conducting a full search and it was appropriate to cordon and contain the scene in the interim. These actions are reflective of an appropriate risk assessment.

Improvements in Police training:

There have been many Coronial recommendations,[41] particularly since the early 1990's, about the need for improvements in Police training, the use of firearms, avoidance of firearms and confrontation, planning and tactics and the like which in general, have been received positively by Victoria Police.

In relation to Operational Safety & Tactics Training, I accept that Victoria Police continue to review the content and effectiveness of OSTT. It is of course appropriate to review each critical incident and implement change where shortcomings are identified. As with any profession, educational and training improvements should also endeavour to be proactive and progressive not merely reactive.

I am satisfied that Victoria Police has endeavoured to improve training of its' members both in response to Mr Biggs' death and from a proactive perspective. An example of this is The Strategic Directions Paper, *Providing policing services to people with, or affected by, mental disorders*, which outlines the Mental Health Strategy for Victoria Police.[42] In addition to improving the training of recruit and probationary constables, the Paper proposes directional change for OSTT:

> *...the OSTT course needs to better cover the range of mental disorders, particularly as the diversity of behaviours and cognitive impairment has significant implications for communications, defensive tactics and conflict resolution. The review suggests that mental health should be a permanent component of the course.*[43]

Another example of the evolving nature of Police training is the availability, since October 2006, of the Mental Health First Aid course which has in part arisen out of the Office of Police Integrity November 2005 Report and has been tailored to the needs of operational policing in consultation with ORYGEN Research Centre at Melbourne University. Other improvements in Police training have continued since the completion of this Inquest. The ongoing improvements to the availability of information on Victoria Police intranet is another example. This tool should provide support to officers dealing with people with

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41 Many arising from the "Shootings Inquiry" conducted by Coroner Hallenstein in 1994.

42 See Exhibit 22

43 p.40 - Exhibit 22

behavioural problems through, for example, the ability to "flag" individuals with identified problems who have previously come into contact with Police and by providing contact details across relevant agencies.

I accept that Victoria Police Command are cognisant of the need to improve the *interface* between their officers and members of the public presenting with behavioural problems. One of the challenges for the organisation is the implementation of a satisfactory standard of education to a level where they achieve not only the skill set to be able to implement operational safety principles but also achieve a consistent attitudinal approach by its' officers in dealing with people with mental and behavioural disorders.

In relation to this investigation, there is no evidence that Sergeant Cahir and L/S/C Hawkins turned their collective minds to the Hazard Identification, Assess Risk, Risk Controls (HIARCC) assessment tool when they initially came upon Mr Biggs in Lygon Street. Their training appears to have played such a small part in their actions. They were both up-to-date with OSTT but appear to have lacked the capacity to implement it. The actions of Sergeant Cahir are difficult to reconcile with the fact that he has been a fully operational officer for some 13 years.

Having accepted continuing improvements to OSTT since Mr Biggs' death, particularly with the emphasis on dealing with people with mental and behavioural problems, it appears unnecessary to make any formal recommendations for improvements to the content. The **frequency of OSTT** however does, in my view, require review. A two day course every 6 months is a commendable achievement by Victoria Police but is unlikely to contemporaneously represent a sufficient allocation of training time. The breadth and range of matters that operational members must be aware of, brought up-to-date in and kept proficient at, exceeds, in my view, the allocated time set aside. As the range of equipment available for use by officers has expanded and the need for them to increase their knowledge base about changing community behaviour, so should the amount of their training.

I recommend that Victoria police review the time allocated to OSTT each year with a view to expanding on the current two days twice a year to ensure all operational safety principals have been taught to a level of proficiency.

Concluding Findings & Comments:

At the conclusion of the Inquest Mr Biggs' mother, Mrs Cooper, addressed me and stated that although she did not fully understand the circumstances of her son's death she did not blame the police officers. She stated:

> *I feel my son was mentally disturbed and under the influence of some drugs and I feel that he instigated this disturbance.*

It is not possible to know why Mr Biggs went out into the community armed with his smaraui swords, nor possible to know what he was thinking or what he intended. There is insufficient evidence to attribute his behaviour towards Segeant Cahir to some intense dislike for Police. His behaviour towards Police on 21 May 2004, is to the contrary. There

is no evidence that he had planned this violent rampage. Changes in his behaviour had been observed in the month before his death and irrational and erratic behaviour had been observed in the fortnight beforehand, however, it is not known whether he was suffering from any behavioural/mental health issues independant from those traits that can be induced by drugs. **Professor Olaf Drummer**,[44] in his *viva voce* evidence stated that methamphetamine in particular, *can cause a person to exert aggression, sometimes socio-violent behaviour.*[45]

It is more probable that Mr Biggs' behaviour on 22 May 2004, was influenced by drugs. The evidence supports a conclusion that on or around 22 May 2004, he had been using significant quantities of drugs that can affect cognitive function - *the ability to think and reason.*[46] Drugs which could have worsened whatever state of mind he may have been in at the time.

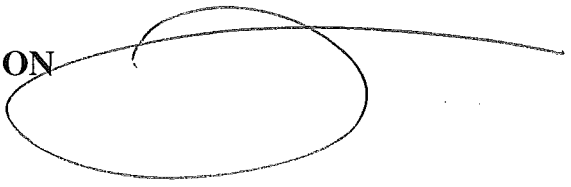
To that extent, Gregory Biggs did instigate the disturbance but the outcome was at the behest of Victoria Police Officer, Sergeant Cahir. There are cogent and persuasive proofs to reach a "comfortable satisfaction" and conclude that the actions and/or omissions of Sergeant Cahir were causal factors in Gregory Biggs' death.

I accept and adopt the medical cause of death as identified by Dr Malcolm Dodd and **I find** that **GREGORY RAM BIGGS** died from external blood loss due to laceration of the right axillary artery from a single gunshot wound to the upper right back area in circumstances which leads me to conclude that his death was preventable.

I find and believe that Sergeant Cahir failed to take reasonable care for his own health and safety and/or the health and safety of L/S/C Hawkins when he removed himself from the police vehicle and confronted Mr Biggs and as such may have committed an indictable offence as defined and intended by section 25 *Occupational Health and Safety Act* 2004.

In the circumstances, pursuant to section 21(3) *Coroners Act* 1985 I am required to report my belief to the Director of Public Prosecutions.

AUDREY JAMIESON
CORONER
23 October 2009



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[44] Professor Drummer is a Forensic Pharmacologist and head (Scientific Services) at the Victorian Institute of Forensic Medicine.

[45] See Transcript of Proceedings @ p217

[46] See Transcript of proceedings @p 223 - Professor Olaf Drummer.

Witnesses providing *viva voce* evidence:

Ms Josephine Paratore, Ms Erin Blackett, Mr Will Stoyles, Ms Sarina Papa, Community Corrections Officer, Dr Malcolm Dodd, Forensic Pathologist, Mr Hugh Whitehead, Ms Claire Wood, S/C Timothy Carlin, Mr Joshua Rouillon, Professor Olaf Drummer, Ms Meagan Hughes, S/C Lisa Cook, Sergeant Paul Tymms, Senior Constable Darren Bugelly, Senior Sergeant Miles, Commander Ashley Dickinson, S/C Matthew Ross, Detective Inspector Robert May and Detective Senior Sergeant Jeffrey Maher.

Appearances:

- Mr Andrew Moore of Counsel - assisting the Coroner (Office of Public Prosecutions)
- Mr George Georgiou of Counsel - on behalf of Mrs Janet Cooper - mother of Mr Bigg's (Victoria Legal Aid)
- Ms Mandy Fox - on behalf of Corrections Victoria
- Mr Ron Gipp of Counsel - on behalf of L/S/C John Hawkins (Russell Kennedy)
- Mr Martin Grinberg of Counsel - on behalf of Sergeant Samuel Cahir (Minter Ellison)
- Ms Fiona Ellis of Counsel - on behalf of the Chief Commissioner of Police (Victorian Government Solicitors Office)
- Mr Sean Cash of Counsel - on behalf of TMU Officers S/C Matthew Ross, Constable Timothy Carlin and S/C Darren Bugelly (DLA Phillips Fox)

Distribution of Finding:

Mrs Janet Cooper and other family members
Attorney-General of Victoria
Director of Public Prosecutions
Chief Commissioner of Police
Corrections Victoria
Detective Senior Sergeant Jeffrey Maher
All legal firms representing the Interested Parties.