IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4328

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: GREGORY JOHN CAULFIELD

Delivered On:	8 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	22, 23, 24 and 25 July 2013
Findings of:	IAIN WEST, DEPUTY STATE CORONER
Representation:	Ms Meaghan Fitzgerald instructed by Fitzroy Legal Service on behalf of relatives of the deceased Ms Rachel Ellyard instructed by Victorian Government Solicitors for the Chief Commissioner of Police Mr Paul Lawrie instructed by Lander & Rogers for Constable Saunders, Senior Constable Lee, Constable Christensen and Constable Gurney.
Counsel Assisting the Coroner	Ms Naomi Hodgeson instructed by Coroners Court In-House Solicitors Service

I, IAIN WEST, Deputy State Coroner having investigated the death of GREGORY JOHN CAULFIELD

AND having held an inquest in relation to this death on 22, 23, 24 and 25 July 2013
at Coroners Court, Melbourne
find that the identity of the deceased was GREGORY JOHN CAULFIELD
born on 18 January 1977
and the death occurred on 16 November 2011
at 141 Nicholson Street, Carlton
from:

1 (a) Multiple injuries sustained in a fall from a height

in the following circumstances:

1. Gregory John Caulfield[1], born 18 January 1977, was 34 years of age at the time of his death. He was the son of Faye and John Caulfield and the older brother of Kylie, Peter, Sonia, Trina, Rebecca, Nicole and Andrew. Greg was also the father of two sons, Ethan who was born in 2004 and Jackson who was born in 2001.

2. At approximately 2.20pm on 16 November 2011, Greg fell from the balcony of Flat 92, 141 Nicholson Street, Carlton following Victoria Police being called to the residence in relation to a burglary in progress. As a result, Greg sustained fatal injuries.

Medical Examination

3. A post mortem examination was conducted by Dr Heinrich Bouwer, forensic pathologist, Victorian Institute of Forensic Medicine (VIFM), who found the cause of death to be '*multiple injuries sustained in a fall from a height*'. There were no feet or lower leg fractures to suggest that Greg landed on his feet. Chronic hepatitis was also noted.

4. Dr Bouwer conducted an examination of the body under an ultraviolet light which demonstrated areas of fluorescence, mainly on the right side of the face, hands and jumper consistent with Oleoresin Capsicum (OC) Spray.

5. The toxicological results '*detected amphetamine and methamphetamine in the blood and urine. Phentermine was also detected in the blood as well as urine... Clonazepam, together*

[1] I will refer to the deceased as Greg and note that this is how the family refer to him.

with clonazepam metabolites (benzodiazepine), were detected in blood and urine. Morphine and codeine were [not] detected in urine, but in blood. The heroin specific metabolite 6-Monoacetylmorhone was not detected in urine, however this does not exclude recent use of heroin.'[2]

Purposes of the Coronial Investigation

6. The primary purpose of the coronial investigation of a reportable death[3] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[4] An investigation is conducted pursuant to the *Coroners Act 2008* (the Act). The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

7. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[5] This is referred to as the prevention role of the coroner.

Death in custody

8. Greg's death is a death in custody as he was a person who the police were attempting to arrest at the time of his death. A mandatory inquest is therefore required pursuant to section 52(2)(b) of the Act as part of my investigation.

9. There is no doubt that the Parliament, by legislating that a inquest is required for all deaths in custody (unless a statutory exception applies), has acknowledged that the actions of authorities, including police should be scrutinised in relation to the exercise of the their powers as part of the investigation, where it is relevant to the circumstances of the death.

---

[2] I obtained a further expert toxicological report of Dr Morris Odell for the purpose of my investigation.

[3] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdiction nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury. Clearly, Greg's death falls within this definition.

[4] Section 67 of the Act.

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

THE EVIDENCE

10. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence[6] compiled by Detective Senior Sergeant David Snare[7] including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, other documents tendered through counsel (including counsel assisting), written submissions of Counsel and their replies following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Greg's death. I do not purport to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and where otherwise appropriate.

11. The following witnesses gave evidence at the inquest:

- Mr Andrew Trail
- Constable Lucinda Saunders
- Senior Constable Lindsay Lee
- Constable Rasmus Christensen
- Mr Jesse Gane
- Constable Nathan Gurney
- Senior Constable David Caridi
- Constable Timothy Brannigan
- Constable Robert Andrews
- Senior Sergeant Matthew Hargreaves
- Superintendent Graham Kent
- Detective Leading Senior Constable Kyle Simpson (Investigating Member)

[6] Which also included photos, CCTV footage and audio material.

[7] I was also assisted by Detective Leading Senior Constable Kyle Simpson, Homicide Squad, particularly during the course of the inquest. I am grateful to both members for their assistance with this investigation.

12. I received written submissions from Counsel Assisting and Counsel for the family of the deceased, the Chief Commissioner of Police (CCP) and collectively Constables Saunders, Christensen and Gurney as well as Senior Constable Lee. Reply submissions were received on behalf of Counsel for the family and the CCP.

13. I have been greatly assisted by all the submissions and note that there is little variance in the summaries of evidence provided by the parties, including where the evidence of witnesses accounts departed. I considered those summaries both comprehensive and accurate and have adopted where appropriate, relevant parts in my finding.

UNCONTENTIOUS MATTERS

14. At the completion of the police investigation and prior to the commencement of the inquest, it was apparent that most of the facts about Greg's death are known and were uncontentious. These include the deceased's identity, the medical cause of his death and aspects of the circumstances, including the place and time of his death.

CONTENTIOUS CIRCUMSTANCES – THE FOCUS OF THE INQUEST

15. The primary focus of the broader coronial investigation of Greg's death, including at the inquest, as reflected by the witnesses required to attend the inquest to give evidence, related to the procedures utilised to attempt to arrest and detain Greg including the use of the OC Spray. Issues included:

    - Clarification of the extent to which the four police members planned what would occur.
    - Whether the use of OC Spray was justified in the circumstances?
    - Did the use of OC Spray comply with Victoria Police training and guidelines?
    - Did the risks associated with OC Spray put the Victoria Police member's health and safety as well as Greg at risk?

16. Two additional matters were raised during the investigation. The first was whether Greg was assisted by a third party off the balcony. The second was whether he was in handcuffs at the time of his death.

17. At a directions hearing on 27 November 2012, upon application of the family and after hearing from the CCP, I ruled that my investigation would not include whether the Critical

Incident Response Team should have been called to the scene as part of the first response of the police.

Circumstances of Greg's death

The days preceding the death

18. On Sunday, 13 November 2011, the Bendigo police attended at Ms Natalie Blaney's house at approximately 8.00am after a report of an assault by Greg on Ms Blaney. Ms Blaney said that he was her ex-defacto partner but they had been spending time together recently. She said that it was the first time he had been violent to her and that he had been sick the day before. She noted a distinct change in his behaviour and suspected that it may be drug related. By the time the police attended, Greg had left. Later that morning the evidence suggests that Greg's step-father drove him to Melbourne where he met up with his friend, Mr Jesse Ganes, between 10.30-11.00am near the Southern Cross Railway Station.

19. According to Jesse, at about 7.00am Tuesday 15 November 2011, Greg was involved in an armed robbery in St Kilda and he and Ms Krystal Airey were present. Jesse indicated that there was a serious assault (with a metal pole) perpetrated by Greg which Jesse said was "*fuelled by 'Ice'*". The matter was reported to the police.

20. In the evening of Tuesday, 15 November 2011, Greg and Jesse stayed with Krystal at her flat which was located at Flat 52, 141 Nicholson Street, Carlton. This is the same apartment building where Greg eventually died. According to Krystal, she had been in a relationship with Greg for about 4 months and her father had known him in prison. There is evidence that Greg used drugs, including heroin, on that day and over the preceding days.

Wednesday, 16 November 2011 – day of Greg's death

21. In the very early hours of Wednesday, 16 November 2011 a friend of Krystal's, Mr Troy Travers also spent time with Krystal, Jesse and Greg at her flat. He resided in Flat 92 of the same apartment building.[8]

22. Later Wednesday morning, Troy returned to Krystal's flat and had a coffee with her. At that time, Greg was sleeping in Krystal's bedroom and Jesse was sleeping on the couch. It appears that Krystal gave Troy an iPod and a mobile phone which belonged to Jesse and he left the flat at about 8.26am.

[8] The police attended at Troy's flat following an incident with another individual and Kystal the previous evening. The other individual was charged with drug offences following the incident.

23. Greg, Krystal and Jesse woke around lunchtime and Jesse asked Krystal where his iPod and mobile telephone were. Jesse formed the opinion that Troy had taken these items, and asked Greg to go with him to Troy's flat, to retrieve his property.

24. When they arrived at Flat 92, they knocked on the door but got no response. Greg and Jesse then set about breaking into the property by making a hole in the front door. At some point, Greg went downstairs to Kystal's flat and returned with a more suitable tool which was used to hack a hole through the door.

25. At 2.09 p.m., Mr Andrew Traill, the occupant of the flat positioned opposite Flat 92 rang 000[9], stating that there were two males attempting to break into Flat 92, using some type of tool.

26. At 2.13.10pm, a D24 radio operator, alerted Melbourne North 307 that there was a '*possible hot burg*' in progress at 141 Nicholson Street in Carlton on the ninth floor.

27. The operator said:

> *'...complainant can see two people trying to break the door at the location. Same thing happened last night, he believes it's possibly drug related. Apparently the person that lives at that address was arrested last night for being a drug dealer. They've got possibly crowbars or tools on them, they're still present. Safety principles apply.'*

28. Melbourne North 307 and Fitzroy 307 were the first responders and other units were requested and also responded to the call. Melbourne North 307, comprised S/Cons Lindsay Lee and Con Nathan Gurney.[10] Fitzroy 307, comprised Cons Rasmus Christensen and Cons Lucinda Saunders. The other responders included S/Cons David Caridi, Con Tara Manson, Con Robert Andrews, S/Cons Sarah Read and Con Timothy Brannigan. These members on arrival were deployed to the grounds surrounding the apartment building in the event that any suspects tried to escape.

29. Cons Christensen and Saunders arrived at 141 Nicholson Street, Carlton first and were trying to gain access through the glass doors when S/Cons Lee and Con Gurney arrived. Through S/Con Lee's local knowledge, she was able to gain access simply by forcing the door open.

---

[9] He first rang the Ministry of Housing.

[10] I will use the abbreviation Con for Constable and S/Cons for Senior Constable

30. The evidence suggests that there was a discussion between Cons Saunders and Christensen regarding whether OC Foam should be taken for potential deployment. Its use was, however, discounted because of the relative size of the OC Foam canister. I note that each member had OC Spray fitted on their equipment belt.

31. The CCTV footage obtained by the investigating member from the building shows all four officers entering the apartment building together and then taking a lift to the ninth floor (noted to be at 2.17.34pm).

32. The evidence of the members at inquest reveal that none clearly recall all of the details of the conversation that took place in the lift as it travelled to the ninth floor. The CCTV footage does, however, show S/Cons Lee speaking animatedly. She gave evidence that she was discussing the length of the Integrated Operational Equipment Vest and how the older ones were longer and made it harder to manoeuvre. Apparently, she hadn't been issued a new vest at that time so chose not to wear a vest. Con Gurney was wearing the new vest and she recalled that she instructed him to be the first to exit from the lift.

33. S/Cons Lee had her OC Spray out of her equipment belt in the lift, so it is clear that all four members must have contemplated the potential use of OC Spray during the response.

34. Jesse gave evidence that when the hole in the door of Flat 92 was sufficiently large, he crawled through, reached up, and opened the door from inside, which allowed Greg to push past him and enter the flat.

35. It appears that it was almost immediately after this that the four members emerged from the lift and saw Jesse attempting to gain entry. He was observed to be partially inside the door when he was dragged out of the door by S/Cons Gurney, and handcuffed by one or both of S/Cons Lee and Con Saunders.

36. The evidence suggests that Cons Christensen and Gurney entered Flat 92 through the unlocked door and announced themselves, believing that there may have been another person inside the flat based on the radio transmission. They gave evidence that they had no idea what they might find, including the presence of a victim and therefore had to be prepared for any eventuation.

37. I note the evidence of Con Christensen:

> *Did you turn your mind to the risks you might face as you entered the flat?---Well, those risks are always in your mind.....*

You said in evidence earlier that entry into the flat wasn't without thought?---Yes.

I want you to explain if you can, what that thought process was in those few moments beforehand?---First of all from a legal standpoint a series of indictable offences have been committed so we have an entry power. Second of all, to plan a response there has to be some sort of known – there has to be some sort of event and at this stage we had a call that an aggravated burglary may have been occurring and one or two people may have been involved. There's a lot of unknowns there when we have one person hanging out a door and so there was a lot of unknowns, an aggravated burglary could be with a crowbar, it was suggested, or it could be that there was a person present inside, and so there was a large number of unknowns. Potential for more offenders but also potential for a victim. So those were the thought processes but again, it happens very quickly, like I said, it doesn't happen without thought but you still enter the house quickly.

In the situation that you've described, in those few moments, is the entry into the flat something that you can do absent any risk? Can you do it completely without risk? ---No.

How do you deal with that risk then?---We try and minimise it, yeah. Try and minimise it as best you can. You try and contain or – first of all you have to identify risk and then you try and work from those.

38. It is evident that amongst the four members it was understood that S/Cons Lee and Con Saunders would remain outside the flat with Jesse who was already in hand-cuffs.

39. Flat 92 can be described as a small apartment comprising of a short entrance way which leads to a combined lounge/kitchen room with an exit to a balcony running to the width of this room. In addition, there is a bathroom/laundry (immediately to the right upon entry) and a bedroom located to the left at the end of the entrance way. At the time, most of the floors and surfaces were littered with objects and debris including scissors, long nose pliers and screwdrivers (the scene was noted to be very messy). The scene was captured by the crime examination unit and photographs were taken by police investigators. I also attended the scene immediately following the death.

40. Upon entry to the flat, Con Christensen said he conducted a cursory inspection of the bathroom/laundry, and then proceeded to the lounge/kitchen room, whilst Cons Gurney went into the bedroom.

41. While searching the bedroom, Con Gurney located Greg hiding under a pile of sheets and blankets, in a gap between the bed and the far wall of the bedroom.

42. What followed was described in the submission of the family:

> '*Constable Gurney directed Greg to "get the fuck up." Greg complied with the direction, rising to his feet. Greg then took a couple of steps towards Constable Gurney and Constable Gurney took a few steps back to accommodate this. Constable Gurney ...immediately seized Greg by the left arm, between Greg's elbow and shoulder, using both his hands. He did not issue any statement or direction to Greg before doing so or while doing so. At about this point Greg began to resist.*
>
> *While Constable Gurney was searching the bedroom, Constable Christensen had returned to the bathroom to conduct a more thorough search. While he was in there he heard a shout from the bedroom. ...the words used were to the effect of, 'we said come out'... Constable Christensen immediately went to the bedroom in response..Upon entering the bedroom he encountered Constable Gurney struggling with Greg Caulfield. It appeared to Constable Christensen that Constable Gurney was attempting to bring Greg Caulfield to the ground to affect an arrest. Constable Christensen immediately joined Constable Gurney in a 'hands on' attempt to bring Greg Caulfield under control and arrest him.'*
>
> *...Constable Gurney, Constable Christensen and Mr. Caulfield moved into the lounge area towards the entrance, with Mr. Caulfield still struggling, yelling, and being noncompliant. Constable Christensen says they were attempting to bring him to the ground. Constable Christensen was on the left of Mr. Caulfield and Constable Gurney was on the right-hand side as Mr. Caulfield was put up against the wall.*
>
> *The struggle with Greg Caulfield continued in the entrance hallway until Constable Saunders entered and, without warning, sprayed Greg directly to the face with her OC spray. Greg was immediately affected and fell to his knees.*

43. Con Gurney said of the resistance Greg was providing: '*he was agitated as soon as I touched him, and yeah, he continued to be agitated when Constable Christensen came in as well..... It was a pretty high level of resistance. He was determined that we were not going to touch him.*'

44. Con Saunders' explanation for deployment of the OC Spray was, having heard a commotion

from the flat she entered and observed that '*the male seemed very uncooperative. Rasmus and Constable Gurney kept telling him to stop and just stay where he was. The guy kept moving his arms as though he was trying to resist being held. They looked like they were trying to get him to the ground. I got my OC Spray out of my scabbard on my vest and sprayed the male directly to his face.*'

45. S/Cons Lee's location at the time the OC spray is deployed is unclear. It is her evidence that she was in the flat assisting with the arrest of Greg and received a dose of OC Spray, but the other three officers do not have a specific recollection of her assisting in the attempt to arrest. It is clear however that Jesse was able to flee from the scene. In those circumstances, the most reasonable conclusion is that she was at least inside the flat facing away from Jesse, but unnoticed due to the crowding of five people into a small space and the high intensity of activities that were taking place.

46. S/Cons Lee '*conceded that it was an oversight on the part of Cons Saunders to have left* [Jesse] *unattended in the corridor outside the unit while she went inside to assist other members. She also conceded that she should have given explicit instruction to Cons Saunders that it was her role to remain with* [Jesse]'.

47. There is also some divergence of the evidence regarding what Greg and each of the officers was doing during the struggle. As the submission for the family notes there is some divergence as to whether:

- Con Christensen fell or was knocked backwards by Greg;
- Greg rushed or ran forwards towards the entry to the flat; and
- Greg turned to his left, in the entrance hallway, and braced against the wall.

48. The submission on behalf of the members also acknowledged these differences in the recollection of events and noted that such '*differences in recollection should not be unexpected and serve only to indicate an absence of collusion between the four members. Furthermore, the effects of tunnel vision and auditory exclusion in situations such as this.....Forensic excitement often ignores the reality of fallible human perception and recollection, particularly in the context of rapidly evolving dynamic events.*'

49. No evidence has been put forward which would make this explanation an unreasonable one.

50. As a result of the deployment of the OC Spray, Greg and Cons Christensen and Gurney, all received a primary dose of OC Spray after which Greg fell to his knees. Con Gurney stated

that he thought that Greg *'was debilitated enough that he wasn't going to get back up'*. Cons Christensen and Gurney moved outside of the flat to recuperate, leaving Greg inside the flat alone, as each of the female officers had already left to pursue Jesse. The door to the flat then unexpectedly closed behind the officers and was almost immediately found in a locked state.

51. On the 29 February 2012, the investigating member and Detective Senior Sergeant Snare attended flat 92 in order to test the locking mechanism. Tests revealed that the door would close with the wind, however the door's locking mechanism had to be manipulated in order to lock it.

52. It is clear therefore that as soon as the police exited the flat, Greg must have got up from his kneeling position, made his way to the door and locked it.

53. Con Christensen attempted to gain entry into the flat, first by turning the handle, then kicking the door, however as noted above, the door was locked and entry could not be gained. Con Christensen said that it was *'a matter of seconds'* before these attempts were made. Con Christensen then shouted through the hole in the door for Greg to get down in an effort to effect the arrest, but got no response. When asked why he didn't reach through the hole and unlock the door as Jesse had, he said '*obviously it's a danger for us to stick our head into an area where there is an uncooperative offender, in a room where he can easily arm himself, so yeah, it would – it would be a much too high risk to do something like that.*' I accept that this is a reasonable explanation.

54. As Jesse had been left unattended, he escaped and was later located inside the fire hydrant cabinet on level 7. He was adamant that he was sprayed with OC Spray at this time by a male officer. However, the physical evidence was that of the four officers' OC canisters, only one, that being Cons Saunders' had been deployed. The members also denied deploying OC Spray against Jesse. I find that the weight of the evidence shows that Jesse was not sprayed with OC Spray.

55. S/Cons Caridi was performing duties as Yarra 604 and, as noted above, also responded to the radio broadcast for units to attend. On arrival, he was positioned at the rear of the flats as was Cons Mason and Andrews.

56. As S/Cons Caridi was monitoring the rear of the flats, he looked up and observed an individual (later identified as Greg) on a balcony of either Floor 7, 8, or 9. He said that Greg looked frantic and was looking over the balcony, apparently in an effort to see where he

could climb to. He then observed Greg swing both legs over the balcony railing which caused him to be facing outwards and then turned his body to face the building where he was hanging by both hands in what appeared to be an attempt to lower himself onto the balcony below.

57. The evidence suggests that Greg either let go or lost his grip and commenced to drop. His legs hit the balcony below, which caused him to be flung out and sideways, eventually landing on the ground beneath. S/Cons Caridi observed that there was no other person on the balcony at the time. There is no other evidence to the contrary and I therefore find that no person assisted Greg to get off the balcony.

58. An ambulance was called and police attended to Greg, however, no pulse could be found and he was unable to be assisted. Greg died at the scene.

59. An issue arose with respect to whether Greg was wearing hand-cuffs at the time of his death as the radio transmission of Detective Senior Constable Adam Pongho (Y508) said: '*Yeah Yarra 508, for the information to 265 the deceased is in handcuffs, appears he's jumped, while in custody.*' This fact was inconsistent with the evidence of the other officers who attended upon Greg immediately upon his fall. Further inquiries were made of D/S/Cons Pongho by the investigating member who was advised that '*he was of the belief that he later retracted that when he visually sighted the deceased at that point.*' I was subsequently provided with the entire radio transmission (as were all the parties) and noted that D/S/Cons Pongho does clarify that the deceased was not in hand-cuffs (~2:29:16pm). On the basis of all the evidence, I find that Greg was not in hand-cuffs at the time of his death.

Issues to be considered at the inquest

60. As to the extent to which the four police members planned what would occur at the incident, I note the following:

    a. There was clear and accurate communications through the police radio which were broadcast to all members who attended the incident and each member appeared to have comprehended the information;

    b. The response to the incident was timely and well resourced by Victoria Police in terms of the number of police personnel in attendance, both at the flat and on the ground;

    c. The four members were equipped sufficiently (for example, OC Spray, batons);

d. Although not verbalised, it appears there was an understanding amongst the members that S/Cons Lee was the senior officer in attendance;

e. The four officers met at the scene and travelled in the lift together, with a direction by Sen Cons Lee for Const Gurney to exit the lift first.;

f. The use of OC Spray was at least contemplated by all the officers in attendance;

g. What the police members found when they exited the lift was consistent with the information which had been communicated about the job via the police radio;

h. As soon as the officers exited the lift, they were faced with one offender who needed to be arrested. The fact of his arrest was subsequently communicated on the radio. I also note that that the senior officer (251) can be heard on the radio monitoring the events as they unfold and asking for any developments to be communicated for the benefit of all members in attendance;

i. Although not verbalised by the officers, there appeared to be an understanding that two members would remain with Jesse, who was in custody, and the other two officers would enter the flat;

j. That at the time the officers entered the flat, they had to prepare for any contingency or situation, including the presence of a victim or another armed offender (or offenders);

k. That given that the risks present were unknown, there was a time imperative in the police response; and

l. That Cons Gurney and Christensen entered the flat, and conducted a search by separating, following which Cons Gurney quickly located Greg in the bedroom.

61. The family submissions said that further planning could have taken place. Examples included:

- '*the members could have confirmed that they each had heard the full extent of the radio announcement regarding the job and discussed what measures each might take to ensure their safety, as best they could* (prior to reaching the ninth floor);
- Prior to entry the circumstances '*were not so pressing that the entry could not have been delayed for a matter of a few seconds. Such a delay might have*

allowed the members to complete the arrest of Mr Gane, confirm that there was no one else present in the corridor and have a brief conversation, to ensure that each knew each other's intentions and whereabouts, each agreed that entry into the flat was warranted and at least one member was aware of their responsibility to remain with Mr Gane.' and

- *'members did not need to separate to perform the search. They could have completed it efficiently enough together and communicated with each other throughout'.*

62. I note on the other hand that the submissions on behalf of the four police members are that *'there remained a need to have some form of direct observations of what was occurring on the 9th floor'* and that without these observations, *'it was not possible to plan a response with any meaningful level of detail'* and *'it would not be possible to know what you were planning for'.*

63. I was further advised that in the context of training, Victoria Police does not train members to follow a specific protocol when considering an approach to a particular situation but to analyse the situation and to select an appropriate response (*'there being no such thing as absolute tactics'*[11]). It is understood that the range of possibilities which may be present are vast.

64. There is no doubt that Jesse should have been prevented from escaping, if possible. However, I am not persuaded that it is appropriate to be critical of the overall planning which was engaged in by the police and necessarily limited by the circumstances of the situation.

Use of force and the deployment of OC Spray

65. With respect to the deployment of OC Spray, the primary issue I considered was whether the deployment was justified in the circumstances. This required me to consider whether the use of OC Spray complied with Victoria Police training and guidelines and, as a related issue, whether the risks associated with OC Spray put the Victoria Police member's health and safety, as well as Greg's, at risk.

66. In this context, I accept that the police *'right to use force should be exercised with responsibility and great caution'.*

[11] Hargreaves at page 384

67. The VPM Policy Rules, Procedures and Guidelines contemplate that police members may be required to use force at varying levels depending on the circumstances and that the use of force must be consistent with s 462A of the *Crimes Act 1958*[12]. '*The level of force required to bring an incident under control may need to increase or decrease depending on the situation. Members are trained in a range of techniques and a variety of equipment to enable them to have options when responding to an incident.*' I note that the Operational Safety Principles dictate that when responding to incidents or planning operations that may involve any potential use of force, principles that apply include: *members are to avoid force* (Avoid Force) and *where force cannot be avoided, only use the minimum amount reasonably necessary* (Minimum Force).

68. The deployment of OC Spray against an individual is a 'use of force'. The criteria for the use of OC Spray at the time of the incident was found in the **VPM Instruction 101-3-7 Operational Safety & other Equipment – 7.2.1** ***Criteria for use***

Only use OC Spray/Foam:

- *In situations of violent and serious physical confrontation*
- *In situations where a member believes on reasonable grounds a violent and serious confrontation is imminent.....*

69. The OC Spray Training Manual says that the deployment of OC Spray in an unplanned manner (as in this case) is a tactical decision which is made commensurate with the appropriate level of force required to deal with the situation.

70. The OC Spray Training Manual further states that '*A verbal warning must be given prior to discharging the spray...unless the gravity of the situation makes it impractical to do so.*' And:

The purpose of the warning is twofold. Firstly, as a deterrent to indicate to the subject/s the impending use of OC Spray, and secondly as a signal for other police to invoke various tactics (ie. Take evasive action...)..

The risk assessment must take account of all safety factors including the potential harm to

---

[12] **462A Use of force to prevent the commission of an indictable offence**

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

the member or the subject/s, ie. ..in the case of an attack, give the individual the chance to take evasive action or increase the intensity or achievability of the attack. The risk assessment should be cognisant of the gravity of the overall incident and all the prevailing circumstances. It remains an operational decision whether to warn or not, based on the risk assessment process which when followed will provide justification for the decision.'

71. Con Saunders' explanation for the deployment of the OC Spray is outlined in paragraph 44. She gave evidence that she was aware of the criteria for its use and with the benefit of hindsight (*'in a perfect scenario'*), she would have given a verbal warning for the purpose of warning the other officers present, not for any purpose related to Greg. She also gave evidence that she had deployed OC Spray before and it had been effective in subduing offenders on two other occasions.

72. There was no evidence to suggest that using the OC Spray on the ninth floor or in a confined space were relevant considerations to my investigation nor that OC Foam should have been used as an alternative.[13] It is clear that the police members would have benefited from a verbal warning but a recognised disadvantage of OC deployment is the possibility that police may also be exposed.

73. The evidence is that at least two police members were unable to arrest Greg despite considerable and exhausting efforts and that he was resisting with all his might in at least equal measure. They were employing hands-on tactics. There is evidence that Greg was continually being told to get to the ground (or words to that affect). A number of potential weapons could be seen strewn around the flat. The police gave evidence that they were not in a position to deploy any other tactical option available to them (eg. baton) and it is not clear that any other tactic would be effective or appropriate.

74. In those circumstances, I accept that the decision of Cons Saunders to deploy the OC spray was a reasonable operational decision based on the situation as it presented, *although not executed in an ideal manner* (for the police present). That is, it would be open to conclude that a *serious confrontation was imminent.* This was despite the risk of exposure to either the members or Greg.

[13] I heard evidence from Senior Sergeant Hargreaves that there are no defined circumstances where OC Spray is preferred to OC Foam.

75. I am not persuaded that a warning would have had any impact on Greg's behaviour and the likelihood of him becoming compliant.

76. All members present whilst the OC Spray was deployed were affected by the spray, which can remain in the air for some time. The decision of the officers to remove themselves from the entrance of the flat, for their own safety, for what they thought was a short period of time was also reasonable in the circumstances. There is no evidence to suggest that it was their intention to physically separate themselves from Greg, only move from the vicinity of the spray.

77. As already noted, Cons Gurney and Christensen tried to re-enter the apartment within seconds and did not anticipate the door closing and being locked to prevent not only re-entry but also the after-care they were aware that they were required to provide in accordance with policy and procedure.

78. The four members gave evidence that they did not consider that there was any point of exit from the flat other than the front door, so at that point Greg was, in their minds, contained in the flat after they left it and he closed the door.

79. In addition, given the purpose of a compliance warning, I am not persuaded that it is appropriate to characterise '*OC Spray accompanied by a compliance warning*' as the minimal proportionate use of force against Greg in the circumstances.

80. I am also of the view that no criticism is warranted of the two police members who left the scene in an attempt to re-arrest Jesse rather than assist the police members who remained with Greg.

The Family Submissions

81. Counsel submissions on behalf of the family state that Greg '*almost certainly locked the door after it closed behind the police members*' and that *'in determining the cause of Greg's death, his family accepts that the ultimate decision to escape by attempting to climb down from the balcony, if that is indeed what Greg was doing and intended to do, was Greg's decision and was a cause of death.'*

82. However they also submit that I should find that '*while recognising the causative role that Greg's own decisions played in this tragic incident his family asks the Coroner to find that the lack of verbal communication, planning and leadership by Police members in attendance, leading to a failure to supervise Jesse Gane and an excessive use of force on*

Greg Caulfield, were also causative factors in Greg's death', that is, *'but for the conduct and actions of police members present, Greg would not have been left alone in the ninth floor flat, rendered highly vulnerable and frantic, and would not have died on 16 November 2011.'*

Contribution in the coronial jurisdiction

83. While it is not mandatory to make findings of 'contribution' in the coronial jurisdiction, such findings will be appropriate in some cases. Making a finding of contribution requires the coroner to apply common sense to the facts of a case. The test of contribution is whether a person's conduct caused the death. A coroner should consider whether the outcome was the logical progression of events which would reasonably follow from the conduct under consideration.[14]

84. On a plain view of the evidence, the cause of Greg's death as required by the Act[15] has been determined by Dr Bouwer and is noted above. The mode (or mechanics of his death) appears to be that whilst Greg attempted to lower himself from the balcony of a ninth floor building to a lower balcony he lost control of the manoeuvre he was undertaking causing him to fall from a significant height. The motive for his actions appears to be a desire to escape arrest. Prior to this, the evidence suggests that within seconds of being exposed to OC Spray, Greg got up from a kneeling position, locked the front door of the flat and made his way to the balcony's edge to make his escape. It appears that he was determined not to be arrested by police. These actions appear to be quite conscious and deliberate as well as consistent with his earlier attempt to hide from the police under bed clothing.

85. In my view this set of facts sets out the causes and contributors of Greg's death. I agree with this part of the family submission.

86. I note that the submissions on behalf of the four officers concede that two aspects of the police response were *not ideal* - that being the lack of direction which allowed Jesse to escape and the lack of warning for the OC Spray. The submission goes onto to say that these

---

[14] In *Record of Investigation into Death of Nathan John Jackson Stewart* (2 December 2008), Judge Coate reviewed *Hallenstein* and other cases on when a person contributes to a death and concluded:

> Endeavouring to distil the essence of these cases to come up with a test for contribution which requires the coroner, in the application of common sense to the facts, I conclude that one would have to find that the act or acts departed from the reasonable standards of conduct applicable to the circumstances of the case.

[15] Section 67(1)(b) of the Act has been interpreted as the medical cause of death.

'errors do not mark the four police members' response as inappropriate or fundamentally flawed.'

87. The family agree with these concessions but characterise the fact of Jesse's escape as a general lack of planning, leadership and communication. They further submit that this lack of planning, leadership and communication pervaded the police response to such an extent that there was a '*complete failure of the* operation' and as a result I should find that it contributed to Greg's death. Examples are referenced in paragraph 61.

88. The family submit that there should have been *'*[v]*erbal directions by Constable Gurney to Greg Caulfield as to what Constable Gurney wanted Greg to do prior to the use of force and while using'* and that the manner of Greg's arrest, including a lack of specific verbal direction or negotiation by the police, failed to properly convey to Greg what was required of him and in fact escalated his behaviour.

89. Greg was committing a burglary at the time the police attended and hid under bed-clothing when they arrived. A police officer located him and told him to get up. There is evidence that Greg was continually told to get down (or words to that effect). Based on all the evidence as noted above, I find it implausible to suggest that Greg did not understand that he was being placed under arrest and what was required of him. I also note that prior to the use of OC Spray, the officers attempted to arrest him using hands on tactics and did not resort to any other use of force.

90. There is no doubt that entry to the flat was warranted and Greg's arrest was justified. The evidence also suggests that Greg was physically separated from the police (and *left alone*) because he purposely locked the door to escape from being arrested. There is no evidence to suggest that the police anticipated or should have anticipated what Greg would do.

91. As already noted, I do not regard the use of force on Greg as excessive in the circumstances.

92. Whilst I accept that there was a lack of direction which allowed Jesse to escape and that a warning before the spray would have benefitted police present, I am unable to make a finding that the actions of police contributed to Greg's death. I would be required to conclude that a death in the same manner and circumstances would be reasonably expected as the logical progression of events from the actions of the police. I am unable to conclude that this would be the case.

Background of Gregory Caulfield

93. The family say that Greg '*was a much-loved father, son, brother and uncle. He was a key part of a large family. A family that knew his struggles, but saw his good side and love for his family through it all. A doting father, he showered his boys, Ethan and Jackson, with love and affection, ending each conversations with 'I love you bigger than the world.'*

94. Greg had a number of prior matters and was serving a Community Based Order (CBO) for dishonesty offences (e.g. shop theft) requiring him to perform 40 hours of work as well as undergo assessment and treatment for alcohol or drug addiction and assessment for programs to reduce re-offending and participate is such programs as directed (Cognitive Skills Program). The order commenced on 24 February 2011 and was due to expire on 23 February 2012.

95. Greg appeared to have a long standing drug problem, which appeared to stem from a 'childhood trauma'. According to Jesse in the time he knew him he thought Greg was addicted to heroin and ice, and was using ice to get off heroin. He said in the days preceding his death, Greg had taken suboxone, heroin and ice.

96. Greg disclosed to Community Correctional Services (CCS) that he had mental health issues and he had been provided with the psychological report of Dr Cunningham (prepared as part of the court process and requested by Greg). CCS recommended that Greg get a psychiatric assessment but this didn't eventuate. Greg reoffended on a number of occasions in April 2011 and CCS were advised that he was likely to be remanded. He appears to have continued to reoffend with a consolidation of the charges (e.g. burglary, theft) to occur on 17 November 2011 (the day following his death) which he told his father he would likely receive a jail sentence.

97. Whilst he had priors for escape and failure to appear, Greg's father thought that it was out of character for him to evade police. The evidence does, however, suggest that Greg's behaviour was out of character in the days leading to his death. I also accept that he was likely to be affected by lack of sleep and recent drug use (the previous day). There is no evidence to suggest that Greg, by his actions, intended to take his own life.

98. It is clear from the evidence of Greg's family that he was an extremely generous person, who always helped others. Consistent with this, Greg came to be at the flat following a request from his friend to help him retrieve his property which Greg appeared to have no hesitation in doing, despite any risks to himself.

FINDINGS

99. Having considered all the evidence, I find that Mr Greg John Caulfield born on 18 January 1977 died on 16 November 2011 of multiple injuries sustained in a fall from a height, in the circumstances described above.

100. I further find that the police officers in attendance did not contribute to Greg's death.

COMMENTS AND RECOMMENDATIONS

101. Under section 72(2) of the Act, the coroner may make recommendations on '*any matter connected with a death or fire which the coroner has investigated.* The Act specifically recognises that a recommendation may relate to '*public health and safety or the administration of justice*'.

102. Consistent with the preamble of the Act, recommendations should be designed to reduce the likelihood of another death in similar circumstances, or to prevent a death from the same or similar causes.

103. Legislative obligations follow the making of a recommendation which require Government agencies to give consideration to and make a response.[16] Recommendations and the responses are published in accordance with the Act.

104. Recommendations are essentially public policy proposals to government, public authorities and entities to maintain and improve public health and safety. A recommendation should respond to clearly identified systemic issues which needs to be addressed. The making of recommendations must be evidenced based. That is, a problem/issue has been clearly identified and, if a means of addressing that problem/issue has been proposed, that means should be an effective way of addressing it. Recommendations should ideally find at least some support in the agency subject of the recommendation.

105. A number of recommendations were proposed by counsel for the family.[17] I am not persuaded that there is a properly put basis for the recommendations proposed.

---

[16] Section 72

[17] To enhance the focus in training on the preference for verbal communication before resort to the use of force; for Victoria Police to review and implement improvements in the emphasis of their 'safety first' philosophy in the training delivered to members; to increase communication training and to integrate it into all tactical options training; to enhance the emphasis on the need for warnings prior to use of OC spray; Victoria Police to consider (should OC aerosol sprays be reintroduced at any time) including in training the risk of enhanced and collateral exposure when OC spray is used indoors; Victoria Police to reintroduce into its Policy and Guidelines the requirement that a verbal warning must be given prior to discharging OC products including spray, unless the gravity of the situation makes it impracticable to do

106. It is important to recognise that not every error identified in a set of circumstances necessarily justifies the making of a recommendation.

107. I note that OC Spray will not be used by Victoria Police in future. I further note that the Victoria Police Manual has reintroduced the grounds on which OC Spray can be used [18]but note that the requirement for a verbal warning remains only in the training material. With respect to the latter, however, there is no evidence that Con Saunders was unaware of the requirement to give a warning.

108. I further note that it is already acknowledged by Victoria Police that the process of risk assessment is regarded as an area requiring considerable reinforcement and focus at the operational level. In addition, that junior members of police often don't think that they have time to plan and that there are difficulties with trying to impart this knowledge.[19]

109. Under section 67(3) of the Act, a coroner may also comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.

110. I have already noted that S/Cons Lee was in charge of the operation and admitted that she should have made sure that Jesse was looked after, which effectively allowed him to escape from custody. In addition, I note the concession made that the deployment of OC Spray could have been made with a warning for the benefit of police present.

111. With respect to the Use of Force Form, it is unclear how the relevant VPM was only made available to parties after the conclusion of the evidence and I find it surprising that no police members could make reference to it at the inquest. However, having reviewed the document, it is clear what should be captured by the form and whose responsibility it is for its completion. In those circumstances, I do not propose to make further comment on this matter.

---

so; Victoria Police to use the upcoming period as a valuable opportunity to gather data on the impact of changing to a more discriminating OC product and , ultimately that strong consideration should be given to reintroducing OC sprays to Victoria Police, if they become available on the market again; Victoria Police to clarify the policy around Use of Force Forms and ensure that it is implemented; that the Policy on Use of Force should be amended to require members to record any use of force against them in a Use of Force Form and that Use of Force Policy be amended to clarify which member is responsible for completing a Use of Force Form after an incident.

[18] 3.2 *Procedures and Guidelines - Operational Safety and Equipment* and

[19] Evidence of Hargeaves

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this finding be published on the internet.

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

- Mrs Faye Caulfield
- Mr John Caulfield
- Fitzroy Legal Service on behalf of relatives of the deceased
- Victorian Government Solicitors on behalf of the Chief Commissioner of Police
- Lander & Rogers on behalf of Constable Saunders, Senior Constable Lee, Constable Christensen and Constable Gurney
- Detective Leading Senior Constable Kyle Simpson, Investigating Member, Victoria Police

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: 8 May 2014