IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2004 003645

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: JASON KENNETH CHAPMAN

Delivered On:	20 September 2012
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	14th, 15th and 16th December 2009
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Representation:	Mr Neil McAteer appeared for Chief Commissioner of Police Mr Brian Dennis appeared for Sergeant Van Doren Mr John Goetz appeared for Senior Constables Andrew Ure and James Loader
Counsel Assisting the Coroner	Ms Anne Hassan O.P.P.

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of JASON KENNETH CHAPMAN

AND having held an inquest in relation to this death on 14th, 15th and 16th December 2009

at MELBOURNE

find that the identity of the deceased was JASON KENNETH CHAPMAN

born on 12 October 1973

and the death occurred on 13 October 2004

at 209 Francis Street, Yarraville, Victoria 3013

from:

1a. GUNSHOT WOUNDS TO CHEST

in the following circumstances:

INQUEST PROCESS

1. The Coroners Court is different from other courts as the proceedings are inquisitional rather than adversarial. In other words, there is no trial, with a prosecutor and a defendant. Instead, an inquiry seeks to find, as far as possible, the facts surrounding a person's death; to establish what happened rather than who is to blame. In order to do so, the coroner must contain the investigation and subsequent findings to those matters that fall within a description of being proximate to and connected to the death.

2. Jason Chapman was born in Auckland, New Zealand on the 12th October 1973, and was aged 31 years at the time of his death. He suffered from schizophrenia, which was diagnosed in his early teens and was a user of cannabis, which was thought to have possibly precipitated his mental illness. After leaving school he lived with friends in Auckland where he had a number of jobs, including being a baker, builder and cleaner. Mr Chapman was acknowledged as a good worker, enjoyed a good relationship with his family and had a reputation for being well mannered and respectful, although introverted. At the age of 21 he left Auckland

to travel around Australia, before eventually settling in Melbourne in around 2000. He was unable to find stable employment and was dependant on the Disability Support Pension. The Salvation Army found him residential premises at unit 3/209 Francis Street Yarraville, following an extensive period of homelessness and transitional accommodation.

3. Mr Chapman had ongoing mental health problems, which no doubt were exacerbated by his continued use of illicit drugs and frequent non-compliance with his antipsychotic medication, particularly when he felt well and felt that his symptoms were under control. In September 2003 when he attended the Saltwater Clinic, Mental Health Service, he said that his schizophrenia caused him to hear voices, even when on medication and that he also had persecutory ideas, believing people on television could see him and that they would talk about him in a derogatory manner. In addition, he engaged in a degree of self mutilation, with superficial cuts to the neck and arms as well as cutting the word "die" into his left arm. He reported thoughts of suicide, but not intent, and following periods of lowered mood, when acutely unwell, he underwent periods of hospitalization. Mr Chapman refused assistance to reduce or cease his drug and alcohol use, despite the availability of services to him, and was continued to be prescribed fortnightly injections of medication to control his schizophrenia. His erratic attendance for his depot medication varied from on time, to being up to 28 days late, with him previously not suffering any acute relapse, being most likely attributable to the long half-life of the medication. In September 2004, Mr Chapman's due dates for his depot injections were the 2nd, 16th and 30th, however, having attended on the 2nd, he failed to attend on the 16th. This resulted in follow-up by his case manager and on the 23rd, he attended at Werribee Mercy Mental Health where he was dispensed his last depot medication before his death, as he failed to attend on the 8th October despite attempts to get him to do so.

CIRCUMSTANCES LEADING TO JASON CHAPMAN'S DEATH

4. On the 13th October 2004, at approximately 2.15pm, Mr Chapman was observed standing on Francis Street Yarraville, yelling obscenities at drivers and telling them to get off the road. Francis Street is a busy carriageway that runs in an east

west direction, with provision for two lanes of traffic in each direction. The premises occupied by Mr Chapman, were located on the southern side of the road, approximately 100 metres west of the intersection of Francis Street and Williamstown Road and 18 metres east of Beda Street. Unit 3 is at the end of the 24 metre long driveway, which provides vehicle access to all three units on the block.

5. Shortly after 2.15pm, Athanasios Liordos and his four year old son drove into Francis Street from Williamstown Road. Mr Liordos observed Mr Chapman standing under a billboard on the southern side of the road, holding a large knife. As the vehicle moved slowly forward in completing the turn, Mr Chapman approached the car in an angry and threatening manner, wielding the knife around at the open passenger window and pointing it at the boy. Mr Liordos swerved his vehicle toward the centre of the road and accelerated off along Francis Street, resulting in Mr Chapman running after the car and throwing the knife in its direction. A similar pattern of behaviour involving other motorists continued and at 2.26pm, the unruly and threatening behaviour was reported to police by a Francis Street resident.

6. The first police vehicle arrived at the scene at 2.31pm, with the members being Senior Constable Andrew Ure and Constable Ashley Cormick. Senior Constable Ure observed Mr Chapman to exit his unit and to walk up the drive towards him, holding a knife and yelling obscenities. Mr Chapman, who was seen to be bleeding from the neck and to have blood on his hands, was directed to drop the knife, however, this direction was ignored as he commenced to run at Senior Constable Ure. The officer backed away and drew his firearm before issuing the order, "Police. Don't move", however, Mr Chapman did not respond. Both police members withdrew to a position beside their vehicle and used the bonnet as a buffer as threats to kill were made to them. At this point two civilians appeared and drew Mr Chapman's attention, which lead Senior Constable Ure to use his capsicum spray, although he doubted its effectiveness given the blustery weather conditions. On deploying the spray Mr Chapman was momentarily affected, as only a small amount of the spray made contact with his face, resulting in him stepping back and yelling *"Just shoot me, fuckin kill me"*.

Constable Cormick, who had the wind behind him, then deployed his spray with greater effect. Mr Chapman retreated back down the driveway and into his unit, giving the opportunity to Senior Constable Ure to radio for urgent assistance. This request was made at about 2.35, with the member stating "*…he's just come at us with a knife, he nearly got shot, however he has gone back inside the house…he was walking towards other people that were standing by as well, so I don't know what this guy is thinking at the moment…we're also out of spray as well so we haven't got any other resources at the moment.*"

7. At 2.38pm two further police units from Footscray arrived, followed almost immediately by Acting Sergeant Van Doren, also from Footscray, who was accompanied by Senior Constable Loader. Acting Sergeant Van Doren, equipped with a canister of capsicum foam, joined those members already present at the entrance to the driveway. Within a short time the units present in Francis Street were joined by a unit from Altona North and one from Williamstown, making a total of twelve police members present at the scene. Mr Chapman was observed to exit his premises, shirtless and not holding a knife, and to move up the drive towards the police at a quick walking pace. Stopping halfway up the driveway and whilst continuing to scream and yell aggressively, Senior Constable Ure questioned him as to the whereabouts of the knife, out of concern that it might have been secreted on him. Mr Chapman replied, *"You want a fuckin knife, I'll get a fuckin knife"* and ran back into the premises, before quickly reappearing carrying a large carving knife in his clenched right fist, raised at shoulder height and with the blade protruding. On running towards the police he was again challenged by Senior Constable Ure, directing him not to move and to put the knife down. With the direction being ignored, Acting Sergeant Van Doren began to deploy the capsicum foam aimed at the face and head area, however, Mr Chapman quickly turned and shielded his face with his free hand. Following this he ran back into his unit, leaving the police members standing on the footpath at the top of the driveway. Shortly thereafter, Mr Chapman again exited his premises carrying the knife, beating his chest with his hands and yelling "Come on, come on. How about now", while pointing the knife at the members. He was described as "…really pumped up and very aggressive', whilst police members, Loader and Ure, had their firearms pointing

at him, repeatedly yelling "Drop the knife, drop the knife." Mr Chapman taunted police by quickly moving towards them, waving the knife and saying "Have a go". In an attempt to control the situation, Acting Sergeant Van Doren once more deployed the capsicum foam, however, Mr Chapman was again able to quickly turn to avoid it impacting his face. As he repeatedly yelled, "Come on shoot me" and turned back toward Van Doren, a further spray of foam was deployed, yet again, it was avoided and was not effective in striking his face.

8. As Acting Sergeant Van Doren backed away to a position on the road between two divisional vans, he yelled out to police members to beware of crossfire, as at least two members had their firearms drawn. Both Senior Constables Loader and Ure had their firearms trained on Mr Chapman whilst he moved toward them and whilst they backed away, stopping before encroaching onto Francis Street through concern of stepping into oncoming traffic. There was a lot of yelling by police members and much "raving" by Mr Chapman, with it being observed that "He was holding the knife so tight that the knuckles were white and the veins in his arms were bulging". From a distance of about four metres away from both members, Mr Chapman quickly rushed towards them, with the knife raised higher and putting both in fear for their life. Police continued yelling "Police. Don't move", however, as the direction was ignored, Senior Constable Ure discharged his firearm, hitting Mr Chapman in the left side of the chest. Virtually at the same time, Senior Constable Loader discharged his firearm, followed by Ure discharging a further round. Mr Chapman dropped to a hunched position on the footpath about a metre beyond the driveway, with the knife falling from his hand. Initially he made attempts to raise himself up, ignoring directions to lie down, before collapsing and being secured. He was secured at this time, as police were not in a position to know the nature of the injury he had sustained. He was subsequently assisted by police whilst awaiting ambulance attendance, however, Mr Chapman died at the scene from his chest injuries.

9. Later in the day a post mortem examination was performed by Forensic Pathologist, Dr David Ranson, who found that Mr Chapman died from gunshot injuries to the chest. Dr Ranson detailed three gunshot injuries, although the

order in which they are described, does not necessarily correspond to the order in which they were received. Dr Ranson's findings of injuries sustained were:

- A gunshot wound that passed through the right lower leg adjacent to the ankle, with the bullet exiting and entering the inner aspect of the lower left leg where it lodged.
- A gunshot wound to the left chest, with the projectile crossing behind the spinal column and lodging under the skin.
- A gunshot wound to the right side of the chest, with the projectile exiting the body over the middle back of the chest.

10. In addition, Dr Ranson detailed a series of superficial incised wounds to the neck, the upper chest, upper abdomen, left forearm and upper arm, together with multiple bruising and abrasions to the upper body, head and both upper and lower limbs. The incised wounds were said to be very fresh and of a distribution pattern that are seen when an individual self inflicts such injuries. Dr Ranson further stated that toxicological examination of body fluids revealed the presence of tetrahydrocannabinol (cannabis) at a level highly suggestive of recent use.

11. Forensic examination of the police issue Smith and Wesson firearms revealed that two rounds had been discharged from Senior Constable Ure's gun and a single round from Senior Constable Loader's gun. Further examination of the two bullets recovered from Mr Chapman's body and a third recovered from the scene, revealed that it was Senior Constable Ure who fired the two shots that penetrated the chest. Examination of the two knives located at the scene, one in the vicinity of the intersection of Beda Street and Francis Street, the other in close proximity to the deceased, revealed Mr Chapman's blood on the blade of the former and capsicum spray residue on the latter.

12. The evidence satisfies me that Senior Constable Ure caused the death of Jason Chapman by shooting him in the chest. The shooting occurred in a setting of Senior Constables Ure and Loader being under immediate threat of injury by Mr Chapman, who at the time was armed with a 34cm carving knife.

INQUEST HEARING

13. The inquest focused on three principle issues:

    i) Whether there was effective and coherent management of the site of the incident;

    ii) Police dealing with the mentally impaired and

    iii) The effectiveness of capsicum spray and capsicum foam.

14. Before addressing these issues it is appropriate to acknowledge the difficult and violent situations police members are often confronted with. In this case there was a need for an immediate response without the benefit of time to plan ahead and hence, caution has to be exercised when assessing the appropriateness of actions undertaken. The speed in which the incident unfolded is clear from the chronology of events recorded by Police Communications, with it being approximately 11 minutes from police arrival to the shooting of Mr Chapman. As the circumstances clearly show, police were confronted with an unplanned dynamic operation, that required to be turned into a planned one, and with minimal time to do so. All members involved in the incident had attended the Victoria Police Operational Safety and Tactics Training program (OSTT) and were OSTT qualified. The four major components of the program being:

    a. Conflict Resolution;

    b. Defensive Tactics;

    c. Firearms training and

    d. Scenario Training.

MANAGEMENT OF THE SITE

15. In respect to this issue, counsel assisting submitted that:

a) There was no co-ordinated or considered attempt to control traffic nor pedestrian access in circumstances;

- Where the safety of the public was potentially at risk from the events unfolding
- Where the safety of police members was at risk and
- Where police members' ability to control and deal with Mr Chapman and potentially de-escalate the situation was compromised because the effectiveness of any 'inner cordon' that was established, was highly dependent on traffic management.

b) No one assumed overall control or management of the police members present.

16. The evidence fails to satisfy me that enough was done to protect the public and police by attempting to establish an inner perimeter of containment. This calls into question what, if any, risk assessment was undertaken and by whom. The evidence is that Senior Constable Ure turned his mind to containment and when back-up units Footscray 307 and 308 arrived, approximately seven minutes later, he directed the members to adjacent Bena Street and the laneway on the eastern side of the premises, respectively. Whilst this was clearly aimed at containment and cordon, the focus would have been better directed to preventing traffic and pedestrian movement in Francis Street. It was in Francis Street and at the front of his premises where Mr Chapman had been acting in a threatening manner, with there being no indication of him wishing to avoid police confrontation by fleeing from the scene. On the contrary, he was seeking confrontation by aggressively engaging the members at the front of the premises. The higher priority should have been to cordon off Francis Street at the first opportunity, with this being at the time the Footscray back up units arrived. In addition, it did not occur following the arrival of Footscray 251. Cordoning and containing an area is a key Operational Safety Principle and plays a crucial role in limiting the dangers posed to the individual who is armed, officers who are attempting to resolve the situation and members of the public. The failure to prevent pedestrian and vehicle access had the potential not only to

put the public and police at risk, but to be a likely distraction for Mr Chapman, when his attention was needed whilst communicating with him in an attempt to gain compliance. Whilst the failure to isolate and contain was a serious flaw in managing this incident, it cannot be concluded however, that had it been managed differently the tragic outcome would have been prevented.

17. Criticism has been levelled at Acting Sergeant Jason Van Doren, as the senior police member, for not assuming overall control of the responding members. It was suggested that this would have prevented members acting on their own volition, in an individualistic rather than collective or co-ordinated manner. In assessing the merits of this criticism, the evidence of Acting Sergeant Van Doren's involvement needs to be examined.

    a) Acting Sergeant Van Doren had been at the scene for less than 3 minutes before the shooting took place;

    b) At the time he arrived there were a total of eight police present, 4 of whom had arrived 45 seconds before he did;

    c) In the time between arrival and the shooting, the following events occurred:

        i) Acting Sergeant Van Doren radioed D24 that he and Senior Constable Loader had arrived at the scene;

        ii) At the time of his arrival, he observed only two members, one of whom was Senior Constable Ure. They were standing on the footpath and Senior Constable Ure had his firearm pointing to the ground. Acting Sergeant Van Doren concluded that the other members had gone to the rear of the unit;

        iii) D24 broadcast the details of Mr Chapman's antecedents to all units;

        iv) Acting Sergeant Van Doren and Senior Constable Loader approached Senior Constable Ure who briefed Acting Sergeant Van Doren about the situation;

v) Acting Sergeant Van Doren told members they should get their ballistic vests;

vi) Footscray 308 advised D24 that "... a blokes coming with a knife";

vii) D24 advised all members at Francis Street to move back because a male was coming at Footscray 308 with a knife;

viii) Acting Sergeant Van Doren responded to the radio instruction from D24 by issuing an instruction:"All other members hold your positions thanks" and telling D24 that "Footscray 251 got the (capsicum foam) out, we're sorting it out now";

ix) Acting Sergeant Van Doren, carrying the foam canister, and Senior Constable Loader approached the crew of Footscray 308 and discussed the possible identity of the person armed with the knife. It is not clear, however, whether this may have been a critical briefing about the subject in order to assess the risk, in particular, whether the male might have been armed with a firearm.

x) Approximately 15 seconds after Acting Sergeant Van Doren arrived at the top of the driveway, Mr Chapman come from his unit, walking quickly towards the Acting Sergeant who sprayed him with the foam for one or two seconds, causing him to retreat back to his unit;

xi) Within 5 to 10 seconds, Mr Chapman returned to the doorway with a large carving knife and walked to within 5 to 6 metres of the footpath, waving the knife and challenging the members;

xii) Acting Sergeant Van Doren then sprayed Mr Chapman again for 1 to 2 seconds without effect, and returned to behind the police vehicle, yelling to Constables Ure and Loader to be aware of potential crossfire;

xiii) Mr Chapman quickly rushed toward Senior Constables Ure and Loader with the knife in front of him in a half outstretched arm and Senior

Constable Ure shot him in the left side of the chest, followed by Senior Constable Loader discharging his weapon, also hitting Mr Chapman.

18. I am not satisfied there is a basis for criticism of Acting Sergeant Van Doren's role in this incident, given the rapidity in which the events unfolded in the short period of time in which he was present. Acting Sergeant Van Doren had limited opportunity to orientate himself to the scene before his engagement with Mr Chapman. This involved the use of capsicum foam, with the evidence satisfying me that it was appropriate for the foam to be deployed at the earliest opportunity in an attempt to incapacitate Mr Chapman. Acting Sergeant Van Doren was the only member present who was authorized to use capsicum foam, as Victoria Police policy, as it existed in 2004, mandated that only Sergeants were so authorized. This policy has since been changed, no doubt in recognition of the fact that by drawing a Sergeant into direct confrontation with the subject, deprived him of the opportunity to remain apart to take effective overall command and give direction.

POLICE DEALING WITH THE MENTALLY IMPAIRED

19. No police member at the scene contacted the Critical Incident Response Team, (CIRT) a specialist response unit developed six months earlier to support general divisional units in circumstances involving the reportedly mentally impaired and drug affected. The response as to why this had not occurred is unsatisfactory, with it being suggested that police members at that time, may not have been aware of the unit's existence. If this is accurate, it does not instil confidence in the adequacy of communication and or training programmes. However, had a request for attendance been made, it is speculative as to whether the unit could have responded in time, or if they did, whether their attendance would have changed the outcome.

20. As part of the OSTT course, the members present had been trained in conflict resolution, which involved verbal communications and incident management techniques. The circumstances of the incident highlights the difficulty confronting police in attempting to identify the behavioural issues of a person suffering from mental illness. Evidence was given that experience had shown

that a firm instruction to someone in an altered state of mind may be sufficient to "snap them out" of that state. Whilst this may well be the case, it is appropriate to consider how that firm instruction should be delivered. In this incident, numerous members were repeatedly yelling at Mr Chapman, which raises concern as to the impact this would have had, given his already agitated state. It is entirely conceivable that the effect would have been to arouse within him, a state of heightened agitation. Whilst there is no doubt that firm instructions need to be conveyed, there may be more merit in them being delivered by one member only, hopefully with the effect of focusing the subject's attention to the commands being given. Gaining the full attention of the subject should be paramount and I believe this is more likely achieved on a one to one basis, as attention will be lost in a more confused setting.

21. The OSTT course has been replaced by a new training program known as Tactics and Safety Training (TST), significantly increasing the amount of training time devoted to conflict resolution and mental health issues. A substantial part of the TST program is devoted to identifying the behaviours of persons suffering from mental illness, or exhibiting other behavioural issues and identifying strategies for managing them. The primary focus of the training is on the resolution of incidents through communication and to educate members as to when and how to recognise that a particular tactic is not working and to try a different approach..

EFFECTIVENESS OF CAPSICUM SPRAY AND CAPSICUM FOAM

22. The evidence reveals that the oleoresin capsicum (OC) spray deployed by police members was not effective, and neither was the oleoresin capsicum foam deployed by Acting Sergeant Van Doren. It is unclear as to whether this was simply due to Mr Chapman turning away, or whether it was weather related, as the conditions were blustery, or whether Mr Chapman was a person on whom the spray/foam had little effect. The inquest heard that the spray used by Victoria Police has no effect at all on approximately 5% of people and in relation to the foam that they use, the percentage is approximately 10%. The spray has a minimal effect on approximately 55% of people, with the foam having a similar effect on approximately 50%. The desired effect is achieved on

approximately 40 - 45% of individuals against whom the products are deployed. Whilst the spray is very heavily affected by breeze and wind, the foam is less so, however, it has a lesser range than the spray's maximum of 3 metres. In addition, individuals who are mentally unwell, or highly agitated, have the capacity not to feel pain when self inflicting injuries, such as cutting themselves, and accordingly, it is believed they don't feel the pain associated with oleoresin capsicum. It is understood that the various limitations of both spray and foam are well known to police members. What is of concern in this incident, is that members appeared to be unprepared when the spray and foam proved ineffective. Nevertheless, the chemical agent remains a useful tool to subdue and control combative or violent subjects in many instances.

ISSUES RAISED BY FAMILY

23. Following completion of the evidence a copy of the court documentation was requested by Mr Chapman's family, as they had questions to which they wanted answers. The documentation, including the transcript, was sent to New Zealand where they reside. The court received correspondence from the family on the 11th September 2012, raising a number of concerns that require answering.

24. Of primary concern: "Why did the police send him back to get the knife to only shoot him when he was armed? When they first confronted him he was unarmed." In response to this question, the evidence indicates that Mr Chapman was armed with a knife when he left his unit shortly after police arrived. After running at one of the members and being OC sprayed, he retreated back into his unit only to return shortly thereafter not holding a knife. Police should not be criticized for asking as to the whereabouts of the knife. They had been called to the scene following a report of an unruly male armed with a knife and on attending, witnessed him acting in a threatening and abusive manner towards them, carrying a knife. Despite him being shirtless and not holding a knife on returning outside, I am satisfied it was appropriate to question its whereabouts. Police would be fully aware of the possibility of a knife being secreted in a front or rear track pants pocket, in the waist band at the rear of his pants, or in a sock under his track pants leg.

25. Further concerns and allegations raised:

- Why was the area not contained and secured, with Operational Safety Principles being followed and the emergency response team (CIRT) called?
- The incident was escalated by the aggressive behaviour of inexperienced officers with there appearing to be no effort to de-escalate the incident, "...only a show of male testosterone and aggression".
- Why were the two members who shot Mr Chapman excused from giving evidence? Their failure to want to give evidence leaves the family with the feeling that they have something to hide. "There appears to be conflicting descriptions of separation distance between Jason and the officers".

26. The concerns raised in point one, have been addressed in paragraphs 15 and 18.

27. The evidence does not support the allegation made by the family in point two. The police account of what occurred is not contradicted and their assertive commands in an attempt to gain compliance, should not be misinterpreted. Support for the appropriateness of their actions can be found in the observation of an independent witness, Larry Simmons: "I was impressed with the way the police conducted themselves in their formation and professionalism. They were trying to subdue him verbally and contain the situation". (Statement dated 9 November, 2004.)

28. With respect to the third point, counsel appearing on behalf of the police members made application under the provisions of the Coroners Act to have the witnesses excused. This is their legal right and as I believed from the circumstances of the case; from the nature of the evidence they would be called to give, that there was reasonable ground to apprehend a risk of proceedings against them. According, I excused them from giving evidence as a matter of law. It is not appropriate for the family to conclude that the application not to give evidence is indicative of the members having something to hide. The application I would assume was made on legal advice, with it often being the case that the members would prefer it to be otherwise. In regard to the discrepancy in evidence, it would be wrong for the family to rely on that in

order to impugn the veracity of the witnesses. In any dynamic and volatile incident, discrepancies in evidence are inevitable. Of greater concern would be the absence of discrepancies, giving rise to the possibility of collusion.

29. Family appropriately questioned whether a statement had been obtained from Mr Chapman's case worker at the Flagstaff Outreach programme. Police had not requested a statement and on reviewing the inquest brief, I did not require it. This is because a statement was obtained from Ms Sue Thompson, the case worker's (Leslie Behnam) supervisor. Mr Chapman had a number of case workers when a client of the service, including Ms Thompson, who had remained in contact with him. In her supervisor capacity she was aware of his accommodation issues and ongoing mental health problems, and was in a position to give an overview of his management. In regard to his mental well being, statements were also obtained from his Consultant Psychiatrist, his General Practitioner and a Psychiatric nurse, all addressing his history of schizophrenia and poly substance abuse. In addition statements were obtained from friends. In these circumstances I did not believe a further statement was necessary. As to the family saying that had a statement been obtained from the case worker, "Maybe she would have blown there (sic) suicide theory", I do not view this incident as being one of "suicide by cop".

30. The family believe that the use of pepper spray was wrong as "Jason would never back away from confrontation and he would have seen its use as police attacking him". However, while this may well be true, the police members were not in a position to have that understanding at the time of deploying the chemical in an attempt to subdue and control him.

31. Family questioned the ambulance response time with the evidence satisfying me that the response was within an acceptable time frame. Police Communications' records indicate they were notified of the shooting at 14:42:31. The communication centre notified Melbourne Ambulance Service at 14:42:37. The Footscray Mobile Intensive Care Ambulance (MICA) record indicates their request was received at 14:43 and that they arrived at the scene at 14:49. A back- up unit from Altona received a request at 14:46 and arrived at the scene at 14:50.

32. In their correspondence to the court, the family write of their distress in learning of Mr Chapman's death from a television news report in which his name was released. Clearly this would have been a traumatic experience with the suffering it caused being understandable. It is incumbent on the police, who are responsible for conveying the death message, to ensure as far as is possible, that next of kin are notified before the name is released to the media. As this is not a matter for coronial investigation, I am not privy to what knowledge the police had as to the identity of next of kin, their location, or what opportunity was available to them to make contact with the family.

33. The family question the appropriateness of the police member aiming at the chest, when shooting at Mr Chapman, suggesting it would have been more appropriate to shoot to wound, not to kill. However, police training is to permanently disable and regrettably, this requires shooting to kill. I do not propose to recommend otherwise and accept that the police are in the best position to evaluate the need for this practice. By way of observation, however, it is clear that a person who is merely wounded may retain the capacity to inflict a serious or fatal injury, by thrusting with or throwing a knife. Police are not trained to physically attempt to disarm. I am not satisfied that training in unarmed combat and its application, an issue the family raise, is a plausible means of attempting to disarm an aggressive and mentally unstable assailant, wielding an edged weapon.

34. A further concern raised by the family is the issue of '...police investigating police'. In addition, they stated, "It would appear the police don't think the officers concerned have done anything wrong as they have subsequently been promoted, or had there acting ranks confirmed into full roles". This is an issue that is frequently raised in circumstances involving police contact deaths, including deaths in custody, police shootings and police pursuits. However, there is no other investigative body with the skills to undertake the task. The family need to be mindful of the fact that the investigation is undertaken by the Homicide Squad, overseen by Ethical Standards and the Office of Police Integrity. The deaths are then the subject of coronial investigation in a public forum by way of a mandatory inquest.

35. The family enquire whether the 2005 "Review of fatal shootings by Victoria Police" was made available to me, as its author, Mr Brouwer, Director of the Officer of Police Integrity, was critical of the police handling of the Chapman case. The report was referred to during the course of the inquest and I have read it. Whilst I share some of the criticisms raised by Mr Brouwer, I do not share them all. I am not as critical as he was of the actions of Acting Sergeant Van Doren, with my findings in that regard being based on the material comprising the inquest brief and evidence given and tested through the inquest process.

COMMENTS

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

36. Cordon and containment tactics feature prominently in incidents that culminate in police shootings. This makes it particularly important that the policies, procedures and training underpinning Victoria Police cordon and containment tactics are based on best practice. Additionally, Victoria Police must ensure these tactics are properly executed in the field.

37. It is essential that Victoria Police continually review their training, policies and procedures in order to keep up with what appears to be an increased prevalence of edged weapons being used by people with symptoms of mental disorder. Methods of approach and challenge need input from mental health professionals and from those with negotiating expertise. I understand that training now focuses on educating members as to when and how to recognise that a particular tactic is not working and to try a different approach. This is essential in the management of individuals who are armed and ignoring police instructions, in a setting of indifference as to whether they are shot or not.

RECOMMENDATIONS

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

Recommendation 1: Victoria Police review the practice of challenging people with symptoms of mental disorder and consider alternative methods that may reduce the likelihood of weapon discharge.

Recommendation 2: Victoria Police review training practice in mental health awareness to ensure that emphasis is placed on the recognition of irrational behaviour and its possible causes and that this recognition be used in the development of tactics for the management of the incident.

Recommendation 3: Victoria Police review their policies, procedures and training underpinning cordon and containment practices.

Recommendation 4: Victoria police review their policy and procedures for the deployment of CIRT negotiators.

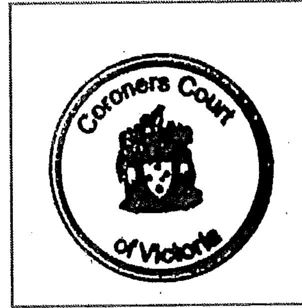
Recommendation 5: Victoria Police give consideration to the immediate deployment of an appropriately trained police dog and trainer, at the time their communications centre is alerted to an event involving an assailant armed with a weapon.

Recommendation 6: Victoria Police review their policy and procedure for delivery of a 'death message' to family.

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

- The family of Jason Chapman
- Chief Commissioner of Police
- Acting Sergeant Van Doren
- Senior Constable Andrew Ure
- Senior Constable James Loader

Signature:



IAIN WEST

DEPUTY STATE CORONER

Date: 20th September 2012