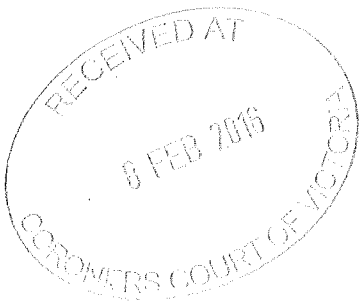
IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE



Court Reference: COR 2010 4818

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PENELOPE PRATT

Delivered On:	5 February 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh St, Southbank
Hearing Dates:	10 December 2015
Findings of:	JUDGE IAN L. GRAY
Representation:	MS ERIN GARDNER, instructed by VGSO for the Chief Commissioner of Police MR PAUL LAWRIE, instructed by Fatmir Badali for Emergency Services Telecommunications Authority
Counsel Assisting the Coroner	MS JESSICA WILBY, Principal In-House Solicitor

I, JUDGE IAN L. GRAY, having investigated the death of PENELOPE PRATT

AND having held an inquest in relation to this death on 10 December 2015
at the Coroners Court, Melbourne
find that the identity of the deceased was PENELOPE LOUISE PRATT
born on 3 May 1983
and the death occurred on 28 November 2010
at 54B Dorset Road, Boronia, Victoria
from:

1 (a) MULTIPLE GUNSHOT INJURIES WITH A STAB INJURY TO THE HEART

in the following circumstances:

1. Ms Penelope Louise Pratt (referred to in my finding as Penny) was the daughter of Julie and Douglas Pratt. Penny was the middle child of five children. Penny's parents separated when she was 11 months old, and she remained living with her mother.

2. Penny had dyslexia and a learning disability which affected her education. Shortly after she commenced at Croydon Secondary College her life began to take a downward turn and Penny commenced smoking cannabis and progressed to using other illicit drugs, including heroin.

3. Throughout her teenage years Penny experienced mental health problems and received ongoing psychiatric care.

4. Penny had two children during her young adult years, a daughter Tahlia and a son, Riley. Tahlia was six and Riley was three at the time of Penny's death. Penny did not have custody of either of her children.

5. In late 2009 Penny inherited approximately $92,000 following her father's death. Penny's mother stated that Penny was irresponsible with the inheritance and spent it all.

6. In June 2010 Penny's partner, Alan Hobson, died as a result of a drug overdose.

7. Penny had a history of illicit drug use and convictions for street offences and in the months leading up to her death she was associating with James Potter and Aaron Gibson, known amphetamines users.[1] Both James Potter and Aaron Gibson had been seen regularly at Penny's unit in Boronia, by Penny's neighbours and friends and in the week prior to Penny's death Aaron Gibson stayed at Penny's unit.[2]

[1] Summary of circumstances, p 15 of brief
[2] Statement of Angel Egginton, p 161 of brief

8. Penny was murdered by James Potter and Aaron Gibson following a dispute over a drug debt. Penny was 27 years old.

9. Just prior to her death Penny made two calls to 000 seeking assistance.

Purposes of the Coronial Investigation

10. The purpose of a coronial investigation into a reportable death[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[4] In the context of a coronial investigation it is the medical cause of death together with the context of background and the surrounding circumstances of death, which are proximate and causally relevant to the death. An investigation is conducted pursuant to the *Coroners Act 2008* (the Act).

11. Coroners are empowered to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice and to make recommendations to any Minister, public statutory body 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 generally referred to as the prevention role.

12. A coroner's findings made on the factual matters are to the requisite standard of proof, the balance of probabilities.[6]

13. The circumstances of Penny's death have been the subject of investigation by Victoria Police on behalf of the Coroner.

14. It was evident that most of the facts about Penny's death were clear including her identity, the medical cause of her death and aspects of the circumstances, including the place and time of her death.

15. After considering all of the material contained within the coronial brief I determined further material was required and it was also necessary to conduct an inquest to assist me in the investigation of Penny's death.

16. This finding is based on the entirety of the investigation material including the file, coronial brief of evidence and the statements and evidence of those witnesses who appeared at the inquest.

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[3] Section 4 of the *Coroners Act 2008* requires certain deaths to be reported to the coroner including all deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury.
[4] Section 67(1) of the *Coroners Act 2008*
[5] Sections 72(1), 72(2) and 67(3) of the Act
[6] As per the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336

Events of 28 November 2010

17. On 28 November 2010, Penny called '000' at approximately 3:29am and 3:41am and requested the attendance of a Crisis Assessment Team (CAT) team as it was the 6 month anniversary of her de facto's death, and she was depressed as a result.

18. At approximately 5:15am an ambulance took Penny to the Maroondah Hospital. Penny, who was expressing grief with respect to her father and former partner, was transferred to the psychiatric ward and it was decided that a brief voluntary admission was suitable.

19. A friend of Penny's, Angel Egginton, visited Penny at the hospital at 7:30pm and Penny indicated to her that she intended to stay overnight.

20. At approximately 10:10pm Aaron Gibson and James Potter went to Penny's unit in Boronia. Finding she wasn't home they spoke to Penny's neighbour and friend, Mr Graham Flannery, saying that they had some money for her. Mr Flannery told them that Penny was at Maroondah Hospital.[7] Mr Flannery then phoned Penny at the hospital and told her that Aaron Gibson and James Potter had money for her.

21. At approximately 10:45pm Aaron Gibson and James Potter attended the Maroondah Hospital.

22. James Potter spoke to the receptionist, who told him that he should not be there as the doors were locked at 10:00pm. James Potter asked to see 'his sister' in a demanding way. As James Potter was swearing and being forceful the receptionist called security, with two security guards attending. The security guards told them they were not allowed into the hospital and asked them to leave.

23. One of the security guards then called Penny's number and told her that her brother was there with some clothes for her and passed the phone to James Potter, who spoke to Penny on the phone in affectionate terms. Penny then asked to leave the hospital.

24. At approximately 11:00pm a medical practitioner assessed Penny and due to her agitation and expressed desire to leave, she was discharged at 11:15pm.[8]

25. Penny was then driven by Aaron Gibson and James Potter to the residence of James Potter's girlfriend, Bianca Clarkson where James Potter resided. Shortly after they arrived at the residence, located at 54B Dorset Road, Boronia, Adrian Krelekamp also arrived at the house.[9]

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[7] Statement of Graham Flannery, p 224 of brief
[8] Statement of Dr Cai, p 244 of brief
[9] Summary, p 17

26. Just before he arrived at the unit, Adrian Krelekamp saw Penny walking on Dorset Road near Alma Avenue.[10]

Calls to 000

27. Penny made two calls to 000 seeking assistance that evening, one at 11:21pm and another at 11:28pm.

28. At 11:21pm Penny rang 000 and said she had been picked up from the Maroondah Hospital, that 'they're drink driving', that she wanted to go back to the hospital and that she would 'cop a beating.'

29. During the call Penny identified two different intersecting roads but the operator could not establish exactly where Penny was calling from. Penny was walking, it is unclear where she was and she said she has just left the hospital. The call-taker tried to engage with Penny who said she 'just wants her money.' Penny then said that she was 'fucking dealing with this' and hung up.

30. At 11:28pm Penny rang 000 again, was asked where she needed police and gave a location as 2 Alma Avenue, Boronia. Penny said there were two people police would want to arrest, told the call-taker that she wanted her money, that they just picked her up and to get to the address. She identified James Potter (or Mendes) and indicated she was hiding in a bush and was going to get bashed and that there were three violent offenders.

31. The call-taker attempted to get Penny to answer her questions about sending the police but Penny became angry, called the call-taker a bitch and the call was terminated.

32. Local police were not notified of either of the calls.[11]

33. Penny then became involved in a verbal argument with Aaron Gibson outside the unit and Adrian Krelekamp, at the direction of James Potter, told them both to come inside.

34. While in the living room Penny became involved in an argument with James Potter about the money he owed her, and asked "*How long do you want me to wait for my money...?*"[12]

35. James Potter told her not to worry about it, but Penny became more agitated, yelling at him.

During the argument Aaron Gibson grabbed Penny's hair, took out a .22 calibre sawn off rifle and shot Penny in the jaw.

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[10] Statement of Adrian Krelekamp, p 266 of brief
[11] Summary, p 19
[12] Statement of Adrian Krelekamp, p 266 of brief

36. Penny was pleading with them, telling them they didn't need to do that before Aaron Gibson moved her to a chair, raised the firearm to the left side of Penny's head and fired a further shot.

37. Aaron Gibson and James Potter then dragged Penny into the bathroom of the unit. James Potter grabbed the firearm and fired a further shot into Penny's right eye. Aaron Gibson then told James Potter to finish the job so he got a large kitchen knife and stabbed Penny several times in the chest before cutting her throat.

38. A short time later Aaron Gibson removed an angle grinder from his backpack, entered the bathroom and started cutting at Penny's head before the angle grinder became entangled in her hair and broke.

39. Penny was then wrapped in the living room rug, placed in the boot of Adrian Krelekamp's car. They took her to the Dandenong Ranges National Park and dumped her body in bushland.

Police investigation

40. On 1 December 2010 Mrs Julie Pratt reported her daughter missing and police established the last time she had been seen was at Maroondah Hospital. On that same day police spoke with James Potter, who denied having seen her.

41. On 13 December 2010 police spoke with Aaron Gibson, who admitted attending Maroondah Hospital with James Potter.[13] Between 15 and 17 December 2010 Homicide Squad members conducted further enquiries and executed search warrants at four addresses.

42. During an interview with police on 19 December 2010 Adrian Krelekamp disclosed the events surrounding Penny's death[14] and directed police to Silvan Road, Olinda, where Penny's body was located.

Forensic Pathology

43. On 19 December 2010 Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem examination that revealed three gun-shot wounds to Penny's head. Dr Burke determined that the cause of death was multiple gunshot injuries in a woman with a stab injury to the heart.

44. Due to the advanced state of decomposition of Penny's body, Dr Burke was unable to ascertain whether there was an incised injury to Penny's neck.

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[13] Statement of Knox CIU member Kellie Graham
[14] Transcript of interview, Exhibit 178, p 800 of brief

45. The linear defect to the skull was consistent with an injury inflicted by an angle grinder and Dr Burke located a piece of fragmented angle grinder disc matted within the hair at the front of Penny's head.

46. Dr Burke was unable to ascertain the order in which the injuries had been inflicted.

47. A toxicological analysis showed the presence of Quetiapine, an antidepressant, within Penny's liver.

Charging and sentencing

48. As a result of the police investigation into Penny's death, Aaron Gibson and James Potter were both charged with Murder.

49. Aaron Gibson was 31 years old at the time of the offence, James Potter was 24.

50. Both had a history of drug taking and regularly used amphetamine together. In the months before Penny's murder both had been seen, sometimes drug affected, at Penny's residence and Aaron Gibson stayed there for a number of days up until 25 November 2010 when Penny asked him to leave.[15]

51. Aaron Gibson plead guilty on 24 October 2011 to Penny's murder and was sentenced on 24 August 2012 to 22 years imprisonment, with a fixed non-parole period of 19 years.

52. Justice Williams was satisfied that Aaron Gibson was under the influence of drugs at the time of the offence.

53. Aaron Gibson told a forensic psychologist that he had obtained the gun several weeks before Penny's murder as protection and that he had no reason for shooting Penny other than feeling distressed and confused about the fact that Penny and James Potter were arguing about a small amount of money allegedly owed to Penny by him. Aaron Gibson said that he had no conflict with Penny.

54. Justice Williams concluded that an aggravating feature of Aaron Gibson's offending was that he was complicit in James Potter's actions in disposing of Penny's body after he shot her and that he encouraged James Potter to keep going and 'finish the job'.

55. Justice Williams noted that Aaron Gibson had reached the age of 33 with no criminal records or history of violent behaviour.

56. James Potter was sentenced on 30 October 2012 to 24 years imprisonment, with a non – parole period of 20 years.

[15] DPP v Gibson [2012] VSC 363

57. Justice Almond accepted that he should not be sentenced on the basis that at the time Penny was picked up from the hospital there was an understanding or agreement in place between Aaron Gibson and James Potter for the offence to be carried out, and that James Potter's complicity occurred at least by the second gun shot, with the aggravating features occurring after that point.

58. James Potter expressed no remorse and took no responsibility for his actions.

59. Justice Almond noted that James Potter was the driving force in relation to the disposal of Penny's body, leaving it unprotected in an open well away from the road so that it would not be readily discovered, reflecting a callous disregard for Penny and her family and a high degree of moral culpability.

60. James Potter had a prior criminal history. In 2008 at age 22 he was convicted of theft, theft of a motor vehicle and common law assault and in 2009 he was convicted of robbery, contravention of an intervention order and failure to answer bail. [16]

61. The sentencing remarks in respect to Aaron Gibson and James Potter require no further elaboration

62. James Potter applied for leave to appeal his conviction, which was dismissed in October 2013.

63. Adrian Krelekamp, 48, was initially charged as an accessory after the fact to murder. As Adrian Krelekamp's evidence was central to the prosecution case he was given immunity on the undertaking that he give evidence.[17]

64. A criminal brief of evidence was compiled by Detective Sergeant Jason Poulton and the coronial investigation was conducted by Detective Sergeant Poulton on my behalf. He prepared a comprehensive coronial brief. During my investigation, it was determined that more information was required about the 000 calls Penny made and that information was obtained.

Police communications – the Standard Operating Procedures (SOPs)

65. Information was sought from the Police Sergeant (Sergeant Chris Morrison) who dealt with the first call from Penny, and from Inspector Peter Ferguson from Police Communications (PC) D24, the local area Commander. Insp. Ferguson is responsible for Victoria Police operational communications including emergency calls state wide.

[16] R v Potter [2012] VSC 511 para 66
[17] Potter v The Queen [2012] VSCA 291

66. Inspector Ferguson gave evidence of the Standard Operating Procedures (SOP) which were applicable in November 2010, and which set out Victoria Police requirements for ESTA operations. CSOPS001 (Call-taking) and CSOPS002 (Radio Communications and Dispatching) set out the obligations of ESTA staff when answering emergency calls, dispatching events and radio communications.

67. CSOPS10 and above are applicable to PC D24 staff performing duty and CSOP 32 sets out the requirements for a Sergeant at PC D24 performing Police Communications Liaison Officer (PCLO) duty.

68. All of these procedures are published on the Victoria Police Intranet and all ESTA and police staff are expected to comply with them in the delivery of service or police duty. The key point is that all emergency call taking and event dispatch are provided to Victoria Police by ESTA.

The sequence of events within Police communications

69. The first call that Penny made at 11:21pm lasted approximately three minutes and was answered by ESTA[18] call-taker 1. The second call made at 11:28pm lasted approximately two minutes and was answered by ESTA call-taker 2.

The First Call

70. CAD Event P1011093346 (the first call) was created at 11:27pm on 28 November 2010 and was created as event code 573 Emergency – Welfare Check and dispatched assigned to the PCLO, Sergeant Morrison, at 11:28pm via the 'ZZZ' dispatch group.

71. The event (P1011093346) contained information received by the call taker from the caller. The Caller Line Identification (CLI) was identified as Penny Pratt of 3/372 Dorset Rd, Boronia.

72. The event body description of the conversation contained the following:

> *Caller Yelling*
>
> *Saying something about being taken to Hosp*
>
> *Also ranting about Drink Driving*
>
> ****S.C.T Used****
>
> *Caller kept saying Alma Rd Boronia – then said near Dorset Rd – CHU before confirmed.*[19]

[18] Emergency Services Telecommunications Authority
[19] Statement of Inspector Chris Morrison, dated 11 September 2014

73. Inspector Ferguson examined the Penny Pratt communications and his outline of the audio recording of the first call at 11:21pm is:

- The female caller is somewhat incoherent and varying between yelling and calm speech and appears to be possibly under the influence of drugs, medication or alcohol.
- There is significant difficulty in identifying the location and was is happening although by the end of the call a location of Alma Ave and Dorset Rd is evident.
- The caller rambles about drink driving and hospitals.
- There is background noise which sounds like vehicles passing.
- The caller identified herself as Penny Pratt.
- The call is terminated by the caller.

74. Sergeant Morrison understood that the caller was referring to a drink driving incident and that someone was going to hospital. As there was not enough information about the current location of the caller Sergeant Morrison then called the mobile phone to see if there was further information he could gain, and to see if police were required to attend at a particular address or whether the caller was travelling in a car.

75. Sergeant Morrison called the number back at 11.28pm. It was engaged and so he left the event open for a few minutes. At 11:36pm Sergeant Morrison proceeded to close the event as he saw that Penny's mobile phone had called police '000' again at 11:32pm. The event was closed at 11:36pm by Sergeant Morrison marked as 'Cancelled Event'.[20]

<u>The Second Call</u>

76. CAD Event P1011093354 was created at 11:32pm on 28 November 2010 in response to the second call Penny made.

77. The caller was recorded as Penny Pratt with a location of 2 Alma Avenue, Ferntree Gully. The event was created as event code 718 – 'Police Non Response Call' and closed as an 'assigned event' by the ESTA call taker, meaning no advice occurs to police in the field or at PC D24.

78. Inspector Ferguson's outline of the audio recording of the second call is as follows:

- The female caller requests police at 2 Alma Ave, Boronia and the call-taker clarifies the location as Ferntree Gully.

[20] Statement of Inspector Ferguson dated 16 September 2014

- The caller is initially coherent however when questioned over why police are required becomes somewhat incoherent and varying between yelling and calm speech.
- The caller appears to possibly be under the influence of drugs, medication or alcohol.
- There is significant difficulty in establishing what is happening.
- The caller rambles about ringing hospital, getting bashed, warrants out for arrest, that she is hiding in a bush and being told by a friend of three violent offenders.
- The caller concludes by calling the call taker a 'fucking bitch' and the call is terminated by the caller.

79. Based on the CAD events and recordings, Inspector Ferguson acknowledged that both the calls presented difficulties in relation to identifying a location for police attendance and what was happening but '*...on both occasions a caller name and location was eventually obtained and therefore police should have been dispatched to investigate. In my view the correct event code for both calls should have been 573 'Emergency – Welfare Check.'*[21]

ESTA

80. A further statement was also sought as to ESTA's handling of the two 000 calls received from Penny. A statement was provided by Mr Mark Richards, the Quality Improvement Manager for ESTA, who is responsible for the audit and investigation of all operational events.[22]

81. ESTA is responsible for emergency communications including emergency call-taking, dispatch and information transfer services for fire services, ambulance and police.

82. ESTA utilises a computer aided dispatch (CAD) system which allows operators to record all call details and assist in pinpointing a location for assistance.

83. ESTA staff operate the CAD for Victoria Police operations including the taking and dispatching of calls for Victoria Police 'events'. If police attendance is required a new 'event' is created in CAD.

84. Call-taker 2, who took the second call, had been employed at ESTA since November 2006 until February 2011 when she was re-trained as a fire call-taker. Call-taker 2 received all training and achieved all necessary competencies in her role as a police and SES call-taker.

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[21] Ibid

[22] Statement of Mark Richards, dated 2 March 2015

85. Mr Richards reviewed the calls and concluded:

(a) The first call correctly resulted in a welfare check event.

(b) It is evident that Penny was expressing immediate concerns for her safety, and while she did speak softly at times and did not provide direct answers to the call-takers questions, she did confirm an address for police attendance. Call-taker 2 failed to appreciate Penny's circumstances.

(c) Penny's inability to provide direct answers to many of the call-taker's questions appears to have resulted in call-taker 2 over-controlling the call, with many instances where she spoke over Penny at times where Penny was trying to explain her situation.

(d) Both the tone and questioning techniques applied by call-taker 2 were not to the required standard of call control and empathy stipulated by ESTA's call-taking SOP.

(e) Call-taker 2 also incorrectly accepted the event as an 'advised event'. The correct procedure would have been for her to create a live CAD event for a welfare check as was the case with the first call.

86. In Mr Richard's opinion operator error was the key issue in the management of Penny's second call.

87. Call-taker 2 was formally counselled after the event and received a first and final warning in respect to any future serious breaches of ESTA's SOPs or customer service standards, she lost her police call-taking qualification and she was demoted. Call-taker 2 also underwent significant further testing regarding dealing with difficult callers.

88. The manner in which Penny was murdered and the fact that she called 000 for assistance generated a lot of media interest. Community focus was directed at call-taker 2, who resigned in November 2012 following the publicity.

Inquest

89. This is not a matter that called for a mandatory inquest as, pursuant to s 52(3)(b) of the *Coroners Act 2008*, a person had been charged with an indictable offence in respect to the death.

90. As a thorough investigation had been conducted into Penny's death and the matter had been through the courts, I determined to conduct a short inquest particularly focussing on the handling of the two calls Penny made to 000.

91. The scope of the inquest focused on these discrete issues:

i. The reason for failure to send police attendance to Penny after her two 000 calls;

ii. The interaction between the 000 call-taker and the police and whether the calls were processed correctly; and

iii. The ESTA and police practices for responding to calls of this nature.

92. The following witnesses gave evidence at the inquest

- Detective Acting Senior Sergeant Jason Poulton, Coroner's Investigator;
- Inspector Peter Ferguson, Local Area Commander for Police Communications D24; and
- Mr Mark Richards, Quality Improvement Manager from ESTA

93. Audios of both phone calls were played during the inquest.

94. At the beginning of the inquest, Ms Julia Oxley, the Chief Executive Officer, made a public statement on behalf of ESTA:

'On behalf of all at ESTA we offer our deepest condolences to Penny's mother Julie and to Penny's family and friends. The circumstances of Penny's death were tragic and we regret what happened. The response to Penny's call was not handled as it should have been and we apologise unreservedly for that. We've also apologised to Penny's mother for not providing her the support she deserved after Penny's death. Everyone at ESTA cares deeply about the service we provide the community and the service we provide. Penny's experience with 000 continues to be felt deeply across our organisation and we have made significant changes to the way we operate as a direct result of what we have learned.'[23]

95. This was, in my view, an entirely appropriate and necessary apology.

96. Inspector Ferguson gave evidence as to call taking procedures and described structured call taking: '*Structured call taking is a program which identifies the event type which is being described by, you know, the emergency caller. It suggests the type of information which is required by police to respond correctly to that event type, so it has a series of questions which are able to be put by the ESTA call taker as prompts or reminders.*'[24]

97. Inspector Ferguson explained that CAD is the Computer Aided Dispatch system operated by ESTA to record the incoming requests for service and the dispatching of the police units.[25] A CAD event code is selected and CAD priorities are the timeframes for ESTA to process

[23] Inquest transcript p 8
[24] Inquest transcript p 18
[25] Inquest transcript p 18

the call and dispatch it to a police unit to attend. Priority 1 is a short timeframe of about 140 seconds, priority 2 is about 300 seconds and priority 3 is about 900 seconds.[26]

98. Inspector Ferguson explained that the PCLOs provide support, assistance and monitoring of ESTA in the call centre and will answer any questions of the dispatchers, provide advice and provide policing input into the decision making.

99. Inspector Ferguson explained that if a call comes from a call-taker and is referred to the PCLO Sergeant it goes to the 'ZZZ event dispatch group' and the PCLO Sergeants are expected to examine the content of the job and make a policing decision as to action. The call-taker first processes the calls, gets a valid location and hits 'accept' on CAD. The event then goes to an emergency services dispatcher who dispatches it.[27] The dispatch then goes to a police field unit to assign attendance by police.

100. In respect to the two calls from Penny on the night that she was murdered the first call was referred to the PCLO, and the second call generated a second event that was not referred and was closed, effectively removing the PCLO's ability to deal with the call in any manner.

101. In response to a question from Counsel Assisting as to whether there is any issue with the extent of the inquiries undertaken by Sergeant Morrison before he closed the call Inspector Ferguson answered *'I can't comment on Morrison's actions on that day. He made those decisions on the information he had before him at the time.'*[28]

102. In Inspector Ferguson's opinion both Penny's calls should have been created as welfare checks. Also, in his view, the existing Victoria Police policies and Standard Operating Procedures are adequate and did not need any amendment as a result of these events.[29]

103. In Inspector Ferguson's view it was non-compliance with the policy by the second ESTA call-taker that was the problem, not the policies or the SOPs. He was clear that in his opinion there is nothing inadequate about the directives expressed in the standard operating procedures to call-takers and that the requirements to pass on or not, or to act or not, are all clear.[30] I accept his evidence on each of these matters.

104. Inspector Ferguson again acknowledged at the inquest how extremely hard the calls were to process: *'I think we have to look at it in the light of what the call taker would have understood at the time, not what we know now. And if we were to take on face value the things known by the individual call takers and the difficulty that they had at that point in*

[26] Inquest transcript p 19
[27] Inquest transcript p 20
[28] Inquest transcript pp 20- 21
[29] Inquest transcript p 21
[30] Inquest transcript pp 21-22

time, I think there is some level of understanding how things have come to where they've come, but I still think we should have had an investigation and we should have had police dispatched on the calls.'[31]

105. Mr Richards from ESTA explained that in respect to the first call 'priority 2' and 'welfare check' is generic coding and was appropriate given the nature of what Penny described in the first call. The event was created as a live event, which meant the dispatcher could either dispatch it to the local unit, seek direction from the field unit or assign it to the PCLO.

106. As outlined earlier, following the first call, the call-taker marked it to the PCLO, who attempted to call the mobile phone being used by Penny as she had hung up. Mr Richards gave evidence that the directions from Victoria Police in the Communications Standard Operating Procedures are that call-takers do not make calls back and that if a call is needed it should be made by a police member.[32]

107. Mr Richards believes the first call was handled correctly and I accept his assessment of the handling of that call. No adverse findings were made by ESTA or the Emergency Services Commissioner about the manner in which the first call taker interacted with Penny or handled that call.

108. The issue is the second call. In Mr Richards' view the second call was marked incorrectly as an 'advised event', and should have been accepted as a 'live event' in CAD. As this call was accepted as an 'advised' event it means a CAD reference number is created but the event does not appear for the dispatcher to dispatch to a unit, or for anything else to be done, effectively closing the event at that time with no other individual able to see it.[33]

109. Mr Richards' re-iterated that call-taker 2 failed to appreciate Penny's circumstances, that the address for police attendance was confirmed, that the call was over-controlled and that the tone in the questioning by call-taker 2 was not the required standard of empathy as stipulated in the Standard Operating Procedure *'..the SOP requires the call takers to have a fine...it's a fine balance between empathy and control but it's important that the call takers listen to what's being said and provide some calming technique in order to calm the callers down to obtain the information. Often callers are distraught and it is still necessary however to get the information from them and there are ways to do that still with showing some empathy but also controlling the caller.'*[34]

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[31] Inquest transcript p 24
[32] Inquest transcript p 28
[33] Inquest transcript, p 20
[34] Inquest transcript p 30

110. The second call was described at the inquest by Mr Richards as follows: '*The call was not well handled. There were opportunities to get a lot more information to provide more calming techniques to seek what was happening, and that event clearly should have been sent to the dispatcher for the determination of whether the police unit should be sent or whether the matter should have been referred to the Police Communications Liaison Officer.*'[35]

111. In Mr Richards' opinion, based on the information he reviewed, the second call should have been marked as priority 2, rather than priority 1, because although Penny made comments about the potential to be attacked, her answers to the questions did not lead to the belief that she was at that point in time in an immediate threat situation. Nonetheless, priority 2 is of course a high priority.

112. Mr Richards agreed with Inspector Ferguson's proposition that in respect to the second call the appropriate CAD event to be created should have been 'welfare check', as with the first call, as it is then either referred to a PCLO Sergeant for a policing decision or direct to dispatch for police attendance.

113. In Mr Richards' opinion the closing off of the second call as an 'advised' event was a completely inadequate response to that call. I accept his evidence and his assessment of the quality of the response to call 2. I also note the fulsome concession made by Mr Lawrie, Counsel for ESTA as to the flawed nature of the response to call 2.

114. It is clear from listening to a recording of the call, that Penny was in a heightened state of anxiety during the second call and appeared to be substance affected and somewhat confused. Mr Richards eloquently described this as a difficulty call-takers are expected to meet as a matter of course: *'This is nothing unusual. A lot of callers, they're calling in their most extreme moment of life. Most people call 000 once. They have an expectation that they're going to be met with a response that's suitable. They have an expectation that we're going to be able to provide them a level of service that they want.'*[36]

115. As a result of Penny's death, ESTA completed an extensive review of their performance management and discipline policy as it stood at the time, and in Mr Richards' opinion a call-taker who performed today the way the second call-taker did would be dismissed. There is now:'*...zero tolerance for the manner of call taker 2's work.*'[37]

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[35] Inquest transcript p 37
[36] Inquest transcript p 40
[37] Inquest transcript p 35

Conclusions

116. Shortly after Penny's death, Mrs Pratt indicated to the Court that she believed that the outcome would have been different if policies had been followed correctly by the second call-taker, that Penny's call should have been given to the local police and it may have been possible that '*...they could have gone and saved Penny's life, or at the very least caught the offenders in the horrific act of torture and murder.*'[38] Mrs Pratt believes that Penny may have lived if the calls were put through. I can fully understand her anguish about this.

117. The question is whether police attendance could have prevented Penny's death and whether or not different handling of the calls had the potential to change events. ESTA submitted that there is insufficient evidence for me to conclude that the events were likely to have been different if the second call had been handled in an appropriate manner – that is, if it had been referred for a dispatch or other police action.

118. ESTA submitted that on the evidence, there was insufficient time for police intervention and the likelihood of Penny being found by police was slender as she had re-entered the Boronia unit with Aaron Gibson and Adrian Krelekamp and was no longer in the street. On that argument this reduced the realistic possibility of effective police intervention substantially.[39] This was in essence Mr Lawrie's submission.

119. From the available evidence, it appears that the approximate time between Penny ending the second call and she, Aaron Gibson and Adrian Krelekamp entering the unit was a matter of minutes. ESTA submitted therefore that the potential for effective police involvement was very low.

120. On this point I took further evidence from the Detective Sergeant Jason Poulton, who referred to the names mentioned by Penny in the first call and the address she specified. His evidence was that this address was very well known to police. In his opinion it followed that had the local police been in possession of this information they may have been in a position to intervene. *"In my opinion local police are well and truly aware of that address, not the actual number 2, it was 54B however it's the second house in...They would also be well aware of James Potter and also that premises occupied by Bianca Clarkson, they're very well-known to the local police...And were then, indeed, and the point I was making is that if a job was dispatched to a local van, in my opinion they would know to knock on the door of that house. Of 54B? Yes."*[40]

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[38] Inquest transcript p 64
[39] Outline of Counsel's submissions of behalf of ESTA
[40] Inquest transcript p 73

121. I accept that evidence.

122. I cannot positively conclude on the balance of probabilities that Penny's death could have been prevented had police been able to intervene earlier However I do conclude that had police been notified and attended the property they may have been able to intervene in what was taking place inside. From that perspective I can fully understand Mrs Pratt's opinion as she stated it at the inquest.

123. There is no need for recommendations about system change in this case. Many policy changes have been implemented as a direct result of the circumstances of Penny's death.

124. ESTA has learned much from Penny's death and it was submitted that whilst the possibility of operator error will always be present, continuous improvements to ESTA's procedures and processes have been made, significantly increasing ESTA's ability to assist someone faced with an emergency such as Penny's. I accept that submission.

125. ESTA highlighted the developments made since Penny's death following the review of the matter include the introduction of the Adverse Events Policy, the Open Disclosure Policy, the increased auditing of events, the creation of a centralised system of reporting and auditing and investigation of 'adverse events' through the Quality Improvement team.

126. ESTA also highlighted technological developments which provide an improved ability to determine the location of a caller using a mobile telephone including "Push MoLI"[41] and the "Smartphone Locator Tool."

127. ESTA submitted that due to the changes to screening of suitable candidates, augmentation to training and auditing and monitoring, centralisation of internal investigation, promotion of self-reporting and the implementation of the recommendations of the Emergency Services Committee that it is not necessary for me to make a recommendation in respect to any improvements.[42] I agree with this submission.

128. ESTA submitted that the failure of call-taker 2 to properly handle the second call from Penny was demonstrative of a personal failure of the call-taker, not indicative of a failure of the ESTA systems at the time. I accept that submission. Considering that call-taker 2 has now left the employ of ESTA and policies have been improved I have no further comment about this aspect of the matter.

129. I again note the apology by Ms Oxley on behalf of ESTA and I express my sincere condolences to Mrs Pratt and the Pratt family for their loss.

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[41] A National Service called Mobile Origin Locator Information which gives an approximate location based on triangulation from mobile phone towers

[42] Inquest transcript p 71

Findings

130. Having considered all the evidence I find that Penelope Pratt died on 28 November 2010 from multiple gunshot injuries with a stab injury to the heart in the circumstances described above.

131. I find that Penny's death was caused by Aaron Gibson and James Potter.

132. I find that the handling of Penny's call by the second call-taker was well below an acceptable standard. I cannot positively conclude that Penny's death would have been prevented had the call been handled correctly. However the mishandling of the call effectively negated any chance of rapid and effective police intervention at the address where she was killed.

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

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

- Ms Julie Pratt, Senior Next of Kin
- VGSO on behalf of the Chief Commissioner of Police
- Mr Fatmir Badali on behalf of ESTA
- The Chief Psychiatrist
- The Clinical Director AMHS, Eastern Health, Upton House
- Office of Correctional Services Review
- Detective Acting Senior Sergeant Jason Poulton, Coroner's Investigator

Signature:

JUDGE IAN L. GRAY
Date: 5/2/16