FORM 37

Rule 60(1)

REDACTED FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 1152/05

Inquest into the Death of MOHAMED ALI CHAOUK

Delivered On:	23rd April, 2010
Delivered At:	County Court at Melbourne
Hearing Dates:	Directions Hearing: 21st May 2007 Directions Hearing: 14th August 2007 Ruling: 20th August 2007 Inquest: 11-14th, 17th-21st September, 2007
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr Raymond GIBSON appeared to assist the Coroner, instructed by Mr Andrew Ooi from the Office of Public Prosecutions. Mr Patrick A. CASEY appeared on behalf of the family of the deceased, instructed by Mr Michael Rafter. Mr John G. OLLE appeared on behalf of Special Operations Group Operators (except Operators 49 & 52) and the Chief Commissioner of Police, instructed by the Victorian Government Solicitor's Office. Mr Ron GIPP appeared on behalf of Special Operations Group Operators 49 & 52, instructed by Russell Kennedy.

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Court reference: 1152/05

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: CHAOUK
First name: MOHAMED
Address: 663 Geelong Road, Brooklyn, Victoria, 3025.

AND having held an inquest in relation to this death on 11-14th, 17th-21st September 2007 at Melbourne Magistrates Court

find that the identity of the deceased was MOHAMED ALI CHAOUK born on the 30th November, 1974,

and that death occurred on the 5th April, 2005,

at 663 Geelong Road, Brooklyn, Victoria 3025

from: 1(a) GUNSHOT WOUNDS TO CHEST AND ABDOMEN

in the following circumstances:

INTRODUCTION

1. Mohamed Ali Chaouk was a 30-year-old single man who resided with his parents and extended family at 663 Geelong Road, Brooklyn. A number of members of his family and their associates were the subject of an investigation of the Organised Crime Squad (OCS) of Victoria Police. In order to bring that investigation to a close, police command authorised simultaneous forced entry by the Special Operations Group (SOG), of two premises in Geelong Road, Brooklyn, which were associated with the Chaouk family - 637 and 663. During entry of 663 Geelong Road, Brooklyn, Mr Chaouk was fatally shot and died almost immediately, despite first aid attention from police at the scene and ambulance officers.

2. This finding is based on the totality of the material the product of the coronial investigation of Mr Chaouk's death, that is the brief compiled by Detective Senior Sergeant Charlie Bezzina from the Homicide Squad,[1] the statements and testimony of those witnesses who testified and any documents tendered through them, a view of the scene and inspection of weapons conducted in the presence of all parties who wished to attend, and the submissions of Counsel.[2] The material and the inquest transcript will remain on the coronial file. I do not purport to summarise all the evidence in this finding but will refer to it only in such detail as is warranted by forensic significance and narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

3. The primary purpose of the coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased, how death occurred, the cause of death and the particulars needed to register the death - effectively, the date and place where the death occurred. In order to distinguish 'how' death occurred from the 'cause' of death, the practice is to refer to the latter as the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death, and the former as the context, or background and surrounding circumstances. These circumstances must be sufficiently proximate and causally relevant to the death, and not merely circumstances which might form part of a narrative culminating in death.

4. Where a deceased is a *person held in care*, their death is reportable, irrespective of the cause of death or the circumstances in which death occurred.[4] Another consequence flowing from this status is that an inquest is mandated by the legislation, as part of the coronial

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1 As is apparent from his own statement, Det Sen Sgt Bezzina's investigation was overseen by members of the Ethical Standards Department and Mr Gerry Feltus from the Police Integrity Commission. See page 307 of the inquest brief. See also transcript page 354 & following regarding the OPI report and lack the one-way flow of information between OPI & Det Sen Sgt Bezzina.

2 The inquest was adjourned to a date to be fixed as the family wished to obtain independent ballistics evidence. Such evidence was not forthcoming and there was no request to re-list the inquest to further canvass this or any other issue. Subsequently, the following written submissions were received - Mr Gipp's submissions dated 29 October 2007 were received from Russell Kennedy on 13 November 2007; Mr Olle's submissions dated 14 December 2007 were received from the Victorian Government Solicitor's Office on 18 December 2007; submissions on behalf of the family (unsigned and undated) were received on 29 April 2008; Mr Gibson's submissions dated 22 May 2008 were received from the Office of Public Prosecutions on 22 May 2008; submissions in response dated 6 June 2008 were received from Mr Gipp, Mr Olle and Mr Gibson.

3 Defined in section 3 of the *Coroners Act 1985*. Apart from the need for a jurisdictional nexus with Victoria, the general definition captures any death "that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury." Although the Coroners Act 2008 commenced operation on 1 November 2009, the effect of transitional provisions is that the 1985 Act continued to apply to inquests commenced before that date. All references to legislative provisions are therefore to the provisions of the 1985 Act unless otherwise indicated.

4 The definition in section 3 of the Act includes those in the legal custody of the Chief Commissioner of Police or in the custody of a member of the police force.

investigation of the death.[5] To this extent, prisoners and others held in the care of the State, are accorded special status, reflecting a recognition of their vulnerability, and of the appropriateness of independent scrutiny afforded by the coronial process.

5. Although Mr Chaouk was not a "person held in care" when he died, the police were in the course of searching his home and arresting a number of suspects. In order to do so most efficaciously, from the perspective of police command, they authorised police to make a forced entry of residential premises shortly after 6:00am, when it was anticipated that not only alleged offenders but others, including women and children, would probably be present and probably asleep. By parity of argument, their actions in so doing, should be subject to a comparable level of scrutiny as if the deceased were a "person held in care", in furtherance of the same legislative intention that all actions of the State with fatal outcome, including the actions of the police, should be subjected to coronial scrutiny.

6. A secondary purpose of coronial investigations arises from the coroner's power to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including public health or safety or the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety . Whilst the *Coroners Act 1985* does not explicitly refer to the purpose of any reports, comments or recommendation made by a coroner, the implicit and generally accepted purpose, is the prevention of similar deaths in the future.[6]

7. Further, if at the conclusion of a coronial investigation, a coroner believes that an indictable offence has been committed in connection with a death, the coroner is under an obligation to report the matter to the Director of Public Prosecutions. This gives rise to something of a paradox, as a coroner is specifically prohibited from including in a finding or comment any statement that a person is or may be guilty of an offence.[7]

FINDINGS AS TO UNCONTENTIOUS MATTERS

8. In relation to Mr Chaouk's death, a number of matters required to be ascertained are uncontentious, namely his identity and the cause, date and place of his death. I find as a matter of formality that Mohamed Ali Chaouk, born on 30th November 1974, died at 663 Geelong

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5 Section 17(1)(b).

6 Compare this with the Coroners Act 2008 which came into operation on 1 November 2009 and in its preamble and purposes explicitly refers to the coroner's prevention role.

7 Sections 21(3) and 19(3) of the Act respectively.

Road, Brooklyn, shortly after 6.05am on 5th April 2005 from gunshot wounds to the chest and abdomen.

9. Furthermore, although there were contentious aspects of the circumstances in which the gunshot wounds were sustained, which will be examined in some detail below, there was no controversy about the identity of the person who shot Mr Chaouk. I formally find that the person referred to throughout the inquest as SOG Operator 52, was the person who fired the fatal shot/s.[8]

CAUSE OF DEATH

10. Professor Stephen Cordner, Head of the Victorian Institute of Forensic Medicine (VIFM) and a very experienced Forensic Pathologist, attended the scene, performed an autopsy on the deceased and provided a detailed report of his findings.[9] Apart from an incidental finding of severe coronary artery disease of significance for first order relatives, and some minor abrasions and bruising, Prof Cordner identified two gunshot wounds to the chest and described their passage through the deceased's body and the resultant damage to vital organs in the following terms -

> *"Wound 1: After entering through wound 1 the projectile has created a defect 5cm in diameter involving the lateral left 6th and 7th ribs at a level 151cm above the heel. There was no damage to the left lung. The track has continued to involve the diaphragm, left lobe of liver, posterior wall of the right ventricle with the two major fragments being embolised into the right lower lobe of the lung. (This accounts for the bullet fragments being in the middle of the right lower lobe of the lung without any damage to the lung itself.)*
>
> *Wound 2: After entry through wound 2 the projectile has pursued a subcutaneous course with a defect approximately 5cm in diameter to emerge through wound 3 and re-enter simultaneously wounds 4 and 5 with the two major components of the projectile being found in the superficial soft tissues of the right side of the neck. No major vital structures were damaged during the course of this projectile..."*[10]

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8 Apart from some senior officers from the SOG, those SOG operators directly involved in the forced entry at 663 Geelong Road, Brooklyn, were not identified by name during the inquest but only by an operator number and rank. This was the course proposed at an early stage and adopted throughout the inquest without demurrer from any party.

9 The autopsy report includes Professor Cordner's formal qualifications and experience, and together with his handwritten notes and a copy of the initial police report of death to the coroner (VP Form 83), was Exhibit "G". At transcript pages 73 and following Professor Cordner testified about his scene attendance and observations.

10 Exhibit "G" page 6 and Transcript pages 53-54, 65, 68. The passage of each gunshot wound is probably easier to understand from the diagrams attached to the autopsy report.

11. Prof Cordner concluded that the cause of Mr Chaouk's death is best expressed as "gunshot wounds to chest and abdomen". Both in the autopsy report and during his testimony, he stressed that the descriptions "gunshot wound 1" and "gunshot wound 2" simply reflected the order in which he described the wounds, and not the order in which they were sustained. He could shed no light on that issue, despite being pressed to do so.[11] Prof Cordner did however agree that although gunshot wound 2 caused a very serious injury, he found no evidence that it caused any obvious damage to structures within the body which would necessarily lead to death as a probable or even possible outcome, so that on its own it might well have been a survivable injury.[12] However, gunshot wound 1 was likely to have proved fatal even with the promptest medical attention.

12. Routine full toxicological analysis of post-mortem blood samples was also undertaken at VIFM. The results revealed that there was no alcohol or other commonly encountered drugs or poisons in Mr Chaouk's blood at or around the time of his death, so that there is no question of impairment of his judgement or that substances played any role in his death.[13]

HOW THE DEATH OCCURRED

13. Although somewhat fluid and variously described in Counsels' submissions, the main focus of the coronial investigation of Mr Chaouk's death including the inquest, were three aspects of the circumstances surrounding the death -

- threshold matters, namely the decision by police command to authorise "forced entry" at 663 Geelong Road, Brooklyn, including deployment of the SOG,
- how forced entry was effected, and
- whether or not Mr Chaouk posed a threat to Operator 52 and was shot in self-defence.

THRESHOLD MATTERS

14. On 24 October 2007, I made an order under section 58(1) prohibiting publication of evidence which disclosed certain police investigative techniques, operational tactics and procedures.[14] In anticipation that this finding, or a redacted version of it is to be published, the same rationale has lead me to be somewhat circumspect about some aspects of the evidence. I have done so in an attempt to strike a balance with the public interest in an open accounting of

11 Transcript pages 59 & 62 for example.
12 Transcript page 54.
13 The toxicologist's report including a list of the drugs tested for is at pages 267-271 of the inquest brief. The list includes ethanol (alcohol), heroin, amphetamines, cannabis and prescription medications.
14 This is a very brief paraphrased summary of the order, which is annexed to this finding as

any police shooting and of the serious allegations made in the course of this inquest. I will invite submissions from the parties after delivery of this finding to address any issues arising.

15. Some knowledge of the police investigations is required to understand the context within which the decision was made to bring the investigation to a close by way of "forced entry" of the premises with SOG deployment in order to execute search warrants and arrest suspects. During October 2004 the Organised Crime Squad's (OCS) Middle Eastern arm began gathering intelligence on a diverse range of criminal activities of the Chaouk family. An investigation plan was formulated and an operation code-named "Vapor" approved by OCS Command on 27 October 2004.

16. As the investigation progressed, there was ongoing review by OCS Command with a 1 May 2005 completion date being set. Investigations continued and by the end of March 2005, OCS investigators considered that they had sufficient evidence to lay a range of charges against several Chaouk family members and their associates, including attempted murder, false imprisonment, drug offences, firearms offences, serious assaults and offences of perverting the course of justice. The decision to move to the arrest phase was precipitated by a belief on the part of OCS investigators that there was a real danger to the safety and welfare of certain individuals if some members of the Chaouk family continued at large and unhindered in their activities.[15]

17. In light of the violent and unpredictable nature of Chaouk family members and their known propensity to carry firearms,[16] OCS sought the assistance of the SOG to effect the arrests. On 23 March 2005, a preliminary briefing took place between the OCS investigators and SOG Operators 34, 41 and 46.[17] The briefing concluded on the basis that the OCS would need to make a formal application for deployment of SOG following police protocols, including their own risk assessment.[18] In anticipation of that application, SOG operators commenced their preparations for deployment.

18. Detective Senior Sergeant Harris of the OCS prepared the "Application for Deployment of the SOG" to assist in the execution of warrants at the two Geelong Road premises, including

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15 See the summary of the investigation prepared by Det Sen Sgt Bezzina and adopted by a number of Counsel in their submissions. A number of witnesses testified as to the fluidity of the investigation and ongoing intelligence gathering which informed the timing and mode of arrest - for example statement of Det Sen Sgt Harris/OCU - Exhibit "H" and transcript page 213.

16 I note that these matters were not contested by counsel representingthe family either in cross-examination or in written submissions.

17 Ibid, transcript page 99 and following, Exhibits "P", "S" & "T".

18 Victoria Police Mannual Instruction 106-2 pertains to deployment of SOG and sets out the circumstances in which SOG must be deployed. There was no issue raised at inquest that the SOG had been deployed in breach or disregard of this protocol. Trancript 106 & following.

his own risk assessment which assessed the risk as "medium to high" and detailed his reasons.[19] The application then went to Detective Superintendent Grant via Detective Inspector Aristidou. The application/risk assessment was amended to include the option of (redacted) at Det Super Grant's request. Ultimately, Det Super Grant concluded that forced entry was the most appropriate option as regards 637 and 663 Geelong Road, Brooklyn.[20] The application was transmitted via by Det Insp Aristidou to the SOG.

19. On 30 March 2005, Inspector Noonan, then Officer-in-Charge of the SOG, consulted with a number of other SOG members to consider the information provided by the OCS as to Operation Vapor.[21] On 31 March 2005, Insp Noonan conducted a detailed risk assessment of the available options based on the information and intelligence available to him. The options he considered were (redacted), (redacted), (redacted), and "forced entry". The first option was discounted due to the (redacted) and the inherent danger to the community. The second, as it was considered unlikely that an opportunity would arise without compromising the operation. The perceived risks associated with the (redacted) option were considered together with a number of strategies for minimising those risks. In the end, this option was also discounted, due to the possibility of a confrontation with members (redacted) otherwise and the possibility of (redactied.[22]

20. Consequently, Insp Noonan concluded that the preferred and safest option was forced entry of the two Geelong Road premises simultaneously. Commander Hart, Specialist Support Department, was the Commander of twelve separate units of Victoria Police, including the SOG. He gave evidence setting out the process for acceptance or approval of the application for SOG deployment. He confirmed that he consulted with Insp Noonan and on 1 April 2005, approved the recommended option of a forced entry of the two premises with SOG deployment.[23]

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19 Reasons included that evidentiary items may be readily destroyed; probability of confrontation with a person who is armed or is reasonably suspected to be armed with a firearm or other lethal weapon; prior history of significant violence; ... targets extremely anti-police and recent deomonstrated behaviour/threats towards member, with indication of firearms.

20 It should be noted that these were not the only premises targeted for search/arrest as part of Operation Vapor - see statement of Detective Superintendent Grant at pages 25-27 of the inquest brief. A total of seven people of interest were identified and seven premises, including the two Geelong Road premises. Transcript page 112.

21 Inspector Elliott, Operator 4, 24 & 34. Apart from a propensity to violence and access to firearms, this information included police intelligence about access to false passports and the risk of flight; the execution of a previous warrant when the father Mr Macchour Chaouk had reportedly poured petrol over himself in an attempt to create a seige situation and avoid apprehension; and that members of the family had cut a hole in the floor of a house they occupied for a hydroponic crop to create an escape route. Exhibits "S" and "BB".

22 Ibid and transcript at pages 331 & following. As described by Inspector Noonan the process of consultation was ongoing and dynamic in terms of options being continually assessed and re-assessed as inforamtion/intelligence came to hand.

23 For reasons which need not be laboured here, the entry was postponed until the 5 April 2005, when at 6.03am Inspector Noonan, as Officer in Charge of the operation gave permission to Operator 34

21. As far as I can glean from Mr Casey's cross-examination at inquest and his written submissions, his criticisms were not of the internal police processes involved but of the decision to conduct a forced entry at all. He argued that this decision and/or the risk assessment/s made by various police officers along the way were flawed, as they disregarded or failed to give due weight to the presence of women and children in the house and, given the early hour, to the risk of confusion and disorientation in the occupants if they were roused from sleep. Mr Casey was also critical of the decision to exercise arrest powers when suspects were not at large but within the confines of their home, posing no immediate threat to anybody.[24]

22. It is inherent in the notion of a risk assessment, that some risks can only be minimised not negated, and that what is required before deciding on a course of action, is a careful and informed consideration of the known or potential risks. Inevitably, a balance will need to be struck between competing interests. The evidence before me supports a finding that significant weight was placed on the need to protect the publi,c by containment of the potential for violence within the perimeter of 663 Geelong Road, while at the same time securing evidence, and not compromising the success of the operation by alerting occupants or their associates.

23. On the assumption that the targets of Operation Vapor needed to be arrested and the two Geelong Road premises searched - matters which are beyond the scope of a coronial investigation - then, as to mode of execution of the relevant warrants, I am satisfied that the decisions to authorise forced entry and to deploy the SOG were not made lightly but with due consideration, and were made in accordance with the relevant police protocols. Moreover, the decisions were amply supported by the information about Operation Vapor provided by the OCS investigators and ongoing intelligence reports.

5 APRIL 2005 - HOW FORCED ENTRY WAS EFFECTED

24. In my view, both in cross-examination and in his submissions, Mr Casey conflated the risk assessments proper and the authority to conduct forced entries, with certain operational and tactical decisions made in the running which he is critical of. Somewhat fluid during the inquest, these criticisms appeared to amount to the following -

- that the use of one rather than the planned two entry points revealed deficiencies in planning[25] and/or inadequate training of SOG Operators,

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to proceed. Exhibit "V" and transcript pages 281 & following - "approval is not absolute and should circumstances present themselves for an alternative option, it may be initiated."

24 Pages 3, 12, 14 of his written submissions.

25 The broader assertion that the whole operation was poorly planned is contrary to the weight of the evidence - see statement of Det Sen Const Warren in the inquest brief; Det Sen Sgt Harris - Exhibit "H"; Insp Elliott - Exhibit "W"; Insp Noonan - Exhibit "BB" and transcript page 334.

- that the practice of operators calling "Police. Don't move." was flawed,
- that there was safer access to the first floor other than the internal staircase, and
- that operators should have climbed the stairs in a staggered fashion.

25. The original plan identified two entry points, the front door for the team of SOG Operators tasked to clear and secure the ground floor, and the front window nearest the stairwell for the team tasked to clear the first floor. Another window nearer the front door was broken (redacted) before the breach of the front door which, was easier than anticipated. As a consequence, both teams entered via the front door, with the upstairs team proceeding immediately to the stairs.[26]

26. A number of operators testified that this change of plan did not reflect poorly on planning but was an example of appropriate flexibility and operational expediency. It was always faster and safer to enter through a door than a window.[27] There was also evidence from a number of SOG officers and operators that although they plan their operations carefully, and rehearse scenarios, they also allow for contingencies and are trained to respond to opportunities as they present themselves. They do not slavishly follow a plan, as if it were a well-rehearsed script, and rely on their specialist training to deal with developments as they unfold.[28]

27. Mr Casey was critical of the practice of a number of operators calling out and repeating the instruction "Police. Don't move." at the one time as they would talk over each other and be unintelligible to the occupants of the premises. A number of police witnesses testified that they are trained to deliver this instruction in a loud, clear voice, in a controlled manner, and to aim to synchronise with other operators in their vicinity so they are not "over-talking".[29]

28. Statements provided by several family members bore out this confusion about who it was that had entered their home. They each refer to the noise associated with the forced entry but deny that the police ever identified themselves as police officers at all, and/or that they recognised them from their uniforms. Apart from the stress of the circumstances, a number of family members had little English and may not have understood the instruction even if they had heard it. The germaine question is whether or not the deceased understood that it was the police, and that will be addressed below.[30]

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26 For example transcript at pages 157, 169, 206-7, 233.
27 For example transcript page 159.
28 For example transcript pages 158, 162, 231.
29 For example transcript pages 32, 130-132, 152, 173.
30 Surprisingly, the deceased's parents did not hear any gunshots or the like either, but Mrs Salwa Chaouk and her husband Mr Walid Chaouk did, as did the deceased's 14-year-old brother Omar Chaouk. Mrs Salwa Chaouk refers to gunshots in both the statement she made to the police with the assistance of an Arabic speaking interpreter, acknowledged at 11.55am on 5 April 2005, and her later statement Exhibit "II". Mr Walid Chaouk testified at inquest - Exhibit "Z" and transcript pages 297 & following. Omar who

29. The suggestion made by Mr Casey that police should have used a loud hailer or other amplification to announce their presence was not considered appropriate. Possible technical problems aside, it is unclear what this would achieve from the point of view of the occupants of the house. In all likelihood, it would alert neighbours.[31]

30. While the existence and location of the internal staircase was known by the police prior to entry, the next criticism also arises from the nature of the particular staircase which was clearly unknown, and realistically, probably unknowable. The staircase which leads to the first floor level comprising a hallway, a bathroom, two bedrooms and an open area, is located along the west wall of the lounge room on the ground floor, and is relatively steep, narrow and confined.[32] To the extent that the criticism relies on hindsight it is unfounded.

31. However, the criticism went beyond this and involved an assertion that there were other safer, viable options for accessing the first floor. In the earlier stages of the inquest, Mr Casey posited the option of using a ladder to access the first floor balcony at the front of the house. Several witnesses disagreed that this was either viable or safer on a number of bases - moving and placing the ladder carried a risk of noise and discovery; climbing would be difficult (redacted)[33] while climbing they could not adequately protect themselves; they would be vulnerable to the ladder becoming unstable or interference from someone on the balcony; any confrontation on the balcony was fraught as it had no railing; their risk would be increased by access taking longer thereby leaving more of them vulnerable for a longer period; and, there was a commensurate risk of compromise to the overall operation.[34]

32. In later cross-examination, the suggestion was that ladders could have been used to access the sloping tiled ground floor roof and enter via the window on the western wall of the first floor, either instead of, or in addition to access via the balcony.[35] This route, it was argued, would have afforded a clear view of the hallway and an opportunity for operators to cover each other.

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31 A number of operators gave evidence along these lines, for example transcript pages 236 & following.

32. In terms of configuration, there are two steps leading up from the loungeroom heading west, then a landing and a left turn to face south and twelve steps up to the first floor landing/hallway which runs east and is entirely to the left from the point of view of those ascending. Immediately ahead of the stairs is a bathroom wall. Heading east along the hallway is the bathroom to the right. The hallway opens out into an open area used as a sitting room/computer room. There are two bedrooms to the left, re-configured from the three bedrooms which appeared on the floor plan available to police.

Difficult to convey in words, photographs taken by police in the aftermath go some way towards conveying these constraints - Exhibit "C". Certainly the view conducted during the inquest with the family's full co-operation was very helpful in this regard, as were the measurements taken - see table of measurements/dimensions Exhibit "L". See also Sen Const Vincent's statement - Exhibit "AA". See also the floor plan available to police during planning of the operation - Exhibit "L".

33 Operator 52's statement at page 155 and following of the inquest brief details the equipment he had on his person during the entry. Trancript 124 & following, 143.

34 For example transcript pages 145, 224-5.

35 Exhibit "C".

Aside from the inherent problems with use of ladders outlined above, there are the inherent dangers of crossing a slanted tiled roof, a risk of additional noise, and the risk of cross-fire in the situation of access from both the balcony and the window.[36] Based on the evidence these were neither viable nor safer options for accessing the first floor. This criticism is unsupported by the evidence and offends common sense.

33. The suggestion that, once inside, operators should have climbed the staircase in staggered fashion, perhaps no more than two at a time, also arises from the narrow, steep and confined nature of the staircase. With no more than two operators on the stairs at a time, they could provide cover and would not be "log-jammed" up against each other unable to retreat. Expressed as a concern about the safety of operators, this also lays a foundation for the assertion that Operator 52 was placed in a vulnerable position, could not retreat and so "shot first" without any real apprehension for his safety or the safety of other operators.[37]

34. The evidence before me was that the very dimensions of the staircase made it difficult for operators to cover each other, and that although this would be somewhat improved with fewer operators on the staircase at the one time, the aim was for operators to arrive simultaneously so that they could saturate the first floor and secure it in the shortest possible time.[38] The staggered ascent clearly undermines this aim. And, in terms of staggered ascent providing a viable and safer option of retreat, I am not persuaded that it is realistic to expect an operator to retreat from confrontation by turning his back to an armed assailant or walking backwards so as to keep an eye on him.

CONFRONTATION AT THE TOP OF THE STAIRS - EVIDENCE OF OPERATORS 52 & 49

35. Within minutes of the shooting, Operators 52 and 49, the members who had discharged their firearms were identified, and separated, before each had a conversation with Insp Noonan about what happened.[39] According to Insp Noonan's statement, the first conversation was with Operator 52 who said he was one of the first through the front door and went through the lounge to the bottom of the staircase as he was tasked to clear the first floor. Once at the bottom of the stairs he ensured that an operator was behind him before starting up the stairs. He continued -

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36 Transcript pages 226-227, 240-241.
37 Transcript 139 & following, 230-231.
38 Transcript page 160.
39 At inquest the account given to Insp Noonan was referred to as the first or earlier account. I note however, that the first account noted in the inquest brief was actually the brief exchange between Operator 52 and Operator 34 - "Are you alright?" "Yeah, he hit me with a sword and I've shot him." - Exhibit "S" page 7 & transcript page 237.

"I was moving quietly and had my torch light on all the way up. When I was a couple of stairs from the top, a big bloke came from my left, he yelled out. He then pulled out a samurai sword out of its sheath and pulled it down. I was calling on him "police, don't move" constantly as this was happening, it all happened so quickly. The sword struck my left arm above my wrist, forcing my gun down as I was holding the fore grip. He then tried to raise and strike me and as he was raising it up again, I was still calling on him "police don't move". He continued with his actions and this was all happening so quick. I had to shoot or he was going to get me again with the sword. I had no doubt he was going to kill me. I thought he had chopped my arm up from the first blow but did not check it until later. As I shot him, he has fallen into the corridor ... just left of the stairs ... I later informed the team leader briefly what happened and was told to wait downstairs. I waited at the front door and then spoke to Inspector Noonan. I fired 3 shots at this person and only fired as I believed the person was about to kill me with the sword. I fired from my M4 ..."[40]

36. In his own statement made the following day, Operator 52 provides a more detailed, but broadly consistent account of the shooting.[41] Mr Casey sought to discredit Operator 52 by reference to perceived discrepancies between the two accounts. In particular he relied on the difference between Operator 52's position when he was attacked - "a couple of stairs from the top" in the earlier account to Insp Noonan and "As I neared the top, I estimate between 4 to 6 stairs from the top" in his statement. I consider this neither a material discrepancy, nor a surprising one, in light of the heat of the moment and the context in which both accounts were giv.en

37. With the obvious rider that the accounts remain untested by cross-examination of Operator 52,[42] close comparison does not disclose any other material discrepancies between the accounts. Significantly, Operator 52 maintains that he fired after being struck by the sword, with another strike imminent and whilst in fear for his life. He also maintains that he continued to call "police, don't move" during the confrontation with Mr Chaouk.

38. After speaking to Operator 52, Inspector Noonan obtained Operator 49's account of events.[43] According to Insp Noonan's statement the account was as follows -

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40 Exhibits "I" and "BB" - the account of the conversation commences at page 11.

41 Acknowledged 2.10pm 6 April 2005 @ Homicide Squad - pages 155-163 of the inquest brief.

42 I have assessed the materiality of such discrepancies as there are by reference to the issues and other evidence without the benefit of hearing from Operator 52, who like Operator 49 was excused from giving evidence on the basis of the right against self-incrimination. My ruling was delivered 14 August 2007 and a copy is annexure 1 to this finding. Mr Andrew Jackson, Counsel then representing the family, did not oppose the application. Nor did Mr Casey seek to re-visit this ruling at any point during the inquest, although on one reading of his submissions, one could be forgiven for thinking otherwise.

43 Inpsector Noonan as this conversation commencing at 6.55am - Exhibit "BB" page 12.

"When he reached the stairs I was approximately 2 steps behind him ... He started up the stairwell and I turned and began to follow him up. At this point I saw him stop suddenly in front of me, my vision was obscured slightly and he appeared to rear back slightly. At that time I saw a metallic glint and saw a male at the top of the stairs. This person then waved a sword in a downward motion towards myself and the other operator. Just prior to moving up the stairs and whilst going up the stairs I could hear yelling coming from upstairs in a loud angry type voice. Myself and the other operator were continually yelling loudly "police don't move" ... When we were approximately 1.5 metres from the male, he did not seem to be listening to us, he was moving down the stairs and I believed he was going to slash at us. I am not sure of what happened to the other operator but I remember seeing the metallic glint and at the same time seeing the oterh operator rear backwards. I assumed the male had done something with the sword. I could see the sword in a raised fashion and it was my belief he was going to bring it down on us. Fearing for my safety and for the other operator, I discharged my handgun once or twice. At the same time I heard the other operator fire his rifle a number of times. The male staggered backwards and fell to his right into the hallway and somehow ended on his left side..."

39. Operator 49 made his statement at the Homicide Squad the following day.[44] His account is also more comprehensive than the earlier account given to Insp Noonan, with the events detailed in a more logical, chronological sequence. The main criticism levelled at Operator 49's account is that he fails tomention the first blow struck by the deceased as described by Operator 52, the one in which the left forearm injury was sustained, which will be discussed below. As I read both accounts given by Operator 49, he refers to seeing only a metallic glint prior to Operator 52 rearing backwards, and not the blow itself. It is tolerably clear that the swinging/striking motion he does see, is more than likely the second one seen by Operator 52, the motion which prompted both operators to react by discharging their weapons. Certainly, Operator 49's account is consistent with Operator 52's on this reading. This is not the stuff of meaningful or material inconsistency which discredits a witness.

EVIDENCE OF OTHER WITNESSES

40. To some extent it speaks to the confines of the staircase that despite their close proximity to the confrontation between the deceased and Operators 52 and 49, none of the other operators climbing the stairs behind them saw what happened. A number of them corroborated the accounts of Operators 52 and 49 to the extent that something happened as they neared the top of the stairs to halt their progress, and that this was followed and/or associated with the discharge of firearms.[45] None of the occupants in the house saw the confrontation between the deceased and Operators 52 and 49 at the top of the stairs, although some heard the sounds of shots or

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44 Pages 143-152 of the inquest brief.

45 Operator 33 - Exhibit "M" & transcript 178; Operator 68 - Exhibit "N" & transcript 185; Operator 66 - Exhibit " R" & transcript 210; Operator 63 - Exhibit "O" & transcript 188; Operator 11 was 6/7th in

banging.[46]

41. The statement of Mr Walid Chaouk acknowledged at the inquest, is substantially different from the earlier statement provided to the police which he did not acknowledge. It is substantially different from his earlier statement and made some months after the events and is mainly an account of his fear and confusion. To the extent that it sheds any light on the confrontation at the top of the stairs, it is at odds with all the other evidence, in that it seems to put the deceased in his bedroom when the shots are fired - *"I started to hear my brother Mouhamed screaming for help from his bedroom it sounded like that and also hearing loud banging noises."* On the other hand, it can also be read consistently with the accounts of Operators 52 and 49 in that they heard yelling coming from their left prior to the confrontation and the shots being fired.[47]

FORENSIC EVIDENCE

42. There was evidence of a forensic nature found at the scene which provides some corroboration of a general rather than specific nature as to the occurrence and approximate location of the confrontation - the samurai sword with the deceased's blood on it found near where his body lay, the scabbard at the base of the staircase, and other swords found at the premises.[48] The scene was extensively photographed, and at an early stage, I indicated that I did not require either the photographers or any other witnesses as to "continuity" to give evidence. In the absence of any application to call such evidence, Mr Casey's criticisms of Sgt Munro as the Officer-in-Charge of the scene for forensic purposes, are ill-considered.[49]

43. Senior Constable Vincent, Firearms and Toolmark Examiner attached to the Forensic Services Centre, attended the scene, provided a detailed report of his findings and was cross-examined at length at the inquest. The salient points of his evidence as regards the shots fired by Operator 52 were that -

- he 52 fired three shots in total, including the fatal/shots and the one which went through the bathroom wall and lodged in a bathroom fitting
- the trajectory of the bullet which lodged in the bathroom could not be accurately plotted due to the likelihood of deflection caused by its travel through the wall

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46 See footnote 30 above.

47 Exhibit "Z" & transcript pages 297 & following.

48 Transcript pages 136, 180, 189. Statements of Det Sen Const Blackburn & Blezard. The photgraphs best depict the location of the cartridges on the staircase - Exhibit "C" photos 92-101.

49 Page 9 of Mr Casey's written submissions and transcript pages

- cartridges from the rifle would eject forcefully to the right immediately upon discharge, and would bounce off any relatively hard surface, so that their location at rest gives only a general indication of his position when he fired
- his position relative to the deceased when he fired could not be calculated with any precision from the the entry wounds, except that the deceased probably presented his left side but was not necessarily square on
- ultimately the use of gun shot residue analysis to calculate the distance between the weapon and the deceased upon discharge was confounded by the interspersal of residue from more than one shot.[50]

44. Sen Const Vincent's evidence about the shot fired by Operator 49 was that -

- he only fired one shot which was probably fired from the left side of the staircase
- the bullet damaged the balusters fifth and fourth from the top in that order, before ricocheting to the right, travelling through the hallway window on the western side of the first floor, and presumably landing outside - it was never found
- the phenomenon of ricochet was extremely unpredictable, and made it difficult to plot the bullet's trajectory with any precision so as to verify where he was standing when he fired.[51]

45. Some of Prof Cordner's evidence went beyond the cause of death and bore relevance to the circumstances, in particular to the nature of the confrontation between the deceased and Operator 52.[52] Although unable to say with precision where the deceased and Operator 52 were relative to each other when the shots were fired, he expressed the opinion that the wounds were intermediate range wounds (about 60cms) and certainly not close or contact wounds. He testified that, although he would defer to a ballistics expert as to gunshot residue analysis, this was his opinion based on gun shot residue stippling on the deceased.[53] Of course, the possibility that either the deceased or Operator 52 moved between each shot cannot be disregarded. He also testified that the pattern or distribution of stippling was consistent with the deceased's left forearm being in front of his chest when he was shot.[54] This is consistent with, but not determinative of, a double-handed swinging action in preparation for striking a forward blow.

THE INJURY SUSTAINED BY OPERATOR 52

46. After participating in the view of the weapons and clothing similar to that worn by

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50 Exhibits "AA", "AA1" and transcript commencing at page 317 & following.
51 Ibid.
52 See paragraph 2 above.
53 Transcript pages 55 & following, 69.
54 Transcript pages 63, 65.

Operator 52[55] and viewing photographs and other evidence, Prof Cordner provided a supplementary report containing his comments about the injury to Operator 52's left forearm, in particular that -

- the abrasion and bruising is not specific for having been caused by the sword but is compatible with it
- the injury was "likely" to have been cushioned by the sleeve of the overalls and "perfectly possibly" the gloves worn
- the injury was minor in a medical sense, that iS it had minor consequences,
- it is virtually impossible to convey meaningfully the degree of force required to cause any particular injury, but it is reasonable to say that the extent of bruising means that more than trivial or mild force was applied, and
- the subjective experience of a particular force does not necessarily correlate strongly with the nature of the force, so that a statement that the blow felt as though it had cut through skin to bone is not necessarily at odds with the fact that it did not.

47. Operator 52 attended his General Practitioner, Dr Keddie, the following day 6 April 2005. The account he gave to Dr Keddie about how the injury was sustained was consistent with other accounts in evidence. When he testified at inquest Dr Keddie expressed the view that the injury was consistent with the blow described by Operator 52, bearing in mind the likely protective effect of his sleeves and glove, and the fact that the sword was decorative and had a blunted cutting edge. Like Prof Cordner, Dr Keddie allowed that the experience of force is subjective.[56]

48. It is appropriate to note Mr Casey's criticism of the investigation in so far as it relates to the failure of Det Sen Sgt Bezzina or forensic officers to retain the particular overalls and gloves worn by Operator 52. The overalls were retained and subjected to forensic examination for blood/DNA analysis, but the gloves were not. No DNA was found on the overalls and no damage identified which might have been caused by the sword strike. However, by the time the inquest commenced, neither were available for production, and overalls and gloves said to be similar were used for the purposes of the inquest. Given the likely issues arising from the circumstances in which the deceased sustained fatal injury, even without hindsight, best practice even should have seen both items retained and made available for examination at inquest.[57]

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55 I note incidentally that the overalls worn by Operator 52 were retained and subjected to forensic examination for any blood or other DNA extraction, with negative results, contrary to assertions in Mr Casey's submissions. See statement of Ms Tridico - Exhibit "Y" and transcript pages 292 & following. Exhibits "EE" & "FF" were "similar" overalls and gloves to those worn by Operator 52 at the time of the shooting. The difference was said to be in colour alone and not in design or fabric.

56 Exhibits "B" & "B1" and transcript at pages 6 & following, esp at page 14. See Prof Cordner's testimony at transcript page 315 & following.

57 Det Sen Sgt Bezzina concedes that he would have kept both items if he had hindsight - transcript page 347.

49. The relatively confined staircase and first floor landing area,[58] combined with the deceased's significant size,[59] were said to render the account of Operator 52 impossible. Mr Casey argued that there was simply not enough room for Mr Chaouk to swing the sword in an overhead motion. For this reason he was critical of the lack of detailed measurements of the scene in the brief compiled by Det Sen Sgt Bezzina, and lack of evidence of a reconstruction of the confrontation. While this complaint was ameliorated to some extent by measurements taken at the view conducted during the inquest, and I have considered those, in the absence of evidence from Operator 52 and his participation in a reconstruction (an to a lesser extent Operator 49), there would be too many unknowns and variables, for a reconstruction to have any probative value.

THE CONFRONTATION FROM MR CHAOUK'S PERSPECTIVE

50. There was no serious suggestion that Mr Chaouk did not appear at the top of the stairs and no direct suggestion, though it was implied from time to time, that he did not bring the sword with him. If I am wrong about that, the weight of the evidence supports a finding that he did so. It is impossible to know what the deceased was thinking as he confronted Operator 52. He had been roused from sleep and alerted to something happening in the house. He was yelling loudly and took the precaution of arming himself with the sword. Decorative though it was, it was still a weapon. He understood English and should have understood the "Police, don't move" call being repeated as the operators approached. While there is a possibility that he did not realise that the operators were police, and acted to protect himself and/or his family, I find it highly improbable that he did not realise that they were in fact police.

51. Taking all the evidence and applying the standard of proof which applies to coronial findings,[60] I find that the deceased appeared on the first floor landing as Operator 52 approached with Operator 49 close behind him halting their ascent; that the deceased ignored their calls and struck Operator 52 to the left forearm with a blunted samurai sword causing him some loss of balance and a minor injury; that the deceased prepared to deliver another blow with the sword causing both Operators 52 and 49 to fear for their own and each others safety, and to protect themselves by discharging their respective weapons.

COMMENTS MADE PURSUANT TO SECTION 19(2) OF THE CORONERS ACT 1985

58 See footnote 32 above esp Exhibit "L" the table of measurements taken at the view.

59 Prof Cordner's measurements were that he was 184 cm in height and weighed 143 kgs, putting him at about twice the weight of the average adult male in the community.

60 The standard is the civil standard of proof with the *Briginshaw* gloss or explication.

52. Dawn raids on residential premises may protect the public at large, by containing the potential for violence within a perimeter, but they carry an inherent risk for all those involved - the innocent occupants of targeted premises, suspects entitled to the presumption of innocence and police officers, even those with specialist training and experience.

53. My clear understanding, based on the totality of the evidence before me, is that forced entry of premises by the police was, and is, considered a last resort option, and that the SOG is not deployed unless articulated criteria are met and/or exigency demands.

54. While I am satisfied that a sound decision was made here to authorise simultaneous forced entry of the two premises, it is important from a public safety perspective that these continue to be last resort measures because of the inherent risks.

DISTRIBUTION LIST

55. The Chaouk Family

The Attorney -General

The Chief Commissioner of Police

Commander, Special Operations Group, Victoria Police

Commander, Organised Crime Squad, Victoria Police

Special Operations Group Operator 52

Special Operator Group Operator 49

Signature:

Paresa Antoniadis SPANOS
Coroner
Date: 23rd April 2010