IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 2028

FINDING INTO DEATH WITH INQUEST[1]

Form 37 Rule 60(1)

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

On 16 September 2016, paragraph 84 was amended pursuant to *Section 76 of the **Coroners Act 2008***

Inquest into the Death of: SAMIR OGRAZDEN

Hearing Dates:	5 December 2011 – 9 December 2011, 12 December 2011 – 16 December 2011, 13 March 2012 – 16 March 2012 and 4 June 2012.
Appearances:	Mr Leighton Gwynn and Ms Nola Karapanagiotidis on behalf of Ms Bobby Cobani (Blake Dawson Lawyers).[2]
	Mr Peter Rozen of Counsel on behalf of the Emergency Services Telecommunications Authority (Gadens Lawyers).
	Mr Ben Ihle of Counsel on behalf of the Chief Commissioner of Police (Victorian Government Solicitors Office).
	Mr Paul Lawrie of Counsel on behalf of Senior Constable Adam McKenzie and Senior Constable David McHenry (Russell Kennedy Lawyers).
Counsel Assisting the Coroner	Mr Mark Rochford, SC and Ms Diana Karamicov (Office of Public Prosecutions).
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	4 July 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne, 3000

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

[2] Now known as Ashurst Australia.

I, AUDREY JAMIESON, Coroner having investigated the death of Samir OGRAZDEN

AND having held an inquest in relation to this death on 5 December 2011 – 9 December 2011, 12 December 2011 – 16 December 2011, 13 March 2012 – 16 March 2012 and 4 June 2012.

at Melbourne

find that the identity of the deceased was Samir OGRAZDEN

born on 28 May 1982

and the death occurred on or about 13 May 2008

at the car park at the rear of 21 Moray Street, South Melbourne

from:

1 (a) GUNSHOT INJURY TO THE NECK

in the following summary of circumstances:

1. On 13 May 2008 at approximately 11.30pm, police intercepted a vehicle in Clarendon Street, South Melbourne. During a search of the vehicle, police located drugs and a firearm. Samir Ograzden was one of the occupants of the vehicle and decamped, running in a direction towards Kings Way. A number of police back-up vehicles responded to the details and pursued Samir Ograzden through the streets of South Melbourne. During the pursuit, Samir Ograzden entered a car park that ran between Kings Way, the corner of Market Street and the rear of 21 Moray Street, and fired upon police. Police returned fire. In the exchange, Senior Constable David McHenry was wounded by a bullet from Samir Ograzden's firearm. Samir Ograzden was hit by one bullet from Constable Adam McKenzie's police issue firearm. Samir Ograzden died at the scene.

BACKGROUND CIRCUMSTANCES

2. Samir Ograzden[3] was 25 years of age at the time of his death. He was the only child of Bobby Cobani and Mernderes Ograzden. His parents separated when he was four months old. Samir had a history of illicit drug use. He commenced using cannabis at the age of 15 years and by 18 years of age, he was addicted to heroin. Several attempts

[3] Ms Bobby Cobani, Samir Ograzden's mother, requested that her son be referred to as "Samir" during the course of the Inquest in place of the more formal reference of "Mr Ograzden". For consistency, I have, in most part, avoided formality and also referred to him only as Samir throughout the Finding.

at detoxification were not entirely successful. Samir also started using other illicit drugs including methamphetamines.

3. In late 2007, Samir commenced cohabitating with his girlfriend, Millie Traynor at 97/22 Kavanagh Street, Southbank. He was unemployed at the time of his death and had a criminal history with convictions for trafficking and possession of drugs, assaults, obtaining property by deception and other dishonesty related offences. Samir was on parole when he was charged with drug offences on 15 January 2007 and 10 July 2007. On 8 October and 16 October 2007, Warrants for Apprehension were issued by the Melbourne Magistrates' Court for his arrest for failing to attend Court regarding the drug offences.

SURROUNDING CIRCUMSTANCES

4. On Monday 13 May 2008 at 11.26pm, Senior Constable (S/C) Julie Stanes and S/C Mark Siragusano were working the South Melbourne Divisional Van (South Melbourne 311) when they intercepted a white Holden sedan, registration number UUL 167 (the vehicle) in Clarendon Street, South Melbourne, for driving straight through a designated left turning and hook turning lane.

5. S/C Stanes approached the driver's side of the vehicle and spoke with the driver, Mr Paul White. The front seat passenger was Mr Manal Choucair. Samir was seated in the back seat.

6. S/C Siragusano checked through the passenger side of the vehicle and after observing that the passengers appeared relaxed, returned to South Melbourne 311 to conduct routine registration checks on the vehicle. Mr White was confirmed as the registered owner of the vehicle who had two conditions on his driver licence, one being a passenger restriction.

7. S/C Stanes returned to South Melbourne 311 and discussed the matter with S/C Siragusano. The officers decided to issue an infringement notice to Mr White for breaching the passenger restriction. S/C Stanes returned to the vehicle and continued speaking with Mr White. S/C Siragusano approached Mr Choucair to obtain his details that were to be entered in the infringement notice. S/C Siragusano observed that Mr Choucair was cradling a green satchel in his lap and had a bum-bag over his shoulder.

S/C Siragusano searched the bum-bag and discovered that it contained cannabis. Mr Choucair was asked to step out of the vehicle and was arrested. S/C Stanes commenced speaking with Samir to establish his identity. When asked, he told S/C Stanes that his name was Josh Cobani and that he resided at . S/C Stanes requested to look inside Samir's bag.

8. Meanwhile, S/C Siragusano returned to the vehicle to check the green satchel positioned in the front passenger foot well and observed a wooden stock from a firearm protruding from the satchel. At this time, S/C Stanes called out that Samir had run off.

9. At 11.44pm, S/C Siragusano notified Police Communications that Samir had run from the vehicle. S/C Stanes discovered Samir's bag contained drugs and a tin containing $10,450 in mainly $100 denominations. S/C Siragusano advised Police Communications that a firearm and drugs were located in the vehicle.

10. At 11.45pm, the Emergency Services Telecommunications Authority (ESTA) Operator gave the "Beacon Warning".[4] The responding police units were:

    a. St Kilda 251 (Sergeant Kate Sommers and Constable Adam McKenzie);

    b. St Kilda 310 (Constable Andrew Sapir and Constable Andrew Nisbet);

    c. Prahran 252 (Sergeant Dean Robinson and Senior Constable Michael Young); and

    d. Prahran 311 (Senior Constable David McHenry and Constable Lisa Griffiths).

11. At 11.46pm, Police Communications notified the K9 Unit that Samir had decamped.

12. At 11.47pm, civilian Mr Angus Booker was driving south along Clarendon Street, South Melbourne. He observed Samir, dressed in a white top and jeans, running from the police car. He followed Samir in his motor vehicle and called Triple 0 (000). Mr Booker saw Samir walk down Bank Street, turn left into Moray Street and walk

[4] "During 1994 the Victoria Police Force undertook a major training program which is commonly referred to as 'Beacon Training'. This name was due to the formation of a project by VicPol Force Command to administer the program called 'Project Beacon'. Beacon training was an integrated training program conducted over 5 days and incorporated....Conflict Resolution, Defensive Tactics Training, Firearms Training and Scenario Training." – Exhibit 37 – Statement of Senior Sergeant Moon dated 20 August 2008.

northwards, turn right into York Street and head towards Kings Way. He then saw him on the eastern side of Kings Way at the United Service Station. Mr Booker saw police vehicles in the area and continued on his way.

13. At 11.50pm, the Prahran 252 unit with Sergeant (Sgt) Dean Robinson responded. The ESTA Operator was notified that Samir had attended at the United Service Station on the outbound side of Kings Way. Sgt Robinson briefly checked a taxi that was refuelling at the United Service Station but was unable to locate Samir.

14. At 11.51pm, Sgt Robinson heard on the police radio that Samir was running north along Kings Way towards the Mercedes Benz dealership.

15. Constable (C/) Andrew Sapir and C/ Andrew Nisbet were travelling in St Kilda 310 north along Kings Way when they observed Samir standing in the middle of the tram tracks on Kings Way. C/ Sapir executed a U-turn and travelled a short distance back south along Kings Way. He stopped the police vehicle near the Mercedes Benz dealership. Samir was located to C/ Sapir's right and at a position about 2 o'clock relative to him. He saw Samir raise his right arm and saw a flash, followed by two loud bangs. C/ Sapir ducked, holding his hands over his head in response to the gunshots. C/ Sapir notified the ESTA Operator that Samir had a firearm and that shots had been fired.

16. The ESTA Operator warned officers to put their ballistic vests on.

17. C/ Lisa Griffiths and S/C David McHenry in Prahran 311 and Sgt Kate Sommers and C/ Adam McKenzie in St Kilda 251 arrived at the scene. Both units arrived at approximately the same time. The members of both units could see Samir.

18. At 11.52pm, S/C McHenry left his vehicle and followed Samir on foot into a car park situated at the rear of 21 Moray Street, South Melbourne. He ran in a northwesterly direction along Kings Way from his vehicle, which was facing northbound along Kings Way.

19. C/ McKenzie also left his vehicle and followed Samir into the car park.

20. Samir was at least 30 metres in front of S/C McHenry when he ran through the car park[5] towards Moray Street and the northwestern corner of the car park. Samir stopped running, turned around towards the police officers, raised his right arm and commenced firing in the direction of both police officers despite both officers shouting for Samir to stop and put his weapon down.

21. C/ McKenzie took cover behind a concrete pylon. S/C McHenry stopped running and found himself in the car park without any cover.

22. S/C McHenry took deliberate aim and fired six shots in the direction of Samir. He dumped his expended rounds and reloaded his weapon as he walked backwards towards the only car in the car park, a small white Mazda sedan.

23. S/C McHenry could see that Samir was doing something with his gun. As S/C McHenry reached the Mazda sedan, he was shot in the back of his right thigh with one bullet.

24. Both S/C McHenry and C/ McKenzie again called upon Samir to drop his weapon. Samir moved further eastwards into the car park and closer towards Kings Way. He fired one more shot towards police. Both C/ McKenzie and S/C McHenry fired three shots from their firearms simultaneously. S/C McHenry fired from behind the Mazda sedan. C/ McKenzie fired the fatal shot from behind the pylon approximately 32 metres from where Samir was standing. Samir fell to the ground.

25. At 11.52pm, the ESTA Operator was notified that the offender was down and that a police member had been shot in the leg. Sgt Somers requested an ambulance and directed that no member approach Samir yet.

26. At 11.54pm, the ESTA Operator advised that an ambulance had been notified.[6]

27. At 11.55pm, the ESTA Operator notified the Metropolitan Ambulance Service to attend.[7]

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[5] The car park is on the western side of Kings Way underneath the Westgate Freeway overpass. At the northern end of this car park is a large building occupied by Konica Minolta (address being 21 Moray Street).

[6] Exhibit 51, Annexure A, paragraphs 43.

[7] Ibid, paragraph 45.

28. At 11.56pm, Sgt Sommers notified the ESTA Operator that Samir had also been shot and was lying on his back on the ground.

29. The Critical Incident Response Team (CIRT) Units advised they would be attending the scene.

30. At 11.58pm, an ambulance was at the scene and attending to S/C McHenry.

31. At 11.59pm, the ESTA Operator advised that a second ambulance would not be attending the scene until directed to do so.

32. On Tuesday, 14 May 2008 at 12.02am, the ESTA Operator advised that a second ambulance was available to treat Samir and waiting for direction to enter the scene.

33. Sgt Sommers notified on the radio that Samir was lying on his back with a firearm in his right hand.

34. Senior (Snr) Sgt Seiz (Collingwood 265) requested over the radio that no unit approach Samir until he could be secured. A decision was made to wait for the CIRT to arrive.

35. At 12.03am, Sgt Robinson requested that the Air Wing Unit attend the scene in order to utilise their overhead lights to help illuminate the area and assist CIRT in effecting Samir's arrest.

36. At 12.06am, the CIRT requested that Samir be cordoned and contained by officers present at the scene until the CIRT units arrived.

37. All officers present at the scene remained in their positions and had their firearms pointed at Samir whilst he lay on the ground.

38. At 12.07am, the K9 Unit arrived at the scene.

39. At 12.10am, the Air Wing Unit arrived at the scene. Using the flir camera,[8] officers were able to project a flir image of Samir on their screen in the aircraft.

40. At 12.13am, the CIRT team arrived at the scene.

[8] Thermal imaging camera.

41. At 12.19am, the Air Wing Unit reported over the police radio that Samir did not appear to be making any movement. The K9 Unit reported over the police radio that there did not appear to be anything in Samir's hand. The Air Wing Unit further reported that there did not appear to be anything in Samir's hand, but it did appear that there was an object six inches from Samir that looked like a pen pistol, or similar. The Air Wing Unit also reported that there appeared to be an object one foot away from Samir's knee.

42. At 12.21am, C/ Nisbet reported over the police radio that Samir appeared to have been coughing approximately 10 mins prior.

43. At 12.23am, the CIRT team moved in to begin effecting Samir's arrest.

44. At 12.25am, the Air Wing Unit advised over the police radio that Samir was in custody.

45. At 12.29am, the CIRT team advised that they had handcuffed Samir and a request was made that his hands were to be covered to enable gun shot residue testing.

46. At 12.30am, the ambulance was permitted to approach and begin treating Samir. One minute later, ambulance paramedics confirmed that Samir was deceased.

INVESTIGATIONS

Identity of the deceased

47. The identity of Samir was confirmed by fingerprint search and comparison, was without dispute and required no additional investigation.

Cause of Death

48. On 14 May 2008 at 10.15am, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed an autopsy on the body of Samir Ograzden. Anatomical findings included:

    a. distant range gunshot entry wound right neck with track extending from right to left, anterior to posterior, slightly superior to inferior, through the right sternocleidomastoid muscle, vertebrae C4 and C5 with a projectile recovered in the left scalene muscles; and

b. active chronic hepatitis, highly suspicious of hepatitis C infection.

49. Toxicological analysis on post mortem specimens identified amphetamines and methamphetamines in blood. Trace levels of diazepam were also identified.

50. Dr Parsons ascribed the medical cause of death of Samir Ograzden to a gunshot injury to the neck. In her Autopsy Report dated 2 July 2008,[9] Dr Parsons commented on the time taken for Samir to die in response to a request made directly to her for this information from Detective Senior Sergeant (D/S/S) Ron Iddles. Dr Parsons stated:

> *On the evening of the incident the ambulance officers were unable to attend to the deceased for 31 minutes after being shot, due to police making sure that the scene was safe for them to enter. In this case the projectile went through the cervical spinal cord, causing almost complete disruption. Injuries above C5 can cause quadriplegia and respiratory failure. This type of injury can cause rapid death from brainstem/cervical dysfunction. In this case both transverse processes which contain the vertebral arteries were also completely destroyed. The vertebral arteries are the main blood supply to the brainstem. Taking into account these facts, it is likely that death in this 25 year old man was in the vicinity of minutes.*

Ballistics results

51. The weapon carried and used by Samir was a semi automatic .22 calibre Phoenix pistol. The magazine of this pistol was able to hold seven rounds. An additional round was located in the chamber of the weapon, making a total of eight rounds. Two unspent bullets were found in the pistol.

52. The fatal shot that killed Samir was fired from the police service revolver of C/ McKenzie.

Coronial Investigation

53. The Coronial investigation and preparation of the inquest brief was undertaken by D/S/S Ronald William Iddles, Homicide Squad, Victoria Police.

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[9] Exhibit 1.

JURISDICTION

54. At the time of Samir's death, the *Coroners Act 1985* (Vic) (Old Act) applied. From 1 November 2009, the *Coroners Act (2008)* (Vic) (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior its introduction.[10]

55. The role of the coronial system in Victoria involves the independent investigation of deaths to determine the cause of death, to contribute to the reduction of the number of preventable deaths and for the promotion of public health and safety and the administration of justice.

56. Section 67 of the Coroners Act sets out the statutory role of the Coroner in that a Coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

57. A Coroner may comment on any matter connected with the death and may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[11]

INQUEST

58. Prior to the commencement of the inquest, four Directions Hearings were held on 18 May 2011, 3 June 2011, 24 August 2011 and 25 October 2011.

59. An inquest was held on 5 December 2011 – 9 December 2011, 12 December 2011 – 16 December 2011, 13 March 2012 – 16 March 2012 and 4 June 2012.

Viva voce evidence at inquest

60. *Viva voce* evidence was obtained from the following witnesses at the inquest:

    a. Dr Sarah Parsons, Forensic Pathologist, VIFM

    b. Senior Constable Mark Siragusano - South Melbourne 311

    c. Senior Constable Julie Stanes - South Melbourne 311

[10] Coroners Act, section 119 and Schedule 1.

[11] Ibid, section 72(1) and (2).

d. Angus Booker

e. Detective Senior Sergeant Ronald Iddles

f. John Sulaj

g. Bruce Kaplan

h. Con Arvanitis

i. Constable Andrew Nisbet – St Kilda 310

j. Constable Andrew Sapir – St Kilda 310

k. Constable Nicole Baker – St Kilda 311

l. Constable Toby Dernelly – St Kilda 311

m. Louise Hay

n. Senior Constable Michael Young - Prahran 252

o. Sergeant Dean Robinson – Prahran 252

p. Richard Hanslow – Ambulance Paramedic

q. Constable Lisa Griffiths – Prahran 311

r. Sergeant Caroline (Kate) Sommers – St Kilda 251

s. Inspector Peter Seiz (was a Senior Sergeant at the time) - Collingwood 265

t. Superintendant Peter Guenther – Security Services Division

u. Detective Senior Constable Tina Dodemaide

v. Leading Senior Constable Mark Chandler

w. Senior Sergeant John Rose – (was a Sergeant at the time) CIRT

x. Detective Sergeant Andrew Collison – Crime 541

y. Detective Sergeant Kelvin Gale

z. Detective Senior Constable Simon Polson – Crime 541

aa. Associate Professor David Ranson, Forensic Pathologist, VIFM

bb. Superintendent Michael Williams

cc. Senior Sergeant Gregory Moon – Operational Tactics & Safety Division

dd. Senior Constable David McHenry[12] - Prahran 311

ee. Senior Constable Adam McKenzie[13] (he was a Constable at the time of the incident) – St Kilda 251; and

ff. Ms Bobby Cobani.

Non-publication Orders

61. On 24 August 2011, an Interim Suppression Order was granted pursuant to section 73(2) of the Coroners Act following an application made by the ESTA. On 5 December 2011, the Interim Order was formalised into a Suppression Order pursuant to section 73(2) of the Coroners Act. The Order was made in the following terms:

Pursuant to s.73(2)(b) of the Coroner's Act, publication is prohibited of any report concerning the inquest into the death of Samir Ograzden that:

(1) identifies or tends to identify:

(a) the name of any caller to the emergency telecommunications service operated by the Emergency Services Telecommunications Authority (ESTA) seeking police assistance in the lead up to Mr Ograzden's death;

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[12] A successful application was made pursuant to section 57 of the *Coroners Act 2008* for David McHenry to be granted a certificate pursuant to section 57(1)(b) of the Act. The certificate enables the witness to give evidence at the Inquest without that evidence being used in any proceeding against him.

[13] A successful application was made pursuant to section 57 of the *Coroners Act 2008* for Adam McKenzie to be granted a certificate pursuant to section 57(1)(b) of the Act. The certificate enables the witness to give evidence at the Inquest without that evidence being used in any proceeding against him.

(b) the name of any ESTA police call takers or dispatchers involved in any of the audio recordings provided by ESTA to the inquest;

(2) that reveals the contents of any event chronologies or audio produced by ESTA to the inquest.

62. This Suppression Order remains in force.[14]

63. On 24 August 2011, an Interim Suppression Order was granted pursuant to section 73(2) of the Coroners Act following an application made by the Chief Commissioner of Police in relation to a number of reports/documents produced in the course of the investigation.

64. This Suppression Order remains in force.

65. On 25 October 2011, an Interim Suppression Order was granted pursuant to section 73(2) of the Coroners Act following an application made by the Chief Commissioner of Police in relation to the statement of Superintendent Peter Guenther. On 13 December 2011, the Interim Order was formalised into a Suppression Order pursuant to section 73(2) of the Coroners Act. The Order was made in the following terms:

> That the evidence of Superintendent Peter Ross Guenther regarding the number of Critical Incident Response Teams available at any one time not be published pursuant to section 73(2) of the Coroners Act 2008, as I reasonably believe that the publication would be contrary to the public interest.

66. This Suppression Order remains in force.

Issues investigated at inquest

67. A number of issues were examined in the course of the inquest including but not limited to:

a. the extent of the communication between Victoria Police and the Adult Parole Board regarding Samir's parole status;

[14] By email dated 2 July 2014, parties were alerted to my intention to vary this Suppression Order on or after 4 July 2014.

b. the conduct of members of Victoria Police who dealt with Samir on 13 May 2008, with regard to:

i. the interception of the vehicle in which Samir was travelling;

ii. the pursuit of Samir once he left the vehicle on foot;

iii. the shooting; and

iv. the provision of medical treatment after Samir was shot.

68. Other issues that arose included:

a. whether there is a universal/consistent understanding of the "Beacon Warning";

b. the extent to which police members wore ballistic vests; and

c. the use of the priority button on police radios.

69. In addition, matters raised and discussed in the course of the inquest included the apparent involvement of the Civil Litigation Team of Victoria Police and their contact with police witnesses, the limitations of Victoria Legal Aid funding to family members of deceased persons and The Police Association's use of the media as it related to the circumstances of Samir's death. Arguably, not all of these issues are germane to my jurisdictional role but may necessitate some general comment.

Submissions

70. At the conclusion of the inquest, Counsel acting on behalf of the individual Interested Parties and Counsel Assisting the Coroner provided final submissions, which I have considered for the purpose of this Finding.

71. Counsel Assisting the Coroner prepared a document entitled "Summary of Facts and Chronology"[15] which was distributed to the Interested Parties. Comments and suggestions for amendments were sought and obtained from Counsel for Ms Cobani, Counsel for ESTA and Counsel for C/ McKenzie and S/C McHenry. Counsel for the Chief Commissioner of Police did not submit any amendments for consideration. The document (Annexure A of Exhibit 51) forms the basis for the findings of fact and is effectively reciprocated under "Surrounding Circumstances" in this Finding. The stated times are taken from a number of documents and statements and are approximates.

[15] Annexure A to Exhibit 51 – Submissions of Counsel Assisting the Coroner.

Cross references of times was done throughout the inquest with reference to Exhibits 29, 30 and 51 (Annexure A).

The extent of communication between Victoria Police and the Adult Parole Board regarding Samir's parole status

72. When Samir was charged with drug offences on two occasions in 2007, the police computer LEAP system did not function to provide a "flag" or indicator that a person was on parole. Had the system provided such a tool to police members, according to D/S/S Iddles, a report would have been forwarded to the Parole Board and this may have resulted in Samir's parole being cancelled.[16] In the event that this had occurred and Samir had been apprehended, he may have been in custody at 13 May 2008.

73. Prior to the completion of the inquest, this issue had been resolved according to D/S/S Iddles who stated that the LEAP system now identifies persons on parole by an *alert that comes up in red.*[17]

74. In the circumstances, no further exploration of this issue was required.

The interception of the vehicle

75. The evidence of S/Cs Siragusano and Stanes was non-contentious and accorded with their respective statements.[18]

76. The conduct of both police officers is not criticised. They searched the vehicle in accordance with police procedure.[19] Once Samir ran from the vehicle, S/C Siragusano notified other units over the radio and immediately called for back up.[20] S/C Siragusano also advised other units that a firearm, drugs and cash had been located in the vehicle.[21]

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[16] Exhibit 44 – Statement of Ronald Iddles dated 16 October 2008, T @ p1524.

[17] T @ p1524 (Iddles).

[18] Exhibit 3 – Statement of Mark Siragusano dated 14 May 2008 and Exhibit 4 – Statement of Julie Stanes dated 14 May 2008.

[19] Victoria Police Manual, Instruction 103-5 Vehicle Intercepts, 2 May 2007.

[20] Exhibit 30, p1, time elapsed 0.06.

[21] Exhibit 30, p1, time elapsed 0.41.

The pursuit of Samir once he departed the vehicle on foot

77. Counsel Assisting submitted that the conduct of the police in their pursuit of Samir should be viewed and considered within a temporal context. I concur and have replicated the two tables setting out the relevant times of the events as they unfolded that were prepared and incorporated into the written submissions.[22]

Table 1

Event	Time it occurred[23]	Time lapsed between events	Time lapsed overall
1. Samir ran from vehicle	23.43.46	Between 1 & 2: 3 mins 34 secs	
2. Samir was spotted by Angus Booker	23.47.20	Between 2 & 4: 3 mins 47 secs	
3. Angus Booker lost sight of Samir	23.49.50	Between 3 & 4: 1 min 17 secs	
4. Samir was first seen in Kings Way (by S/Kilda 310)	23.51.07	Between 4 & 5: 43 secs	Between 1 & 4: 7 mins 21 secs
5. Samir ran into the car park and shots were fired at C/McKenzie and S/C McHenry	23.51.50	Between 5 & 6: 1 min 7 secs	
6. Samir was shot and on the ground	23.52.57		Between 1 & 6: 9 mins 11 secs

[22] Exhibit 51 @ p5 – Counsel Assisting stated that "All times quoted and relied upon are based on the event chronologies that formed part of the inquest brief and Exhibit 30 – Timed transcript of Intergraph communication."

[23] The time as described in the tables uses a 24 hour clock as was used in the tendered documents. Accordingly, I have used a 24 hour clock for the remainder of the finding.

Table 2

Event relevant to S/Kilda 251 (Sgt Sommers)	Time it occurred	Time lapsed between events
1. En route to scene	23.45.20	Between 1 & 2: 5 mins 43 secs
2. Code 5 at scene	23.51.03	Between 2 & 3: 4 secs
3. Samir was first seen in Kings Way (by S/Kilda 310)	23.51.07	
4. Samir was shot and on the ground	23.52.57	Between 2 & 4: 1 min 54 secs
5. Overall time at scene before Samir was shot and on the ground		Between 1 & 4: 7 mins 37 secs

78. From the time Samir ran from the vehicle in Clarendon Street, South Melbourne, to the time he was first seen in Kings Way by C/s Nesbit and Sapir, 7 minutes and 21 seconds had elapsed. During that time, Angus Booker provided a description of Samir and a direction of his travel to the ESTA Operator. Mr Booker eventually lost sight of Samir and it was only when C/s Nesbit and Sapir regained sight of Samir on Kings Way that his precise location was known to police. At 23.51.42, Snr Sgt Seiz radioed that officers should attempt to cordon and contain Samir[24] but while Samir was in the open and could not be seen or located with any certainty, it was not possible to meaningfully implement such a plan.

79. I accept that until Samir had run into the car park there was no opportunity for police to cordon and contain Samir. Any hypothesised opportunity to implement a cordon and contain plan within the car park could not however be realised because of the rapid nature of the unfolding events.

[24] Exhibit 30, @ p4.

80. Only 4 seconds lapsed between Sgt Sommers arriving at the scene and the first sighting of Samir, and 1 minute and 54 seconds between Sgt Sommers arriving at the scene and Samir being shot within the car park.

81. It took Sgt Sommers 5 minutes and 43 seconds to respond to the call and arrive at the scene on Kings Way. I do not accept that it was practical for Sgt Sommers to discuss a plan with C/ McKenzie regarding how they would approach, cordon and contain the fleeing offender as neither Sgt Sommers nor C/ McKenzie knew what they would find when they arrived at Kings Way. Despite this lack of knowledge of what was awaiting them, I accept that Sgt Sommers demonstrably was considering the broader requirements of searching for an offender on foot as she had radioed for the K9 Unit soon after she radioed that she was en route.[25]

82. Samir was seen on Kings Way 4 seconds after Sgt Sommers and C/ McKenzie arrived at the scene. Samir ran into the car park from Kings Way and headed towards Moray Street. The only possible entry into the car park from Kings Way was on foot. The boundary of the car park was barricaded by chains along Kings Way and entry with a vehicle was impossible from this direction. The only vehicle access point was along Moray Street, which required vehicles to leave Kings Way and drive around the car park and other buildings. Although I am not convinced that a thorough analysis of the geography of the location was undertaken by Officers McKenzie and McHenry at the time, it is nevertheless understandable and reasonable that they decided to pursue Samir on foot – they could see him, he was running away and he was running into a car park. Had they not pursued Samir on foot at this point, the likelihood that the officers would lose sight of him would have increased when regard is had to all of these factors.

83. Sgt Sommers was not afforded the opportunity within this timeframe to plan for a cordon and contain. There was no defined geographical boundary and the scenario was fluid and rapidly unfolding.

Sgt Sommers control over C/ McKenzie

84. At the time of the incident, C/ McKenzie, a relatively junior member of Victoria Police was paired with Sgt Sommers. Despite concern that Sgt

[25] Exhibit 30 - Time of Communication: 23.45.10.

Sommers had not exercised some control over preventing C/ McKenzie from taking chase of Samir, the evidence supports that C/ McKenzie was nonetheless considered to be adequately equipped with the skills to be an operational police member by Victoria Police to make independent operational decisions. Snr Sgt Moon gave evidence that members are trained, specifically to be able to respond to incidents such as this one, so that they act without specific instructions being given to them. Snr Sgt Moon explained that this approach was especially important in dynamic and critical incidents such as the current situation.[26] Sgt Sommers agreed with this approach, and indicated that whilst she would have preferred for C/ McKenzie to remain in the car so that she could explain to him why she had made various decisions, she nonetheless wanted officers below her rank and less experienced than herself to be able to think independently and conduct their own risk assessments.[27]

85. Sgt Sommers as the more senior member may have been paired with C/ McKenzie to guide him, but given he was a fully trained officer I accept that in these circumstances Sgt Sommers should not be criticised for not exercising control over C/ McKenzie.

The Foot Pursuit

i) Communication during the foot pursuit

86. In evidence, Snr Sgt Moon said that when officers were in immediate pursuit of a suspect, it was not necessarily expected that they radio the movements of the pursuit. He said:

> *..if you are in immediate pursuit of someone you don't stop to grab the radio and say look I'm getting out of the car now, I'll be taking off after this bloke. You're out of the car and you're gone.*[28]

87. I accept Snr Sgt Moon's comments in this respect and make no criticism of C/ McKenzie and S/C McHenry for not radioing that they were pursuing Samir on foot. I also agree with Snr Sgt Moon's position that it would have been prudent for their partnered officers, Sgt Sommers and C/ Griffiths who were further behind in the pursuit, to pick up the burden of radio communications and inform others that C/

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[26] T @ p1238 (Snr Sgt Moon).

[27] T @ pp 674 – 675 (Sgt Sommers).

[28] T @ p1274 (Snr Sgt Moon).

McKenzie and S/C McHenry were in foot pursuit of Samir.[29] However, I take this criticism no higher as I am not convinced that radio communications at this stage would have altered the outcome.

ii) Confrontation during the foot pursuit

88. I agree with Counsel Assisting's submission that it is erroneous and misleading to depict that Samir was *chased* by police[30] such that it created a confrontation and led Samir to no other option but to shoot at police. This proposition is not supported by the evidence. Samir was given multiple opportunities to disengage as submitted by Counsel for the Chief Commissioner of Police[31] and chose not to. Furthermore, I accept the submission of Counsel on behalf of C/ McKenzie and S/C Mc Henry that it would have been an abrogation of the officers' responsibility to the public had they not pursued Samir. Counsel stated:

> *On one level, McHenry and McKenzie had decided not to engage Samir in that they did not try to chase him down. However a complete disengagement, to not follow and at least observe Samir, would not be consistent with the duty owed by the police to the public at large. Samir was armed with a loaded handgun and he had shown that he was prepared to use it. He was now running through a populous area at night and his intentions were unknown. If the police did not attempt to maintain contact with Samir it would be a fundamental abrogation of their responsibility to protect the public and prevent serious crime.*[32]

89. The sudden and rapidly escalating nature of the incident required police to plan and act immediately.[33] Once engaged in the foot pursuit of Samir, Sgt Robinson stated that the officers could not *disengage because the risk to the community was too great if you did that, if you let him disappear into the dark.*[34] When Samir stopped running and turned in the direction of S/C McHenry and C/ McKenzie, he was not responding to their

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[29] T @ p 1246-1247.

[30] Exhibit 47 - Submissions on behalf of Bobby Cobani @ 3.15-3.23.

[31] Exhibit 49 @ paragraph 40.

[32] Exhibit 50 - @ paragraph 30.

[33] Exhibit 49 – Submissions on behalf of the Chief Commissioner of Police @ p13.

[34] T @ p503 (Sgt Robinson).

commands but instead shot at the officers. S/C McHenry and C/ McKenzie have responded to protect themselves. Snr Sgt Moon stated:

> *.. the outcome of any of these type of incidents is quite often determined by the actions of the subject. If the subject decides to, as in this case, to stop and commence a gunfight, your options at that point in time are to seek cover and ah, return fire.*[35]

90. The use of the term "game on" presented as a most inappropriate and unfortunate use of language by Snr Sgt Moon[36] however I have found that this was not a situation where police created confrontation by pursuing Samir such as I found in the Record of Investigation into the Death of Gregory Ram Biggs[37] as was referred to in the submissions made on behalf of Bobby Cobani. The circumstances in this matter are distinguishable. I do not consider that police escalated the situation with Samir – the situation escalated because of the actions of Samir. In the circumstances I therefore decline from making any recommendations as proposed under paragraph 6.12 in the submissions made on behalf of Bobby Cobani[38] and in declining to do so, I am cognisant of the submissions of Counsel Assisting that I should in particular have regard to 6.12(e) of the submissions because of the importance of conflict resolution as an aspect of policing and a skill in which police should be receiving optimum training. Save to say that I have had regard to that paragraph and to paragraph 6.12(f) as I have previously made recommendations[39] along similar terms, but do not consider that Samir's investigation entertains such recommendations.

The return of fire

91. Sgt Moon made no criticism of officers McHenry and McKenzie for returning fire at Samir. To the contrary, their return of fire was in accordance with their training. He said that although there are many things that would be going through the mind of an officer when confronted by lethal force, they are expected to implement the "Safety First" principles – they must look out for themselves, their partner, seek cover and

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[35] T @ p1213 (Snr Sgt Moon).

[36] T @ pp 1238-1239.

[37] Case No 1798 of 2004.

[38] Exhibit 47 – paragraph 6.12 (@ p17-18).

[39] See Record of Investigation into Death of Gregory Ram Biggs – 1798/08 @ p16.

return fire.[40] Similarly, in response to questions about the appropriateness of the officer's field of fire in the car park, Sgt Moon made no criticism of officers McHenry and McKenzie. He said that the solid wall of the Konica Minolta building behind where Samir was standing was a field of fire reasonably open to them – there was *not a great deal of concern about shots hitting any bystanders or...straying into the public arena.*[41]

92. The discharging of a firearm in an open public space carries an enormous risk to the health and safety of members of the public. When there is an exchange of fire in a public space, the risk to members of the public is manifestly increased and is not an activity that can reasonably be condoned. Although there was traffic on Kings Way at the time of the incident, there is however no evidence of pedestrian traffic either on Kings Way or in the immediate surrounding streets and no evidence of any occupants in the Konica Minolta building. In all of the circumstances, I make no criticism of S/C McHenry or C/ McKenzie for returning fire at Samir at that time and in that location.

The role of Sgt Sommers

93. There was much criticism of Sgt Sommers in the discharge of her duties as the St Kilda 251. In the submissions made on behalf of Bobby Cobani, Sgt Sommers was accused of being *repetitive and hysterical* in her radio transmissions that were highlighted by her inability to convey the exact location for the CIRT to attend.[42] It was further submitted that Sgt Sommers *failed to exercise control over the incident* and that this was highlighted by the ESTA Operator seeking clarification from Sgt Seiz whether he was coordinating the scene.[43]

94. I do not accept the basis on which the criticism of Sgt Sommers is made - that is, the radio transmissions. This was undoubtedly a highly emotionally charged situation involving firearms, but I did not detect hysteria in Sgt Sommers' communications. She called for backup from appropriate specialist units, she made clear directions that no one was to approach Samir and she was correct to confirm her position as being in charge with the ESTA Operator who was also involved in this emotionally charged

[40] T @ p 1242 (Sgt Moon).

[41] T 2 p1249 (Sgt Moon).

[42] Exhibit 47 @ paragraph 3.30; Exhibit 30 @ 23:53:46 (p5).

[43] Exhibit 30 @ 23:55.23 (p6).

event, albeit remotely. In addition, I did not detect from the evidence of the responding officers any confusion amongst them as to the identity of the officer in charge of the scene.

95. Furthermore, from my own viewing of the scene and noting the number of different ways witnesses have described the location, it is understandable that Sgt Sommers' reporting of the location at the time was not readily understood to all. I would also opine that the location of the incident was difficult to describe.

96. I do however accept that Sgt Sommers should have removed herself from the cordon after Samir had been shot and fell to the ground in order to better manage the scene.[44] As Snr Sgt Moon opined:

> *..her span of control at that point in time was starting to widen and it's getting fairly difficult to manage at that point in time.*[45]

97. I also accept the submissions made on behalf of Bobby Cobani that the evidence establishes that Sgt Sommers was incorrect in her belief that Samir had a firearm in his hand once he had been shot and fell to the ground.[46] However, each member forming part of the cordon had different vantage points of Samir and I accept that this reasonably explains the belief that Sgt Sommers held about Samir holding a firearm in his hand once he had been shot. She could not see if Samir was injured[47] and she also held the belief that Samir continued to pose an immediate threat.[48] She was entitled to her beliefs given how the events had unfolded including the fact that one of her officers had been shot. Snr Sgt Moon supported Sgt Sommers' belief when he stated Samir

> *.. could still pose a viable threat...just the fact you're shot doesn't mean you can't function.*[49]

98. The decision of Sgt Sommers to not approach Samir was a reasonable one in all the circumstances known to her at that time. The directive from Collingwood 265, Snr Sgt

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[44] T @ p1242 (Sgt Moon); Exhibit 51 - Submissions of Counsel Assisting @ pp11-12.

[45] T @ p1223.

[46] Exhibit 47 @ paragraph 3.36.

[47] T @ p650 (Sgt Sommers).

[48] T @ p677 (Sgt Sommers).

[49] T @ p1225 (Snr Sgt Moon).

Seiz, that *no member is to approach until the Security has arrived,*[50] effectively reinforced Sgt Sommers' immediate decision and removed any thought she had about approaching Samir[51] until the CIRT arrived. Snr Sgt Moon also stated that *the decision to call in the CIRT to secure him, I think that was a good and valid call.*[52]

99. However, as time progressed and the CIRT had not yet arrived, the decision not to approach Samir became unreasonable. No officer reported Samir moving however no one questioned the ongoing reasonableness of the command not to approach. Sgt Robinson said that he was prepared to effect the arrest but had been told not to and was obeying orders.[53] He said:

> *...the fact that there had been no movement, this would be different if there was movement from the person who was on the ground, but my attitude at that point, and it hasn't changed to this day, was that, he was in fact deceased.*[54]

100. Snr Sgt Seiz said in his evidence that given the time that had lapsed, he had considered requesting officers to move in on Samir but simultaneously rejected such a call as he would never place others in that position of potential danger.[55] Snr Sgt Seiz's directive not to approach Samir was communicated at 23.52.41 that is, prior to the communication from Sgt Sommers at 00.02.01 that she believed Samir held a firearm in his right hand.[56] I thus reject the submission that Snr Sgt Seiz's directive *was coloured*[57] by Sgt Sommers as the evidence suggests that Snr Sgt Seiz's initial directive was made independently of the communication of Sgt Sommers. His reinforcement of his directive was immediately after Sgt Sommers' communication at 00.02.01 but rather than be *coloured* by Sgt Sommers, I accept his evidence that *he* did not want to put anyone at risk.

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[50] Exhibit 30 @ 00:2.01 (p9).

[51] T @ pp 677-678 (Sgt Sommers).

[52] T @ p 1225 (Snr Sgt Moon).

[53] T @ pp 579 - 580 (Sgt Robinson).

[54] T @ p579 (Sgt Robinson).

[55] T @ pp 747-748 (Snr Sgt Seiz).

[56] Exhibit 30.

[57] Exhibit 47 @ paragraph 3.42.

The role of the CIRT

101. The CIRT were not briefed about Samir's potential to require urgent medical attention until they arrived at the scene.[58] Although Sgt Rose said that he could factor this information into his risk assessment, the reality of the situation was that it would not have assisted CIRT in its response time as the CIRT are restricted by the speed at which their vehicles can travel. Sgt Rose stated:

> *We get there as fast as we can. Our vehicles are classified as white class vehicles which mean we can't exceed the speed limit due to policy. We get there and kit up as fast as we can.*[59]

102. Sgt Rose stated *that in this particular instance, we were moving very quickly to kit up as fast as we could.*[60] Nevertheless, the CIRT took approximately 17 minutes to arrive at the scene due to the process of planning, driving to the scene and kitting up. After confirming the arrest plan, the CIRT moved in on Samir. At the direction of Sgt Rose, L/S/C Adamson secured the firearm and L/S/C Noonan commenced communications with Samir, however Samir did not respond to L/S/C Noonan's verbal commands. From his position, Sgt Rose *could see a large amount of blood coming from behind Samir's (sic) head.*[61] Sgt Rose directed two of his CIRT officers to move in and arrest Samir. When the officers rolled Samir over and applied the flexi-cuffs, Sgt Rose could *see injury to the rear of Samir's (sic) head* and he acted quickly to summon the ambulance to attend.[62]

The provision of medical treatment after Samir was shot

103. Members of the Metropolitan Ambulance Service declared Samir dead 39 minutes[63] after he was reported going to ground.

104. I accept that this matter warranted the attendance of the CIRT, however the time taken for the CIRT to arrive at the scene from Flinders Street,[64] be in position to effect the

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[58] T @ p949 (Sgt Rose).

[59] T @ p950, 1001 (Sgt Rose).

[60] T @ p971 (Sgt Rose).

[61] T @ p927 (Sgt Rose).

[62] T @ p927 (Sgt Rose).

[63] Radio transmission was made that Samir was down at 11.52pm and a transmission was made that the Ambulance Service had declared Samir deceased at 12.31am the following morning.

arrest of Samir and facilitate the provision of medical attention was unacceptable. In any critical incident, the general members who have been involved in the incident and are remaining to secure the scene should be supported by a more timely response from the specialist unit.

105. Furthermore, I agree with the submissions made on behalf of Bobby Cobani and supported by Counsel Assisting, that the decision to handcuff an obviously dead man was unnecessary. If not entirely apparent to officers in the cordon who had been directed to await the attendance of the specialist team, it would have been apparent to members of the CIRT that Samir posed no threat to them when they moved in on him, secured his firearm and observed that he was obviously at the very least unconscious.[65] I do not accept that Samir could have reasonably posed a threat to themselves or to ambulance paramedics at this time.

The cause of death

106. In her *viva voce* evidence, Dr Parsons described that Samir's bilateral vertebral arteries were completely destroyed by the gunshot wound. These arteries, she explained, are the main mechanism for blood supply to the brain, thus death would have resulted within five minutes.[66]

107. She further explained that the bullet had completely severed Samir's cervical spine, and hence, this injury could have resulted in instantaneous respiratory or cardiac failure. Death could have been instantaneous or could have occurred within minutes; however Dr Parsons could not definitively say which occurred in Samir's case,[67] although she was certain that the injuries sustained were very unlikely to be survivable, even with immediate medical intervention.[68]

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[64] T S p934-939 (Sgt Rose).

[65] T @ p956 (Rose).

[66] T @ p20 (Dr Parsons).

[67] T @ p21 (Dr Parsons).

[68] T @ p21 (Dr Parsons).

Training and risk assessments

108. S/C McHenry and C/ McKenzie were appropriately Operational Safety Tactics Training (OSTT) qualified at the time of the incident.[69]

109. Sgt Sommers, as a sub-officer had received training in scene management.[70]

110. Snr Sgt Moon partook in the post incident debrief process and reviewed the actions of the police officers on the night. He opined that risk assessments were taking place all the way through the incident.[71]

111. The Chief Commissioner of Police similarly submitted that there is also direct evidence from the officers who were asked about their thought processes on the night that clearly identifies that the officers were continually engaging in risk assessments.[72]

112. I accept the opinion of Snr Sgt Moon and the submissions of the Chief Commissioner of Police in this regard. Further, I agree with Counsel Assisting that there was no evidence that the risk assessments conducted by the officers on the night did not accord with their training. Snr Sgt Moon also opined that even with the updated training regime[73] as it existed at the time of the inquest, he would not have expected a different response from the officers, and in particular S/C McHenry and C/ McKenzie, to a situation such as unfolded on the night of 13 May 2008.

113. There is no specific training package within OSTT for foot pursuits of armed offenders,[74] however I accept Snr Sgt Moon's evidence that the scenario that unfolded on 13 May 2008, was *"unique"* in two respects – first, he said that rarely would an offender being pursued on foot turn and engage police with a firearm and secondly, it was unique in the distances over which the incident occurred, that is, "*this is a long range encounter*".[75]

114. Submissions made on behalf of Bobby Cobani stated that:

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[69] Exhibit 37 @ p4 – Statement of Snr Sgt Moon confirms he examined the training records of both officers.

[70] T @ p1222 (Snr Sgt Moon).

[71] T @ p1234 (Snr Sgt Moon).

[72] Exhibit 49 @ paragraphs 23-24 (pp8-9).

[73] ICCS (Incident Command and Control System).

[74] T @ p 1284 (Moon).

[75] T @ 1284 (Snr Sgt Moon).

> *..the failure to adopt policies or train members specifically in relation to a foot pursuit scenario heightens the risk that members will fall back on a strategy of pursuit and confrontation; and allow the other person to dictate the outcome.*[76]

115. A number of recommendations were proposed in the submissions and Counsel Assisting supported them to the extent that from a public safety perspective, specific training should be provided in this regard *in order that police members are aware and prepared to deal with particular issues that may arise in such circumstances.*[77]

116. Police officers who come to be involved in the foot pursuit scenario must assess whether there is a greater risk to self and public safety in trying to apprehend the fleeing offender quickly or whether they would be exposing self and the public to greater risk in the event that disengagement enabled the offender to get away. As each scenario is likely to be *unique*, it is impossible to accept the proposition that de-escalation universally equates to control.

117. Nevertheless, it was fortuitous that this foot pursuit and subsequent exchange of gunfire occurred in the evening when there were few members of the public in the immediate vicinity and thus exposed to risk. De-escalation/disengagement was likely to have resulted in Samir, still armed with a handgun, fleeing the area and/or going to a more populated area of the city. Ultimately, despite a number of possible hypotheses, no cogent or clear evidence was provided that de-escalation/disengagement was more likely to have enabled police to adopt a more controlled response to cordon and contain Samir.

118. The particular circumstances of the foot pursuit of Samir are indicative that there is a range of scenarios involving a foot pursuit of an armed or suspected armed offender. The submissions for additional training to specifically address these circumstances are compelling.

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[76] Exhibit 47 @ paragraph 7.10 (p19).

[77] Exhibit 51 @ paragraph 63 (p15).

Vulnerable persons[78]

119. I do not accept that there was sufficient evidence available to the officers on the night of 13 May 2008 that would have or should have alerted them to Samir being drug affected. There was no evidence that he was drug affected from the officers who had the closest interaction with Samir at the intercepted vehicle. In particular, S/C Stanes specifically said that Samir did not appear to her to be drug affected.[79]

120. The finding of drugs in the vehicle does not of itself mean Samir was drug affected and/or in any other way, a vulnerable person. The toxicological analysis[80] on post mortem blood should not be the basis of retrospectively creating a suspicion that Samir was behaving under the influence of drugs such that *an opportunity was lost to consider and apply the training given to members in relation to dealing with vulnerable people.*[81]

121. I accept that a training package on Vulnerable Persons was developed and introduced into the OSTT program in 2010. Additionally, following a recommendation of Judge Jennifer Coate in the Finding into Death with Inquest into the death of Tyler Cassidy,[82] I understand that additional work was undertaken on this training module to address the scope of Her Honour's recommendation to *equip Victoria Police to safely and effectively manage vulnerable youth.* In the response to Her Honour's recommendation dated 17 February 2012, Deputy Commissioner Kieran Walshe stated that it was anticipated that the youth specific training package would be completed and ready for delivery at the OSTT cycle commencing 1 July 2012. Her Honour also made a recommendation for an additional component in the OSTT to *assist police to safely manage people who may be in crisis or possibly intent on bringing about their own death at the hands of police.* Deputy Commissioner Kieran Walshe also responded that research undertaken in this area would enable the recommendation to be implemented.

122. Although the expansion of the Vulnerable Persons training package to incorporate a youth specific component and police use of force with vulnerable people is not

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[78] Exhibit 47 @ paragraph 5.

[79] T @ p82 (S/C Stanes).

[80] Inquest brief, p46.

[81] Exhibit 47 @ paragraph 5.4 (p13).

[82] Finding into Death with Inquest – Tyler Jordan Cassidy COR 2008 5542.

specifically relevant to Samir's circumstances, it does reflect a willingness by Victoria Police to positively respond to circumstances that highlight a shortcoming in their training.

123. As the evidence in this case does not support that Samir was a vulnerable person, I concur with Counsel Assisting that although the two recommendations sought in the submission made on behalf of Bobby Cobani in this regard[83] have merit, the evidence and my findings in this inquest do not support these recommendations being made.

The "Beacon Warning"

124. Most of the police witnesses were asked what they understood the "Beacon Warning" to have meant to them on the night of 13 May 2008. Their responses varied. There did not appear to be a universal understanding of the warning/concept. D/S/S Iddles confirmed that the phrase is historical and is no longer used at the Police Academy or at OSTT.[84] D/S/S Iddles believed the phrase to be outdated and *there would be members that wouldn't even understand what it was.* He said that ESTA/VicPol needed to review using it.[85]

125. Mr Rosen of Counsel on behalf of ESTA (and supported by Counsel Assisting) submitted that the evidence did support a general understanding of the meaning of the warning and how it should influence their policing response despite the absence of a universal definition. In his written submissions, Mr Rosen stated:

> *Most understood the warning as a trigger for the particular application of the operational safety principles including "safety first".*[86]

126. I accept this submission and that the form of warning given by the ESTA Operator was in accordance with the applicable ESTA/VicPol procedures at the time.[87] I also acknowledge that since the events of 13 and 14 May 2008, there has been a change to ESTA/VicPol procedures that followed a recommendation by ESTA to Victoria Police

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[83] Exhibit 47 @ paragraph 5.6 (p14).

[84] T @ p1536 – 1537.

[85] T @ p1537.

[86] Exhibit 48 @ p3.

[87] ESTA-VicPol Operating Work Instruction: ECVPP 0002 – VicPol- Police Event Dispatching/Event Management, (Version 8.01, 15 January 2008) (see Annexure "A" to Exhibit 48) and Work Instruction ECVPWI 0028 (Version 5.1, 17 March 2006) - see Annexure "B" to Exhibit 48.

that the "Beacon warning" be changed to a "Safety Principles warning". The purpose of the relevant work instruction for the ESTA Operator/Dispatcher is:

> *To provide clear and concise instructions to all ESTA Operations staff performing call taking / Dispatch duties associated with VicPol as to the requirements of Victoria Police Command for the approved 'Safety Principles' warning to [broadcast to] field units when certain circumstances are presented in events for dispatch.*[88]

127. Clause 2.1 of the Instruction permits the dispatcher to abbreviate the formal warning *"OPS Safety Principles Apply"* to *"Safety Principles Apply"* provided the intent of the warning is conveyed to the attending Unit(s).

128. The ESTA/VicPol procedure changes that specifically relate to the replacement of the "Beacon Warning" with the "Safety Warning" are appropriate as the "Safety Warning" is more contemporary with current OSTT and hence *better understood*[89] by police members.

129. I am ultimately satisfied that despite the lack of a universal understanding of the "Beacon Warning", all police members involved in the incident responded appropriately.

Ballistic Vests

130. The lack of use of ballistic vests by officers involved in the pursuit of Samir became an issue during the inquest. Neither S/C McHenry nor C/ McKenzie were wearing a ballistic vest at the time they confronted Samir.

131. At 23.51.36[90] after Samir first fired shots towards C/s Nesbit and Sapir in Kings Way, a call was made by the ESTA Operator that ballistic vests be donned by officers: *All units vests on, put your vests on.*

132. In his evidence, Inspector Seiz stated that he would have expected officers to follow the ESTA Operators directions *unless it placed their lives at risk.*[91] D/S/S Iddles agreed

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[88] ECVPWI 0028 – VicPol – Broadcast of 'Safety Principles' Warning in Dispatch in Certain Events (Version 11.01, 30/11/11) – Annexure "D" to Exhibit 48.

[89] Exhibit 48 @ p7.

[90] Exhibit 30 @ p4.

[91] T @ p739-740.

that it was not always practically viable to put the vest on when something is unfolding quickly such as in this case.[92] The vests at the time were uncomfortable to wear in that they were bulky, could restrict movement[93] and access to operational equipment, although it was still possible to run in them.[94]

133. As the gunshot injury to the back of the right leg received by S/C McHenry would not have been prevented if he had worn his ballistic vest, I make no further comment on the probative value of officers always being required to put their vests on before chasing a fleeing offender or indeed wearing them at all times. Save to say that since Samir's death there is a new model of personal issue ballistic vests that, although they may remain *uncomfortable,* are more readily worn. The wearing of the new issue ballistic vest is not mandated and it remains a matter of choice for the individual officer.[95]

Radio use – the priority button

134. The lack of use of the priority/distress button became an issue during the inquest. Its use and effect was described in detail by Sgt Robinson in particular, that it acted to alert ESTA that an emergency call was being made.[96] Sgt Robinson said that the activating of the priority/distress button enabled a police member to cut into or interrupt the police communications radio channel. He stated:

> *I believe it gives ten seconds of open mic and locks out any other communication. Further to that, you then have to reset your own – if it's on a portable device or a vehicle, you then have to reset the device again. It flags with....ESTA saying it's an emergency call. It identifies the unit that you're calling from and....once you've had your ten seconds of open air, you then have to reset....and I believe you have to do that before you can make further communications...*[97]

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[92] T @ p1534 (Detective Snr Sgt Iddles).

[93] T @ p574-575. (Sgt Robinson).

[94] T @ p576.

[95] T @ p1533 (Iddles).

[96] T @ pp 449, 450, 487 (Sgt Robinson).

[97] T @ p450 (Sgt Robinson).

135. I accept the submission of Counsel Assisting that when regard is given to the short amount of time that transpired between the particular events in this incident that the use of the priority button, and especially the ten seconds of radio transmission overriding, would more likely have caused confusion and disorganisation to the response of officers on the night rather than assist in maximising effective communication. Sgt Robinson also stated *I don't think it would have assisted on the night.*[98]

136. I did not hear any evidence to convince me to the contrary view.

Independence of Police Investigations

137. I make no criticism of the investigation conducted on my behalf by D/S/S Iddles however, I agree with the State Coroner (as she then was) Judge Jennifer Coate, when she said in the Finding into death of Tyler Cassidy[99] that whilst police remain the investigators in police related fatalities, the concern about the perception of a lack of transparency as to the nature of the investigation will not abate. Her Honour recommended that:

> *To allay perceptions regarding collusion and bias, without compromising the coherence of the account given by Victoria Police members following a police contact related death, I recommend that the Secretary to the Victorian Department of Justice provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in the incident.*[100]

138. Coroner Peter White adopted the same recommendation in his Finding into the Death of Shane Bennett.[101]

139. On 2 October 2012, the Court received the response to the recommendation from Dr Claire Noone, Acting Secretary to the Department of Justice, declining to adopt the recommendations on the grounds that the recommendations:

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[98] T @ p450 (Sgt Robinson).

[99] Finding into Death with Inquest – Tyler Jordan Cassidy – COR 2008 5542.

[100] *Op cit* - Recommendation 8 @ p 130.

[101] Finding into Death with Inquest – Shane Bennett – COR 2008 1132 - Recommendation 6.

a. *are based on a perception that collusion or bias may occur in the interview process although both you and Coroner White do not identify any actual collusion or bias during the interviews of police members in either inquest;*

b. *have been rendered less necessary with the changes made to the Victoria Police oversight and conflict of interest rules in relation to such investigations; and*

c. *risk interfering in the operational independence of Victoria Police in conducting these investigations in a timely manner.*

140. It is predominately the *perception* of lack of transparency that continues to intrude generally into police contact investigations and specifically in this matter, when the perception of collusion was aired after it became apparent that the Civil Litigation Team of Victoria Police had approached police witnesses leading up to the commencement of the inquest. The creation of the perception of collusion was unnecessary and could have been avoided if Civil Litigation had informed my investigator of their approaches. This is particularly so when following these meetings, some of the witness sought to make changes to their original statements.[102]

141. The changes to police oversight of these types of investigations and changes to the conflict of interest rules have greatly assisted Coroners, however the public perception of transparency and collusion are still palpable. Despite the Acting Secretary's response, I find that the wording of Judge Coate's recommendation remains applicable to this matter.

The Police Association's use of the media

142. I decline to make any comment pursuant to section 67(3) of the Coroners Act or recommendation pursuant to section 72(2) of the Coroners Act in respect of the matters raised in submissions made on behalf of Bobby Cobani that relate to the Police Association.[103] The Police Association was not represented at the inquest and any such comment or recommendation would require a broad interpretation of the phrase *"any matter connected with the death"* that I am not prepared to give.

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[102] T @ pp107-108.

[103] Exhibit 47 @ paragraph 17.

The limitations of Victoria Legal Aid funding to family members of deceased persons

143. In relation to the submissions made on behalf of Bobby Cobani about the availability of Legal Aid funding to family members of deceased persons, I also refrain from making any recommendation pursuant to section 72(2) of the Coroners Act as ultimately these are matters for the Director of Legal Aid and could be construed as matters political rather than coronial.

144. By way of comment however, I acknowledge that Bobby Cobani advised me that she had been unable to secure sufficient Legal Aid funding for representation at the inquest. If Counsel and instructing solicitors had not been prepared to act for her *pro bono*, her ability to meaningfully participate in the inquest would have been severely curtailed. She said:

> *In the event that I might have had to represent myself, I resigned myself to reading the brief. I read 187 pages of the 481 page brief and the memory still lingers. No mother should have to read of so many accounts of her son's last half hour on earth.*[104]

145. The inequity is blatant particularly in matters such as this investigation where there is police involvement in the death. Victoria Police and individual police officers do not, as far as I am aware, ever require the assistance of Legal Aid and they are on all occasions well represented – as they are entitled to be and indeed in my opinion, should be. However, such an entitlement should also be afforded to families. Freckelton and McGregor in a recent article in the *Journal of Law and Medicine* (JLM)[105] discussed coronial law and practice from a human rights perspective. A section within the article specifically discussed the right to legal representation of which they said:

> *In general terms, there is no right for any person to legal aid. It depends on whether they satisfy any jurisdiction's eligibility requirements.*[106]

146. As in the submissions made on behalf of Bobby Cobani, the article made reference to *R (Humberstone) v Legal Services Commission [2010] EWHC 760* - a matter that was

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[104] T @ p1517 (Bobby Cobani).

[105] Coronial Law and practice: A human rights perspective, Ian Freckelton SC and Simon McGregor (2014) 21 JLM 584.

[106] *Op cit* @ p594.

the subject of a successful judicial review from a decision of the Legal Services Commission of England and Wales not to grant legal aid to the mother for an inquest into her son's death. Hickinbotham J held that the right to life under Art 2 of the European Convention on Human Rights (ECHR) *on occasion will require a person to be legally represented and that the complexity of the inquest, the seriousness of the allegations made about the cause and circumstances of the death and the views of the coroner are factors that should be considered. The principle question, he held, is whether a refusal of funding to a family member breaches the state's obligation to carry out an effective investigation into a death.*[107]

147. Bobby Cobani was of course able to participate appropriately and effectively in this inquest into her son's death but only through the goodwill of others. Whether similar reasoning as applied in Miss Humberstone's case should apply to Victorian applications for Legal Aid such as in Bobby Cobani's case is not a matter for me, but perhaps for the application related to the right to life under section 9 of the *Victorian Charter of Human Rights and Responsibility Act 2006* (Vic) to be tested in a superior jurisdiction.

Further comments

148. Ms Cobani made contact with the Court on several occasions after the close of evidence at the inquest. She was referred back to her legal representatives. I understand from court staff that Ms Cobani remains aggrieved about the manner in which her son died at the hands of police and concerned that I may not have heard all the relevant evidence of the circumstances. This is my interpretation of her communications to court staff as conveyed to me, as I did not personally read any of her written communications received after the close of evidence.

149. I have received no formal request to re-open the investigation and have thus proceeded to finalise the matter.

150. Ms Cobani has lost her son. She is entitled to feel aggrieved at how his death came about. He was only 25 years of age. The death of Samir was a violent death and occurred in circumstances that are unacceptable and abhorrent to our society. However, the context in which Samir's death occurred cannot be forgotten. Samir was in the

[107] *Op cit.*

company of two colleagues in a vehicle where a firearm, drugs and a large amount of cash were discovered. Samir was not a law abiding citizen. He decamped from the intercepted vehicle with another firearm on a background of already having breached his parole and appears to have been avoiding police as there were outstanding warrants for his arrest. Samir was certainly at risk of being goaled. After decamping from the intercepted vehicle, Samir did not desist from fleeing from police even when it was apparent he was being pursued by them. To the contrary, he continued in his attempt to remain at large. Whilst being chased Samir did not respond to the police commands to stop. Samir fired shots at police in the first instance.

151. I doubt Bobby Cobani will ever understand what led Samir to adopt this course of action on the night of 13 May 2008. I accept that she will never forget it. The impact on her life and those of S/C McHenry, C / McKenzie and Sgt Sommers will be long lasting. This violent scenario has deeply affected many.

FINDINGS

1. I find that the identity of the deceased was Samir Ograzden, date of birth 28 May 1982.

2. I find that S/C Stanes and S/C Siragusano acted appropriately in initiating and managing the vehicle intercept.

3. I make no adverse finding against the ESTA Operator in the discharge of her duties on 13 and 14 May 2008.

4. I make no adverse finding against the ESTA Operator in her articulation of the "Beacon Warning" on 13 May 2008. The warning was given without delay when the suspicion was raised that Samir maybe carrying a firearm.

5. I find that the pursuit of Samir was appropriate in the circumstances. He had decamped from a police intercept and the concern that he may have been armed was based on clear and cogent evidence of the discovery of a firearm in the intercepted vehicle. It was appropriate to utilise available resources to apprehend Samir. I accept that the police response was focused on locating and apprehending Samir and protecting the public from a suspected armed offender. Once the suspicion was realised and Samir shot at police, I find that it was reasonable and appropriate for S/C McHenry and C/ McKenzie to return fire, and in the circumstances I make no adverse finding against either officer.

6. I find that the foot pursuit of Samir was reasonable and appropriate in these particular circumstances.

7. I find that the post shooting scene could have been better managed by Sgt Sommers had she removed herself from the cordon however, her management decisions made no difference to the outcome and as such I make no adverse finding against Sgt Sommers.

8. I find that the involvement of the CIRT in no way contributed to resolving the incident or securing the scene however I further find that the time taken for the CIRT to be operationally involved at the scene and effect the arrest of Samir did not cause or in any way contribute to his death.

9. I accept and adopt the medical cause of death as ascribed by Dr Sarah Parsons and I find that Samir Ograzden died from a gunshot injury to the neck.

10. AND I further adopt the opinions of Dr Parsons and find that Samir's death would not have been survivable and would likely have occurred within minutes even if he had been afforded immediate medical intervention.

11. AND in conclusion, I find that Samir's death could have been avoided if he had remained at the intercepted vehicle where, like his colleagues, he would have been lawfully arrested and detained in custody.

RECOMMENDATIONS

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

1. The handcuffing of Samir by CIRT members was unnecessary in the circumstances. With the aim of managing seriously injured and deceased persons more humanely, I adopt the suggestion for a recommendation made by Counsel on behalf of Bobby Cobani[108] and supported by Counsel Assisting.[109]

   I recommend that the training in respect of containment, restraint and arresting of seriously injured or deceased persons be reviewed and modified if appropriate, but at a minimum to take into account the necessity to proceed to handcuff a seriously injured or deceased person in circumstances where:

[108] Exhibit 47 @ p24.

[109] Exhibit 51 @ p17.

a. it is not necessary to give effect to containment, restraint and an arrest; and

b. it would be inhumane to handcuff that person; and/or

c. handcuffing the seriously injured person may cause further injury.

2. With the aim of improving the integrity of an investigation into police contact matters and improving disclosure and distribution of relevant material in a timely manner I recommend:

a. investigating officers conduct a video recorded walkthrough of the scene of the incident;

b. where possible and appropriate, interviews with police officers involved in police-related fatalities should be video recorded; and

c. all relevant notes and materials be disclosed and provided to the Coroner and the investigating officer, Counsel Assisting and Interested Parties prior to the commencement of the inquest.

3. With the aim of reducing *perceptions* of bias and collusion by families involved in the inquests of police contact deaths, I reiterate and repeat Recommendation 8 of Judge Jennifer Coate made in the Finding into the Death of Tyler Cassidy:

> *To allay perceptions regarding collusion and bias, without compromising the coherence of the account given by Victoria Police members following a police contact related death, I recommend that the Secretary to the Victorian Department of Justice provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in the incident.*[110]

4. With the aim of reducing perceptions of bias and collusion by families involved in the inquests of police contact deaths I adopt in part the proposed recommendations made on behalf of Bobby Cobani in relation to the involvement of Civil Litigation and I recommend that:

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[110] *Op cit* - Recommendation 8 @ p 130.

a. in preparation for giving evidence at an inquest in police contact matters that a policy be developed that embraces the concept of transparency and ensures that when the Civil Litigation team instigate meetings between police witnesses and the Civil Litigation team, a member of Professional Standards is present at such meetings or if Recommendation 3 is adopted, an institutionally independent, legally trained person is present at these meetings; and

b. protocols are established to ensure that evidentiary materials and aids produced to officers during these meetings and/or provided to the Civil Litigation team by police witnesses should be disclosed to the Court, the investigating officer, Counsel Assisting and Interested Parties in a timely manner.

5. With the aim of minimising risks and harm to police officers, offenders and members of the public, I recommend that a training module on foot pursuits of armed and suspected armed offenders be developed and incorporated into the Victoria Police Manual and introduced by way of an OSTT component. Such a module should provide guidance to officers on the use of alternative tactical options to maintaining a foot pursuit against an armed or suspected armed offender such as but not limited to:

a. ensuring one member of a team takes responsibility for making radio communication about the direction and/or context of the foot pursuit;

b. considering whether disengagement is in the interests of public safety; and

c. considering whether the circumstances warrant the use of specialist resources.

6. With the aim of improving scene management decision making and providing support to officer assuming 251 responsibilities, I recommend that there be a review of the sub-officers' training in this regard.

I direct that the Finding be published on the internet.

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

Mr Mark Bradley, Ashurst Australia on behalf of Ms Bobby Cobani

Mr Jason Ong, Office of Public Prosecutions, Assisting the Coroner

Mr Benjamin Lloyd, Russell Kennedy Lawyers on behalf of Constable McKenzie and Senior Constable Henry

Ms Monika Pekevska, Victorian Government Solicitors Office on behalf of Chief Commissioner of Police

Mr F Badali, Gadens Lawyers on behalf of Emergency Services Telecommunications Authority

Ms Debora Coombs on behalf of Corrections Victoria

Detective Senior Sergeant Ronald Iddles

Signature:

AUDREY JAMIESON
CORONER
Date: **4 July 2014**