consumption of alcohol on that evening, a possible sense of rejection from his friends and his youth may all have contributed to his loss of control of his emotions that evening. Professor McGorry stated that the effects of alcohol can increase emotional lability, irrationality, anger and distress.[193]

237. Professor McGorry also noted that in adolescence, a young person's mood and emotions can change quickly and the shifts can be quite intense: "*...People can be assessed and assumed to be pretty stable but things can change very rapidly and people can get into a very deep depression or a deep intense anger or a highly risky suicidal situation having been apparently perfectly okay some hours earlier, we see this all the time.*" [194]

Conclusion

238. I have strived to provide answers to the questions that haunt Tyler's family and us as a community more broadly. What caused this poor boy to be in the state he was in on this night? Based on what the investigation revealed, I find the most likely answer to be that there was a combination of factors which caused Tyler's state on this evening, as suggested by Professor McGorry: Tyler's unresolved grief at the loss of his father, accentuated by the anniversary of his father's death proximal to these events; his consumption of alcohol in the context of evidence as to his prior erratic, irrational and risk-taking behaviour when affected by alcohol; the impulsivity of adolescence generally and his particular history of lack of impulse control; together with whatever was causing the state of mind he was endeavouring to describe or at least hint at to his friend Emily the night before; plus a possible perceived list of rejections which included his expulsion from Southern Cross Soldiers and his inability to return to Diamond Creek that night to be with his friends.

239. Tyler was desperate that night. Desperate to be with his friends, perhaps seeking some distraction from the inner despair he was in for reasons, sadly, we can now never know. Just as Tyler was not prepared to tell Emily in life what was so deeply troubling him, we are not going to find that without him here to answer those questions.

SUICIDE

240. The issue of whether or not Tyler was engaged in an act of "*suicide*" on this night was raised, both on the evidence, and in final submissions in the Inquest. It was a highly contentious and complex issue, which understandably aroused extremely strong emotions, in particular for Tyler's family. Further, not only was it submitted that the evidence was contentious, but there was contention in the submissions as to the current state of the law in Victoria. Given that, I consider it necessary to examine both the law and the evidence.

---

[193] Transcript 2631.

[194] At transcript 2630, Professor McGorry stated that young people generally have a diminished capacity to moderate impulsive action and emotional response as a result of the incomplete maturation of the frontal cortex.

The law of "suicide"

241. "*Suicide*" is the language of the criminal law. The crime of suicide was abolished in Victoria in 1967 by an amendment to the *Crimes Act 1958* (No. 7546). Section 6 A of the *Crimes Act 1958* (Vic) states that: "*The rule of law whereby it is a crime for a person to commit or to attempt to commit suicide is hereby abrogated.*"

Not a crime

242. The law of suicide developed in the shadow of its history as a criminal offence. Cummins J in the *DPP v Rolfe*[195] in 2008 stated that suicide is a tragedy but it is not a crime. However, there is still considerable moral, religious, linguistic, social, health and even legal disquiet about when a finding of "suicide" or the intentional taking of one's own life can or should be made.

243. In the course of submissions, I was not referred to any definitive Victorian or Australian authority on the test a Coroner should apply when making a finding of "suicide." In this context, I note that Coroners will generally avoid using the language of either the criminal or the civil law.[196] The development of the law of "*suicide*", such as it is, in both Victoria and Australia, since its decriminalisation appears to have developed in the context of either criminal prosecutions for assisted suicide[197] or civil cases relevant to worker's compensation or insurance claims.

The Coroners' test for "suicide"

244. In my view, the appropriate question is properly framed as one in which I must consider whether or not, in doing what he did on that night, Tyler was engaged in a voluntary and deliberate course of conduct or act or acts in which he consciously intended at the moment of engagement in the acts, by those acts, to end his own life.

The presumption

245. Some time was devoted to this question, as to whether or not there is a presumption against "*suicide*". In my view, the current state of the law is that a finding that a person intentionally took his or her own life is a very serious and weighty finding to make. Consistent with the UK authorities,[198] making such a finding can only be done based upon the evidence which satisfies the Coroner to the appropriate evidentiary standard of proof. In other words, such a finding must not be presumed, based on what appears to be "a likely explanation" but rather by finding proof to the proper evidentiary standard.[199]

246. In my view, this is the proper interpretation of where the authorities lie in this country. In Australia, the presumption has been commented upon by the Chief Justice of the South Australian Supreme Court, the Honourable Chief Justice Doyle. His Honour

---

[195] *DPP v Rolfe* [2008] VSC 528.
[196] See s. 69 *Coroners Act 2008,* which prohibits a coroner stating in a finding that a person is or may be guilty of a criminal offence.
[197] Given that incites or aids and abets a suicide is still a crime, there are still prosecutions for this offence in Victoria. See *DPP v Rolfe* [2008] VSC 528.
[198] *R v Coroner for the City of London, Ex parte Barber* [1975] 1 WLR 1310.
[199] Ibid.

stated that the presumption against "*suicide*" was "no more than a presumption of fact, based upon common sense and experience".[200] This statement appears to be consistent with Thomas J in *Clark*[201]. In *Clark's* case, His Honour stated that a finding of "*suicide*" cannot be made without evidence of appropriate weight and to the proper evidentiary standard. In the coronial context, this seems to me to be a proper and sensible way to approach this issue and to be based on the authorities.

Burden of proof

247. This is not a jurisdiction which operates *inter partes.* It is an inquisitorial court.[202]

248. That is, *interested parties* are not parties in any comparative way to the civil or criminal law. No interested party in an inquest carries a burden of proof that requires rebutting. The inquest is an investigation or inquiry into the circumstances in which the death occurred and so there is no *burden of proof* that sits upon a party which requires *rebutting* in the classic model of the traditional civil or criminal proceeding. This does not remove the requirement for evidence to the proper evidentiary standard to be identified before the finding can be made, but in my view the emphasis is firmly on the *proper evidentiary standard.*

The evidentiary standard or standard of proof

249. Whilst the suggestion was raised in the course of submissions that a finding of intentional taking of one's own life can only be made if the Court is satisfied to the evidentiary standard of beyond reasonable doubt, I was not referred to any authority in Australia to support that submission. Given that a finding of "suicide" is not a crime, I am satisfied that the proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life, is what is referred to as the *Briginshaw* standard.[203]

250. The most oft cited passage to explain what that means is the following from Dixon J (as he then was) in *Briginshaw v Briginshaw*:

> *At common law no third standard of persuasion was definitely developed. Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*

---

[200] *South Australian Health Commission v McArdle* Unreported Supreme Court of South Australia, Doyle CJ, Millhouse and Nyland JJ, 26 May 1998.
[201] *Clark* [1991] 2 Qld R R 11.
[202] *Coroners Act 2008* s. 1 (d).
[203] *Briginshaw v Briginshaw* 60 CLR 336.

251. Applied in this context, I take the view to make a finding that Tyler was engaged in conscious, deliberate and voluntary acts with the intention of ending his life is a finding of considerable gravity and consequence, and can only be made by applying the *Briginshaw* standard to the evidence.

Intention

252. If the Coroner can find a voluntary, conscious and deliberate act or acts, then discerning the intention of a person engaged in those acts can be a very complex task for a Coroner. The Coroner must endeavour to discern on the evidence (to the *Briginshaw* standard): did the person have the capacity to form the intent and what was that intent at the time at which those voluntary, conscious and deliberate acts were engaged in? Did the intention remain fixed or did it change part way through the voluntary, conscious and deliberate acts?

The evidence as to voluntary, conscious and deliberate acts and intent

253. Tyler was clearly agitated when he arrived back at his home that night. In his first statement, Mr Taylor stated that Mrs Cassidy had told him that Tyler was threatening to kill himself and saying that the police were after him. Whilst Mr Taylor sought to resile from this in his second statement, I consider it more likely than not that Tyler was expressing such thoughts at home that night. It is consistent with what Tyler did after he left home. It is consistent with Mrs Cassidy ringing Blake to help her with Tyler and it is consistent with Blake's level of concern for his brother and how he reacted. It is also consistent with Mrs Cassidy ringing the police to help her find Tyler and bring him home safely that night. Mrs Cassidy described Tyler when he came home that night as "*boiling and furious, his jugular veins were popping out of his neck, and his face was bright red*". She stated that he said: "*I'm messed up ... my brain is fucked*".

254. The text messages that pass between Tyler and his brother Blake are both terribly sad and powerful evidence of what was going through Tyler's mind at that time he sent them.

255. As Blake was making his way home, the content of the text message exchanges with Tyler caused him considerable concern. Blake stated that he was worried about Tyler's state of mind as a result of the information he had from his mother at the time of Tyler's messages and the fact that Tyler was not answering his calls. Between 9.07pm and 9.36pm, the following text messages passed between Tyler and Blake:

> Tyler to Blake: *I'm sick of it*
> Blake replied: *of wat*
> Blake to Tyler: *plz answer my call*
> Blake to Tyler: *I love u just remember. Nothing elce matters*
> Tyler replied: *I fucken hate what I am plear go b happy 4 me*
> Blake replied: *Tyler u r the smartest person i have ev met. Where can i meet u*
> Tyler replied: *No were stow talken just rember i love t nd mum and r 2 week 4 this life*

Blake replied: *No your not I love u; u r strong; Les tak about it; Just let me c u; U have so much 2 live 4* and *Remember what we talku about lart time. The alchole is not making u think*[204]

256. In Blake's statement he said that he was concerned that Tyler was going to kill himself. He stated that when he sent Tyler the message: "*U have so much 2 live 4*" that was because he was concerned about what Tyler was going to do. He gave evidence that he thought Tyler *"was going to kill himself"*.[205] Blake told his friend James Wendt, that he thought Tyler was going to kill himself.[206]

257. The evidence is that Blake called 000 at 9.23pm and said to the 000 operator "*my brother said he was going to top himself and he just called me and said that police were going to shoot him"*.[207]

258. The next relevant piece of evidence on this issue is Tyler's communications to 000 at 21.18. As set out above, before entering Northcote Plaza Tyler rang 000. He was demanding that the operator send the police to Northcote Plaza as there was a psychopath there with a shotgun. Tyler was trying to describe where he was by telling the operator to send police to the corner of Blythe and High Streets. He described what he was wearing by telling the operator: "*He's wearing a blue flanny*". As the operator was trying to establish the location, Tyler repeated several times: "*Shoot him dead. Shoot him fucken dead, you hear me?"* As the operator tried to clarify what the problem was the following exchange happened:

Operator: What's the problem?
Tyler: ...is a psychopath...
Operator: What is he doing?
Tyler: ...and he's got a shot gun. He's gone crazy. Shoot him now. Alright? Shoot him.
Operator: Whereabouts is he at the moment?
Tyler: Northcote Plaza. Shoot him fucking dead.
Operator: How can he be at Northcote Plaza and you've given me Blythe Street and High Street?
Tyler: yeah, coz that's where he fucken is. That's fucken Northcote Plaza, you dumb shit.
Operator: That's not Northcote Plaza.
Tyler: Shoot him fucken dead.[208]

---

[204] Inquest Brief page 920.
[205] Inquest Brief 191.
[206] Evidence of James Wendt at transcript page 839. James gave evidence that he believes this telephone call took place at 9.15–9.20pm although the telephone records from Blake's phone have him placing a call to James at 21.42 (see Inquest Brief page 1891).
[207] Inquest Brief 2192 (Blake is referring to the final call in which Tyler tells him about the presence of the police in All Nations Park – just before the second foaming – minutes before he was shot dead).
[208] When a person dials 000, they are put through to the Emergency Service Authority that is called Emergency Services Telecommunications Authority or ESTA. The service is sometimes referred to by

259. Tyler was wearing a blue flannelette shirt and headed for Northcote Plaza as he made that call. It was an unequivocal call to 000 to try and get police to attend and look for a person in a blue flannelette shirt. The inference I draw from that is he wanted police to believe that the person in the blue flannelette shirt would be armed with a shot gun.

260. A minute or two after this call, Tyler entered Northcote Plaza and went to the Kmart store where he obtained the knives as described previously. His entry into and exit from the store was very open and public. He did not wish to obtain the knives by stealth. He removed the packaging in the store walking through the shopping centre holding one knife in each hand with the tips pointed upwards and slashing at packaging and a drink machine as he left Kmart.

261. As he walked through the Plaza, approaching various people throughout the Plaza including Angelo Mascetti, Jay Westaway-Shaw, Mr Skordos and Mr Gregory, he was holding the knives very visibly, apparently calculated to frighten people such that they would call the police. His actions by holding the knives and presenting them to people were underlined by repeating words such as: "*Call the fucking police. Someone is going to die. They won't listen to me. They might listen to you*".[209]

262. The inference I draw from that is he wanted to leave no doubt about the necessity to call the police.

263. When Tyler saw the police arrive at Liquorland, he ran down onto the road to be in their path.[210]

264. The evidence is that Tyler repeatedly yelled at the police to kill him and shoot him and that he wanted to die and continued to tell them that they would die if they did not kill him.

265. He told his brother Blake, in his poignant last words to him, when he took Blake's call standing in the park just before the second foaming, that the police were going to shoot him.

266. He continued to walk towards LSC Dods when firearms were drawn and pointed at him. When he was warned about coming any closer, when a warning shot was fired into the ground beside him, when shots were fired at his legs and most likely struck him, and then a hail of bullets as he mounted the steps, he advanced.

267. Professor McGorry was pressed in various ways on his view about whether or not he thought Tyler was suicidal or engaged in an act of suicide. He was reluctant to be drawn on this direct question. However, when asked by Counsel for the four members as to

---

police as D24, which was the emergency number for police only before there was an amalgamation of the emergency services. These various terms are used interchangeably throughout the evidence.

[209] Statement of Angelo Mascetti, Inquest Brief page 258.

[210] Statement of Daniel Chowne, Inquest Brief 383.

whether or not he agreed that Tyler was acting in an utterly irrational and suicidal way when confronting the police in the way he did, Professor McGorry stated: "*...Well, it was certainly highly – highly dangerous to his survival, yes*".[211]

268. Professor McGorry was prepared to say that Tyler appeared to be a young man who was extremely impulsive,[212] experiencing dramatic fluctuations of mood. Of young people in crisis generally, he stated it must be understood that *"coping responses to stressful or challenging environmental circumstances can be overwhelmed temporarily and intense distress and maladaptive coping responses are manifest... Such maladaptive coping responses may involve suicidal behaviour or self-harm, aggression, abuse of alcohol and drugs and/or disorganised behaviour. These maladaptive behaviours are very common in young people in this age group and are increasingly seen in the public arena".*[213]

269. This opinion of Professor McGorry was quite consistent with the assessment of Tyler by Dr Coventry, who, in his statement, found that Tyler had some self-harming behaviours "*...which appeared transient and impulsive and related to external stressors. He never expressed any clear suicidal ideation with planned intent. Tyler struggled with anger management and control of strong emotional states, making him prone to acting out his feelings with aggressive behaviour directed towards others".*[214]

270. Professor McGorry was reluctant to be drawn on whether or not Tyler, as he engaged in the behaviour set out above, was engaged in a conscious and deliberate plan intended to result in a lethal confrontation with the police. Professor McGorry did not reject that proposition but rather chose to answer by indicating that that sort of "linear pathway" is much less common in young people.[215]

271. The evidence of Professor McGorry[216] was that suicidality can be fleeting and transitory in young persons and that "you've got a fighting chance with people that are suicidal" if you can stop them and start working with what Professor McGorry called the "non-suicidal" or "pro-life" part of them.[217]

272. The evidence of Tyler's apparent calm and rational, albeit somewhat odd, engagement with both Ms Fradd and Ms Model; and his ability to interact in a friendly, albeit distracted and agitated, way with Daniel Chowne is consistent with Professor McGorry's evidence that a young person like Tyler may experience dramatic fluctuations of mood "almost moment to moment".[218]

---

[211] Transcript 3487.
[212] Transcript 3483.
[213] Statement of Professor McGorry.
[214] Statement of Dr Coventry, Inquest Brief page 338; see also Appendix 27 Austin CAMHS records.
[215] Transcript 3490.
[216] Transcript 2667.
[217] Transcript 3491.
[218] Transcript 3490–3491.

273. Professor McGorry also stated that a young person, apparently settled and positive and having plans for the future or planning was not a contra-indicator to suicide. Indeed, Professor McGorry stated that in a young person like Tyler, he could get into a different mindset very quickly because a young person's control system is not fully developed.[219] In fact, he described it as a bit of a trap in that someone could be assessed as apparently pretty stable, "*but things can change very rapidly, and people can get into a very deep depression, or a deep intense anger, or a highly risky suicidal situation having been apparently OK some hours earlier. We see this all the time*".[220]

274. Counsel for the family, strongly resisted a finding of "suicide" and submitted that I should rely on the evidence of Vic Sant who had worked with a number of other children displaying far greater difficulties around aggression, self-harm and suicidality than Tyler.[221] I accept that Mr Sant would have been working with far less functional young people than Tyler Cassidy, but that does not assist in making an assessment of Tyler's conduct or intentions on this evening.

275. Counsel for the family also sought to rely upon the evidence of Mrs Cassidy and Ms Rowena Bailey from The Island, that whilst Tyler had exhibited behavioural difficulties in the past, he was doing well at The Island school and was excited about his future and actively making plans.[222] I accept that evidence. It cannot but help add to the depth of pain the Cassidy family must feel. It no doubt just makes his death harder to understand, to accept and to bear for the family.

Was Tyler's capacity to form the intent to end his life vitiated because of his age, the effects of alcohol and his unstable and erratic behaviour?

276. Counsel for the family raised this issue as one which would, when combined with Tyler's other underlying issues on that night, mean he did not have the capacity to sufficiently reason through his actions to allow a conclusion that he was intent on actually ending his life.

277. The horror and tragedy of what is known as "*youth suicide*" is sadly familiar to Coroners. However, I understood the submission to be directed to a consideration of finding that Tyler's age, *combined* with the effects of the alcohol and his highly aroused and agitated state on this night meant that his capacity to form the intent to end his life in this way could not be found to the *Briginshaw* standard.

278. Tyler's history of extreme lack of impulse control dated back to his early childhood. His history of being easily aroused to *uncontrollable* anger was well-documented in the material. His history of "acting out" his extreme anger against others was also documented in his history. He told his mother that night as she tried to get him to engage with her, his brain was *"fucked"* and that he was *"messed up"*. His history of

---

[219] Transcript 2632.
[220] Transcript 2632.
[221] Transcript 892.
[222] See Statement of Mrs Cassidy dated 11 October 2010.

vulnerability to alcohol triggering his inability to control himself is also contained in the evidence.

279. On the evidence, Tyler was being driven by very powerful emotional distress which overwhelmed him and his ability to control himself. He was disinhibited by alcohol. When Tyler got to the skate park and met his friend Daniel, he would not be dissuaded by his friend Daniel Chowne to put the knives down.

Conclusions on the issue of whether Tyler was engaged in an act or acts intended to end his life

280. The evidence about why Tyler was in such an overwhelmed and uncontrolled state of agitation and crisis that night is not capable of producing a definitive answer.

281. I agree with the words of Professor McGorry, that what Tyler did on this night was that he engaged in acts *"highly... highly dangerous to his survival"*.

282. Tyler had a long documented history of an extreme lack of impulse control, spanning back to his childhood, that was not within the normal developmental parameters. The evidence is that on this night he was experiencing extreme and dramatic fluctuations in mood. I come to this conclusion based on the evidence of not only what he was doing on the way back to his home, but also at his home and then at Northcote Plaza. One minute he was holding up knives to staff at Liquorland and threatening to kill and the next minute he was talking to Ms Fradd and Ms Model, patting their dog, and talking to his friend Daniel and then next minute he was threatening to kill police. On this basis, I conclude that although his actions were conscious and deliberate, they were not voluntary. I find that when he was engaged in these acts, highly dangerous to his survival, it was at a time when he no longer had control of himself. He was so overwhelmed by his emotions that it is not appropriate to conclude that he was acting voluntarily.

283. We remain shocked and bewildered that this can happen in our community.

284. Professor McGorry's evidence was that there were many more like Tyler out there in the community. By this, I assume that Professor McGorry was meaning to indicate that this situation is one that we must face as a community. It is an issue of considerable and urgent proportions for Victoria Police.

285. Superintendent Williams gave evidence that since January 2009, Victoria Police have commenced collecting data as to the numbers of such incidents Victoria Police are facing operationally. His evidence was that there had been 90 such incidents from January 2009 up until the time at which he gave his evidence.

286. The hideous pain and tragedy of Tyler's life being lost this night in this way, is that had he been able to be kept alive, by the next day or week or month he may well have recovered sufficiently to be safe to be put back with his family and resume his life.

287. The evidence in this case places a considerable weight upon Victoria Police to come to terms with this foreseeable risk, highlighted by the evidence of Professor McGorry and Superintendent Williams. Tyler's tragic death must forever be the clarion call for Victoria Police.

DISCUSSION AS TO WHAT COULD HAVE BEEN DIFFERENT

288. There were approximately 73 seconds from the time Acting Sergeant Gevaux gave the direction to LSC Dods and S/C Blundell upon sighting Tyler to "*cordon and contain*" and "*wait for the canine unit*", to when LSC Dods requested the ambulance to attend the scene after Tyler was fatally shot.

289. Inevitably, questions as to whether there were alternatives to the approach that was taken that may have created sufficient time and space for an opportunity to attempt to negotiate a non-fatal resolution must be addressed, as part of the function of this jurisdiction and its purpose as set out in the Preamble to the *Coroners Act 2008*.

290. It was submitted by Counsel on behalf of the Chief Commissioner of Police that:

> *The members who fired at Tyler did so in circumstances where there was no other realistic option available to them. They attended in the vicinity of All Nations Park in Northcote Plaza as the initial police response to the public calls for assistance regarding "the male" (i.e. Tyler) in and around Northcote Plaza, armed with knives and threatening to kill people. Police did not know who the male with the knives was or that he was under the influence of alcohol. Nor did they know his age.*[223]

291. The issues arising from this tragedy require some examination of training as it was in December 2008, how this incident stands up to examination against training as it then was and what has changed since December 2008.

Operational Safety and Tactics Training (OSTT)

292. In 1994, in the wake of an inordinately high number of police shootings in Victoria, and coronial recommendations about what needed to change, Victoria Police implemented a new training regime called Operational Safety and Tactics Training (OSTT) through what was known as Project Beacon. One of the objectives of this new training regime was to ensure that operational police are required to regularly undergo training in operational safety and tactics and not just rely on what they were taught as recruits in their initial training. During late 1994 and early 1995, all operational members of Victoria Police likely to come into contact with an armed person were required to attend a five-day "Beacon" training course. Thereafter, operational members have been required to attend twice per year to supplement and refresh that training.[224]

---

[223] Final written submissions for Chief Commissioner of Police, paragraphs 2–4, page 2.
[224] Statement of Senior Sergeant Moon, page 565, Inquest Brief.

293. The OSTT program consists of four components which are conflict resolution, defensive tactics (incorporating restraint and control), Firearms, and Scenario training. The scenario training is the practical application of the afore-mentioned techniques. The techniques are intended to equip the members with an array of operational tools and skills which the member must adapt to the operational situation he or she faces at any given time. The evidence of all of the police witnesses was that there are no absolute tactics or formulaic responses to operational situations. Members must use their own experience and training to both assess the situation and choose the appropriate response.

294. The evidence was that each operational member of Victoria Police since 1994 has been required to attend an OSTT program twice per year. The program is described as developmental and sworn employees must attend in order to carry operational safety equipment.[225] The skills and techniques taught to police, both as recruits and in their regular twice yearly OSTT, were and remain underpinned by what are known as the 10 Operational Safety Principles developed as part of Operation Beacon.[226]

295. These principles are in the Victoria Police Manual as follows:

> **Safety first** – the safety of police, the public and offenders or suspects is paramount
> **Risk assessment** – is to be applied to all incidents and operations
> **Take charge** – exercise effective command and control
> **Planned response** – take every opportunity to convert an unplanned response into a planned operation
> **Cordon and containment** – unless impractical, adopt a 'cordon and containment' approach
> **Avoid confrontation** – a violent confrontation is to be avoided
> **Avoid force** – the use of force is to be avoided
> **Minimum force** – where use of force cannot be avoided, only use the minimum amount reasonably necessary
> **Forced entry searches** – are to be used only as a last resort
> **Resources** – it is accepted that the 'safety first' principle may require the deployment of more resources, more complex planning and more time to complete.[227]

296. It was also the evidence from both the police witnesses and Professor McGorry that there will be some situations that are so inherently dangerous and unable to be managed according to the best principles and good training and application of those skills that will result in a fatal outcome.

---

[225] Victoria Police Manual 101-2.
[226] Inquest Brief 3139, Statement of Senior Sergeant Miles.
[227] Inquest Brief 2678 VPM 101-1.

EXAMINATION OF THIS INCIDENT AGAINST TRAINING AS AT DECEMBER 2008

Background and training of these particular members

297. The four members involved in Tyler's death were each up to date with their OSTT.

298. LSC Dods joined Victoria Police in June 2000 and had been an operational member for eight years as at December 2008. Prior to becoming a member of Victoria Police, LSC Dods had worked in both primary and secondary schools teaching music.

299. He had been stationed at Northcote for about 18 months prior to this night, having transferred from Preston. He had last completed OSTT in November 2008.

300. LSC Dods and S/C Blundell gave evidence that they had both attended critical incidents prior to this incident. S/C Blundell gave evidence that in 2007 he had attended an incident in which a person threatened to self-harm with kerosene. On that occasion he was the senior member attending the scene and met with a family member down the street prior to attending the scene.[228] LSC Dods gave evidence that he had also attended critical incidents that involved situations of violence and gave evidence of one in particular, involving him liaising with the Critical Incident Response Team (CIRT) and stated that it had concluded in a peaceful surrender of an armed person.[229]

301. C. De Propertis gave evidence that she had attended critical incidents prior to this event. She stated one had involved a male with knives, who was threatening to kill himself and his two young children.[230]

302. C. Ferrante gave evidence that she too had been involved in a critical incident prior to 2008, involving family violence in which OC spray was deployed ultimately without effect by the attending supervisor.[231]

303. As is often said, but worth restating, any "hindsight" analysis must acknowledge the difference between the split-second decision-making required of police members risking their own lives to protect us in these "life and death" situations; and the coronial process of having huge amounts of information systematically laid out, contemplated, analysed and discussed for days and, in this case, months. The purpose of the coronial analysis is to not only find what happened on this night, but to analyse it against the systems in place generally to identify mistakes, gaps, failures in systems or areas for improvement to assist in the reduction of preventable deaths. It is on this basis that the following analysis is undertaken.

---

[228] Transcript 3614.
[229] Transcript 3615.
[230] Transcript 3972.
[231] Transcript 4063.

Risk assessment

304. Risk assessment is one of the 10 safety principles and it guides police in all incidents. According to Superintendent Michael Williams,[232] it is the primary driver for the planning process. A risk assessment must precede any selection of a tactical option. He provided material as to risk assessment which included the concept of "hazard identification" which is the member asking: "*What am I confronted with?*", "*What are the risks to all parties*?" and "*What can I do to reduce or eliminate the risk?*"[233]

Gathering information

305. Both Professor McGorry and Superintendent Williams gave evidence that how much information police have at the time of the initial risk assessment is a key variable as to how the subject/person is approached and the likely outcome. The more information quickly and competently mustered, the better the ability to make a quality assessment.

What information did the police have?

306. When the van driven by S/C Blundell with LSC Dods arrived in the vicinity of the Liquorland drive-through, Mr Gregory was still on the phone to the 000 operator. LSC Dods spoke to Mr Gregory for an estimated four seconds and Ms Fradd for a few seconds. They did not ask Mr Gregory what the male had said, or done, or whether he appeared affected by drugs or alcohol and they had not heard what Mr Gregory had told 000 including that Tyler was demanding that the police be called.

307. They had heard that the male had not tried to steal anything from Kmart but had stated to a passerby: "*call the cops as I'm killing people tonight*". Mr Gregory confirmed the male was carrying two large knives and he directed them to the All Nations Park.[234]

308. S/C Blundell in evidence stated that, not surprisingly, he particularly remembered the last section of the communication: "*I'm killing people tonight*".[235] He stated that was very, very clear in his mind. The evidence of LSC Dods and S/C Blundell was that, given the information they had of a man armed with two knives in a shopping centre threatening to kill people, their first plan was to locate the man to make a risk assessment of him and develop a plan from there.

309. Superintendent Williams stated that the information gathering techniques taught at that time compared to now are different and involve more in depth discussions prior to attending. He also stated that the training as at December 2008 did not adequately address the seeking of background information. He agreed that there were "clear indications of disturbing behavioural cues"[236] but concluded that the police responded to them.

---

[232] Superintendent Williams served in Victoria Police from 1969 to 2007 at which time he retired. In 2008, Mr Williams (as he then was) was offered a consultancy job by Victoria Police to review 11 police shootings. The focus of the report was to identify commonalities in the shootings and to analyse why they were happening.
[233] Exhibit 100.
[234] Inquest Brief 363–379.
[235] Transcript 3838.
[236] Inquest Brief 3625.

Locating Tyler as part of the risk assessment

310. The evidence of LSC Dods was that the plan was first to locate the male, then to assess the risk, to establish whether he was armed, assess his demeanour and proceed from there. Acting Sergeant Gevaux[237] agreed that locating the subject was a very important priority as did Assistant Commissioner Fontana[238] (AC Fontana) and Superintendent Williams.

311. Each witness stated that uppermost in the mind of the members, given what they had heard, would be considerable concern about the risk to members of the public until the subject is located. The evidence from the four members is that this was uppermost in their minds as part of what they saw as their primary duty to secure the protection of the public from an armed male threatening to kill people. There would be few in the community who would wish anything other than this to be the primary focus. However, part of the simultaneous process of risk assessment is not only to gather the information, but process its meaning. All of the members listening in that night heard that the male was asking for the police to be called but there is no evidence that this information had any impact on the way in which the four members approached Tyler or advice being given to them by supervisors assisting with the incident.

Estimate of age of Tyler

312. Given Tyler's age and the evidence of Professor McGorry about the differences between the behaviour and capacity of a young person compared to an adult, the issue of Tyler's age was a central feature of this inquest. It was submitted by Counsel for Victoria Legal Aid (VLA) that the evidence showed that age did not play a part in the risk assessment process and it should have. Professor McGorry gave evidence that determining the age of the subject was a vital part of the information gathering process for the purposes of risk assessment and planning and tactical communication.[239]

313. The evidence of LSC Dods,[240] S/C Blundell[241] and C. Ferrante[242] was that they did not consider age as relevant as the presence of the weapons and the threat that the subject posed was their primary consideration. LSC Dods was asked whether or not it would have made a difference if he had known how old Tyler was. He indicated that it would not have made a difference whilst he was threatening to kill, as he did not appear to be someone who could be reasoned with at that point.

314. There was a range of estimates about the age of Tyler given by a number of people who saw Tyler during the last couple of hours of his life. Some witnesses estimated he was between about 17 to 19 years of age (Mr Westaway-Shaw, Alexsandr Kostadinosksi and Natasha Joyce, Mr Skordos and Ms Birney) and others thought he was between 20

[237] Transcript 2527.
[238] Transcript 2538.
[239] Transcript 2649.
[240] Transcript 3865.
[241] Transcript 3914.
[242] Transcript 4084.

and 30 years of age (Tara Kohte). The police members largely shied away from making age estimates. LSC Dods said he had no idea how old the male was, S/C Blundell assumed he was in his early 20s, C. Ferrante was not sure how old he was but stated she did not think that he appeared to be 15 years old.

315. The closing submissions on behalf of the four members in addressing this issue noted that the situation was "that a person of modest years was wielding two weapons, each of which could cause death".[243] On the other hand, Counsel for VLA submitted that: "*failing to consider age as relevant in assessing risk means that members are prevented from adopting a different, more effective, mode of engagement to safely remove the threat commensurate with a young person's stage of cognitive and emotional development and the factors Professor McGorry highlighted*".[244]

316. A combination of evidence, expert opinion and commonsense dictates that this submission is correct. Deciding on the manner of engagement in a critical incident requires age to be a relevant consideration as part of considering the "who am I dealing with" question identified as part of a risk assessment.

317. The evidence highlights the variation in age estimates that were made by eyewitnesses on this night which leaves open the question of how possible it would have been to estimate Tyler's age in the condition he was in and given what he was doing and saying. However, the evidence from Professor McGorry is that Tyler's age was a highly relevant consideration, both as to risk assessment and tactical communications, and should have at least been asked of the eyewitnesses Mr Gregory and Mr Skordos. It would have added no more than a second or two to the approach to Tyler.

Consideration of Tyler's state of mind as part of the risk assessment and style of initial approach

318. The evidence from the police witnesses is that consideration of a person's mental and physical condition is part of a risk assessment. However, there was considerable evidence that this aspect of Victoria Police training and skill development in its members had been in decline in the years leading up to Tyler's death. Superintendent Williams' February 2009 review discusses the "*presumption of rationality*" that was a recurring feature of the review he conducted. This "*presumption*" was evident on this night.

319. The evidence is that LSC Dods assessed Tyler as someone who could not be reasoned with although he did not consider whether this was actual irrationality or not.[245] S/C Blundell[246] thought Tyler might have been affected by crystal methamphetamine and that may have been having an effect on his state of mind. C. Ferrante[247] thought Tyler

[243] Final written submissions from Counsel for the four police members, paragraph 49.
[244] Final written submissions of VLA, page 12.
[245] Transcript 3647–3673.
[246] Transcript 3866–3867.
[247] Transcript 4104–4105.

might at least be acting partially irrationally and C. De Propertis thought Tyler's behaviour very abnormal.[248]

320. Despite these assessments, the effect of the evidence given by the members was that this was irrelevant to how they had to respond, as they were required to remove the threat that Tyler posed by brandishing the knives and moving towards them.

321. LSC Dods' evidence about Tyler's rationality was that, although he knew that the male appeared aggressive and had been making threats to kill and was carrying two large knives and threatening to endanger the public, he did not know whether his behaviour was irrational.[249] When questioned on this, he would not engage in whether or not he could assess his rationality because he was not trained in psychology. He also stated that someone who carries knives around and issues threats cannot be rational, but he went on to say Tyler could have been making rational decisions in that context to achieve his aims.[250] LSC Dods was the first in the series of eyewitnesses who had encountered Tyler that night who did not conclude that there was something significantly wrong with Tyler.

322. It is not difficult to understand why LSC Dods was reluctant to come to terms with this issue, but it must be faced. There was considerable evidence that Tyler's death has been responded to inside Victoria Police with a major redevelopment of skills and training to members to enhance their ability to deal with people with a range of vulnerabilities including serious life threatening mental health issues. Consistent with the evidence of Superintendent Williams and Professor McGorry, assessing whether or not the subject may be suffering from some form of mental disturbance or affected by drugs or alcohol or both, must be factored into any risk assessment. It must then be the basis for planning, choosing tactical options for communication and approach to the subject. What happened on this night appears to be the product of the limitations of training and skills development as it was in December 2008.

323. Superintendent Williams although initially critical of the risk assessment made by LSC Dods and S/C Blundell, after having a more complete set of material, identified a range of risk assessments that were made. He stated that once he was able to see all of the material he could not identify any part of the encounter where risk assessments should have been made but were not. He listed a number of risk assessments that were made which included locating Tyler, confirming what resources were on the way, the deployment of OC foam as a risk control measure, assessment as to the safety of members of the public when Tyler ran into the park where lighting was minimal and he went on to list a number of actions taken by LSC Dods as he had to continuously reassess the risks that he faced. He concluded that LSC Dods was continually assessing risks and options. Assistant Commissioner Fontana agreed with this assessment.[251]

---

[248] Transcript 3990.
[249] Transcript 3641.
[250] Transcript 3642.
[251] Transcript 2527.

324. In the opinion of Superintendent Williams, the risk assessment at the first engagement was commensurate with the training that had been delivered at the time.[252]

325. I have understood this evidence from Superintendent Williams to mean that a risk assessment should incorporate factoring in the vulnerabilities of the subject, including mental state and age or apparent age. This does not appear to have been done to any significant degree on this night, but it is apparent from the evidence of Superintendent Williams that this was consistent with the skills the members were provided with at that time.

326. The information that they had about Tyler asking for the police to be called did not cause any apparent change in planning, approach or tactics. The "*presumption of rationality*" spoken about by Superintendent Williams was evident in the style of approach which had the members yelling repeated commands to no effect. The information that, for no apparent reason, a male publicly walked into a store and took knives and was walking through a public place threatening to kill people, did not cause any apparent thinking about the likely instability of such a person and the need for a tailored approach to such a person.

Planned response

327. Planning the response and not rushing in to resolve the situation as quickly as possible is a fundamental tenet of the 10 Operational Safety Principles. Taking every opportunity to convert an unplanned episode into a planned response is the aim. Using tactical options to create time and space to slow down the incident are recognised as best practice in managing critical incidents. Tactical options such as style and content of verbal communication, endeavouring to cordon and contain the subject by maintaining safe and effective barriers between the public and the members, keeping sufficient distance to achieve some space and communicating the plan to the other members present are the aims. It is accepted that they will not always be achievable.

328. Superintendent Williams initially stated that he thought there was a lack of planning evidenced in these circumstances, including that the members were working independently of each other in a spontaneous and reactive way and not working as a team.[253] However, Superintendent Williams in his last statement, having had the opportunity to look at far more evidence than was available to him at the time of his initial assessment, concluded that there was appropriate planning demonstrated by the members at critical stages.[254] Superintendent Williams concluded that the planning undertaken by the members LSC Dods and S/C Blundell was in accordance with the training in place at the time.[255] This was also the opinion of AC Fontana who had conducted the internal review for Victoria Police. AC Fontana noted in his review that there was no evidence that the members engaged in pre-planning as they were travelling

[252] Transcript 3262.
[253] Inquest Brief 2436, Williams First Report.
[254] Inquest Brief 3622–3633.
[255] Inquest Brief 3625.

to or arriving at the scene and gathering information. AC Fontana noted that training needed to actively promote the need for a pre-planned approach with an emphasis on the plan for the initial approach.[256]

329. Various options were put to the four police members during the inquest about options they had to stop and plan and be better prepared before "*rushing*" in to confront Tyler. The members rejected any suggestion that stopping and discussing what to do before locating Tyler was a realistic option in the circumstances, given the risk to the public of any delay on their part. They also rejected the option of waiting for the canine unit to arrive or CIRT as they were faced with an armed and apparently violent offender who was threatening to kill people. The police stated they had to consider the safety of the public in the full knowledge that the public were in and out of the shopping centre and potentially in the park.[257]

330. They were aware that all available units had been called and they were aware that the canine unit was four to five minutes away and that Acting Sergeant Gevaux was on his way and had directed them to "cordon and contain" and to wait for the canine unit.[258]

331. LSC Dods had requested assistance from the AirWing to search the park. LSC Dods was familiar with the park and knew it to be an area that was not accessible by car and an area frequented by people walking to and from the shopping centre or going for an evening walk or exercise. He had also requested C. Ferrante and C. De Propertis to go to the other side of the park to assist in locating the subject.

332. Given that LSC Dods and S/C Blundell knew that there was an armed male threatening to kill people in and around a busy pre-Christmas shopping centre and adjoining park, any assessment of their decision to focus on locating the armed male must conclude this was the only realistic option they had at that time. AC Fontana was not critical of the decision of the members to get there and assess the situation rather than meet first.[259] He rejected the idea of a rendezvous point in circumstances such as these, indicating that the first priority would be to secure the safety of members of the public to make sure no-one was at immediate threat.

333. The evidence as to the second part of the plan was to locate the male and then make an assessment and try and see what was on his mind.

334. In closing submissions, for the four police members on the issue of whether or not they should have waited for the arrival of the canine unit or further units or members from the Northcote police station, it was submitted that this analysis fails to come to terms with the urgency of the situation and lacks practicality. It was submitted that it was urgent for the members to locate Tyler who was reported to be armed with knives and threatening to kill people. As stated above, there is little doubt that there was an urgent

[256] Inquest Brief 2322.
[257] Written submissions of the four police members, page 43.
[258] Issued at 21.30.12, Inquest Brief 2202.
[259] Transcript 2515-2538-9.

need from the information available to locate the male. Once he was located, the next tactical decision was what options, if any, were available to create time and space to wait for those resources to arrive?

Communicating the plan between each other

335. The evidence is that they were taken by surprise by Tyler suddenly appearing before them on the roadway.

336. From the time when LSC Dods and S/C Blundell first saw Tyler on the roadway, and decided to get out of their vehicle and engage with him in the manner described, they made assumptions about where C. Ferrante and C. De Propertis were and what they would do. LSC Dods states he knew they were somewhere to the rear of them about 100 yards back. LSC Dods' evidence was that even though he did not communicate a plan to C. Ferrante and C. De Propertis, he was comfortable that they would work out what to do by taking the lead from him.[260] The evidence of S/C Blundell was that there was no purpose in discussing with 3PS303 what the approach to Tyler would be as "*there was a real sense of urgency about locating the male due to the threat to the public that were certainly in the area of the shopping centre and very much potentially in the area of the All Nations Park*".[261]

337. As LSC Dods and S/C Blundell drove to the scene, there was no evidence of discussion between them about any plan of how to approach the situation that faced them. LSC Dods said "*the plan at this point was to try and attempt some negotiations. To establish whether he was armed, trying to determine what his demeanour was and proceed from there*".[262] The evidence is that there was no conversation between LSC Dods and S/C Blundell before they both got out of the car, other than to confirm that they had located the male they were looking for when he stood in front of them on the roadway.

338. AC Fontana's opinion as to the response of the four members was that it was spontaneous and reactive, but not out of accord with their training. However, in his review he noted that the members needed to actively communicate the plan to each other as they arrived.[263]

339. On the issue of communication between the four members as to how to approach this situation, it was conceded in closing submissions that there was little by way of explicit verbal communication between LSC Dods and S/C Blundell and, indeed, the two Preston members. It was submitted on their behalf that what took place should be interpreted with an understanding that the members knew how each of the others was going to act in accordance with their training and would understand how to work together by watching and interacting with each other and thereby knowing what to do intuitively. The example was given of how the members automatically formed a cordon when in the park with

[260] Transcript 3644.
[261] Transcript 3854.
[262] Transcript 3641.
[263] Transcript 2535.

Tyler consistent with the training. It was also submitted that the urgency of the situation did not allow for discussions.

340. The issue was raised of why one of the other three members did not warn LSC Dods that he was getting backed into danger. In submissions for the four members, it was said on their behalf, that any submission critical of the members for not warning LSC Dods that he was getting backed up the stair is one made with the benefit of hindsight and in the cold hard light of day. It was submitted that it is criticism which does into take into account the truly frightening situation the members were in.

341. Those submissions are correct, but it is necessary in an analysis such as this to make this observation. I do highlight the issue in a critical sense. Communication between each other is what is required of the members. The need to ensure the plan is not only formed and redeveloped as the situation changes, but communicated to each other, has been a common recurring feature identified by the Williams Review in 2009.

Locking down the Plaza

342. A discussion about the possibility of locking down the Northcote Plaza arose during the course of the Inquest to minimise members of the public being put at risk and to remove that concern for the police.

343. The police evidence was that it would be dangerous to do until the armed male had been located, as the risk of locking the armed male into the shopping centre remained high with such a strategy. It arose because it was what Mr Mascetti, the duty manager at Coles, thought he should organise after having his encounter with Tyler.

344. It was the evidence of LSC Dods that it would be good sense, once Tyler had been located, to have had the Plaza secured in the interest of public safety. He went on to observe that such an action should be done at the direction of someone not embedded in the situation such as the operations commander.

345. Again, given the speed with which the situation escalated, this did not arise but it does demonstrate that with time and space and good active operation oversight and command, more strategic options open up.

Getting out of the van

346. S/C Blundell stated that when he first saw Tyler coming towards them on the roadway, he thought they needed to get out of the van and speak with him and assess the situation for themselves. It was his view that the only option was to get out of the van.

347. AC Fontana was also of the view that the decision to leave the van and interact with Tyler was appropriate[264] and Superintendent Williams agreed.[265] Both LSC Dods and S/C Blundell rejected the option of standing behind their van door to create a barrier

[264] Transcript 2597.
[265] Transcript 3259.

between themselves and Tyler as this would have reduced their tactical options including the use of deploying foam.

348. LSC Dods was concerned that had they not got out of the van:

> *...it would have been quite simple for him to just run away to an area that our vehicle could not follow easily and then we would have lost the contact that we had and the observations that we had of him if we remained in our vehicle. So I still say we needed to get out of the car and at least speak with him to find out if he still had the weapons and what was going on in his mind.*[266]

Whilst LSC Dods agreed in evidence that there were options available to him at the time he made the decision to get out of the van, he maintained that to not get out of the van would allow Tyler free access to anywhere and that:

> *...would be tantamount to a dereliction to the public safety not to respond to the confrontation that was before us. Our responsibility is to the public safety. It is also Tyler's safety but we have a responsibility to react to protect the public and anyone who may be near, and there were at least two dozen vehicles in that car park.*[267]

349. The evidence is that the general principles are when police are confronted by a person armed with an edged weapon, the appropriate action wherever possible is to attempt to communicate with the subject to create time and space and wait for more resources. That is, to try and "*slow down*" the incident where possible. This must be done in the context of risk assessment and planning based on that risk assessment. The situation will often be highly dynamic and confronting. Strategies for creating time and space will assist in enhancing the capacity to reduce tension and confrontation unless no other option is available but the starting point is to try all of the less confronting options where practical.

350. Superintendent Williams gave evidence that he would be "*disappointed*" if, as a consequence of the training subsequent to this incident, there was not some change to how such an incident would be handled. He stated that the training since December 2008 may dictate a different response towards risk assessment; specifically risk control strategies and that now one control strategy "*might be to not engage*".

351. On this point, Superintendent Williams gave evidence that when he examined the decade of training pre-2008, he was unable to locate any in depth training in relation to the skill of disengagement. He stated that recently, the training cycles' had some focus on scenarios where members turn and run away and then stop and observe and by doing that, they put distance between themselves and the subject and the use of obstacles slows down any means of advance.[268]

---

[266] Transcript 3709.
[267] Transcript 3649-3 and transcript 3655 & 3598–3599.
[268] Transcript 3266 & 3337.

352. This was a situation wherein LSC Dods and S/C Blundell were effectively taken by surprise by Tyler appearing in front of them. It was at this point, before they get out of the van, that there was an opportunity to engage in some planning and communication both with C. Ferrante and C. De Propertis and between each other. The principle of having a chance to convert an unplanned response to a planned response may have had a chance at that moment. Tyler was focused on them. The evidence of LSC Dods is that he was standing still. They could see him. They could see that no other person was in the vicinity and at risk at that point in time. However, the decision that the members made to get out of the van was clearly driven by their justifiable concern that members of the public may appear at any moment or Tyler may run either into the shopping centre or into the park where members of the public were likely to be.

353. It is not possible to conclude that staying in the van whilst plans were made and communicated would have averted the outcome. It may have "*slowed down*" the encounter, but as LSC Dods and S/C Blundell state it may have put lives of other members of the public at risk. They did not consider they had any other option than to get out of the van and immediately engage in the manner described.

Form of communication with the subject / negotiation or confrontation

354. When LSC Dods and S/C Blundell got out of the van, LSC Dods had his OC foam canister in hand and S/C Blundell had his firearm drawn. They commenced with loud repeated commands to Tyler to show his hands. Once he did, they then loudly commanded him to drop the weapons. This form of engagement raised the question of how a different approach might have created a different outcome. It was the evidence of the four members that substantive and reasonable negotiations cannot take place when life is threatened at the end of a knife.

355. It was the evidence of LSC Dods that he needed to make the area safe for the public and the police and that required him disarming Tyler. LSC Dods stated they needed to get out of the van to see if the male still had the weapons and what was going on in his mind.[269]

356. On the other hand, the evidence of Professor McGorry was that generally speaking a great deal of patience, maturity, genuine empathy with an understanding of the mindset of the young person and a range of professional skills are required when interacting with a young person in crisis or a highly emotional state. He stated that it cannot be assumed that they will be able to engage in the same way as a mature adult. Professor McGorry's evidence was that this was a very dangerous situation that the police were dealing with, but if it was safe to keep talking for the next 30 seconds or minutes and nobody was going to be attacked, then best practice is to keep talking and try and negotiate what is possible.[270] Professor McGorry went on to say: "*The ideal to aim for is that you can actually work out how to talk to the person and not have this sort of rigid routine of things you go through, for example, disarming the person, before you can negotiate any*

[269] Transcript 3645.
[270] Transcript 2674.

further".[271] Professor McGorry acknowledged that this would depend on the risks to police and the public. He also observed that the age of the person is important because a different response was needed for someone who is 15 as opposed to someone who is 45.[272]

357. However, Professor McGorry added the rider to the need to be patient and tailor the response to a young person in crisis: "*...If you've got the space to do it*".[273] The effect of his evidence was also an acknowledgement that if a young person is heavily armed; there may sometimes be situations where some of the ground rules will be difficult to follow since members of the public may be at immediate risk of harm or death.

358. There is little doubt that the members were faced with a highly dangerous and complex situation in which they had to make very rapid decisions under enormous pressure.

359. Senior Sergeant is in charge of the OSTT Unit and has been there for the past 19 years as both a sergeant and now Senior Sergeant. It was the evidence of Senior Sergeant Miles that as at 2008, police were trained that principles of negotiation were based on gaining empathy, providing feedback and developing rapport.[274] Accepting that, there is no evidence that this was attempted in the approach to Tyler. Whilst in final submissions from Counsel for the Chief Commissioner of Police, it was put that Tyler was completely unresponsive to any attempts to engage him verbally and was both verbally and physically "*defiant*" – yelling "*show us your hands*" whilst holding guns and OC foam cannot realistically be described as an attempt to engage him or gain empathy or develop rapport.

360. It was also put that all attempts by Tyler's family and friends to engage him up until that point had failed and, it is so, that this is the evidence. One can put it no higher than it might have made a difference to how Tyler responded at that moment, but it would be hard to conclude that it was not "*worth a try*" to make an initial attempt to find out who he was and what he wanted, consistent both with the risk assessment principle of finding out "*who am I confronted with*" and the principles as set out by Professor McGorry of best practice in approaching a suspected vulnerable person. Indeed, it was the evidence of LSC Dods that they needed to get out of the car and engage with Tyler to try and establish what was going on in his mind. There was no evidence of any aspect of this approach which could be described as trying to establish what was in Tyler's mind.

361. The evidence in support of the potential opportunity resides in the evidence of Blake, Ms Fradd, Ms Model and Mr Chowne whose interactions with Tyler suggest he was capable of positive engagement. The evidence of Professor McGorry, however, was that the lack of knowledge by police of Tyler's momentary capacity to connect with Ms Fradd

[271] Transcript 2637–2638; 2665–2666.
[272] Transcript 2648.
[273] Transcript 2670.
[274] Transcript 3567.

and Ms Model and their dog would not have affected their decision-making. He went on to say that "*momentary capacity to connect was an encouraging sign*".[275]

362. As stated above, I do not conclude that such an approach would have been successful or changed the outcome, especially given the evidence that Tyler was refusing to speak to his brother, but it was worth a try.

363. It was the effect of the evidence of Superintendent Williams that he would hope that the new developments and focus in current OSTT would now result in a different approach to the initial approach adopted on this night.

Style of communication

364. There was considerable discussion about the style and form of communication used by the police both initially and throughout the engagement with Tyler. In final submissions by Counsel for the Chief Commissioner of Police,[276] it was agreed that prior to Tyler's death police were trained to use clear, concise, authoritative language when dealing with violent or potentially violent situations and that the emphasis on developing tactical communication skills in police members' training had waned. On this issue of form of tactical communication, Senior Sergeant Miles gave evidence that as at 2008 the police were provided with a list of commands aimed at ensuring the subject requires a clear understanding of what is required of them. They should be loud and clear and to the point.[277] He also agreed that the first priority is to aim to create a safe environment.

365. The evidence was that when LSC Dods and S/C Blundell got out of the car they commenced with very loud commands to Tyler. LSC Dods agreed that he had used his loudest *"drum majors' voice"* to Tyler to get him to show his hands, when he got out of the police van. When questioned about the appropriateness of this approach he disagreed that it was beneficial to not yell at a person who is threatening violence with two knives. When asked to explain this, LSC Dods said he remained confident this was the appropriate tactical approach in the circumstances. He explained by saying *"the male appeared very confrontational, just by the way he was presenting himself on the road. He was presenting two knives and waving them at us, and issuing threats. I was of the opinion that speaking softly in response was not going to be productive for me."*[278] S/C Blundell agreed, stating the circumstances did not allow for an opportunity "*to have a quiet and relaxed and soothing approach*".[279]

366. C. De Propertis made the same point when she stated it thus: "*if someone is coming towards you threatening to kill you or injure you and they have the capability to do it, in that they have access to weapons, they're holding weapons, that's the number one priority you have got to negate that risk or you've got to at least control it*".[280] She went

[275] Transcript 2681–2682.
[276] Paragraph 14.
[277] Transcript page 3567; 3598.
[278] Transcript 3646.
[279] Transcript 3878.
[280] Transcript 3991.

on to say if someone's behaviour is putting your life at serious risk, *"you have to be concise and you have to be clear with the directions that you're giving, because you've only got a very short space of time to communicate what you need to and just try to control the threat".*[281]

367. In essence, in response to suggestions and submissions that the style should have been more conciliatory or less overbearing and aggressive, the submissions on behalf of the four members were: (a) this would have been contrary to the tactical training as at December 2008; (b) it would lack clarity; (c) it would run the risk that the subject would not hear what the police were saying; (d) it would not have been authoritative; (e) it would have been inadequate to meet the escalating threat; and (f) it would have been most unlikely to succeed taking into account what the police already knew of Tyler's behaviour.[282]

368. Submissions on behalf of the four police members rejected any notion that Tyler was overwhelmed or frightened or disoriented by instructions shouted at him. It was submitted that his response was ongoing aggression and threats to hurt and kill police and continuing to brandish the knives.

369. On the other hand, Professor McGorry gave evidence that it is counter-productive to confront, threaten, and shout at or rapidly approach anyone, particularly a young person who is potentially going to overreact or react in ways that one cannot predict and to do so might provoke or exacerbate or inflame the situation. He was at some pains to qualify what he had to say by noting that it does all depend on the situation. Professor McGorry set out what he meant to convey:

> *(a) a calm non-threatening manner and presence is essential, noting and acknowledging the emotional state of the young person, offering to listen and to try to help; (b) avoidance of face-to-face or eyeball to eyeball contact can be helpful to reduce the sense of threat that can be amplified by projection of internal anger and fear into the police and others encountered; (c) sufficient backup persons in the background to contain the situation should it get out of hand but kept in reserve. This was described as an implicit but not flaunted show of strength; (d) clear proposals to defuse the situation, for example an instruction to the young person to relinquish any weapons, to let the police know what the young person is seeking to achieve, or what he or she wants to see happen or is demanding, and offers to provide immediate access to family, friends or other trusted people, if at all possible offers of food and drink ... There is a need to reduce the level of "projection" of anger and fear.*[283]

Cordon and contain/manage

370. The purpose of the Operational Safety Principle of cordon and contain was introduced to try and create a barrier between the harm posed by the subject and the

---

[281] Transcript 3995.
[282] Written submissions of the four members, page 46.
[283] Transcript 2652–2653.

public and to create time and space to develop a planned and strategic approach to resolution of the incident; including attempted negotiations, tactical communications and endeavouring to establish some line of communication with the subject that is not immediately aimed at overpowering the individual.

371. The evidence is that Acting Sergeant Gevaux gave the direction to LSC Dods on the initial sighting of Tyler but LSC Dods stated that the direction quickly became irrelevant, as Tyler suddenly appeared and then started to advance, thus breaking any attempt at a cordon. The evidence is that the members did form a loose mobile cordon once they regrouped in the park around Tyler. AC Fontana stated that the members were trying to keep Tyler contained and the public safe, but he observed if someone had that single-minded determination then training is not always going to work.[284]

372. LSC Dods gave evidence that he heard Acting Sergeant Gevaux give the instruction to "*cordon and contain and wait for the canine*" either just before or just after he got out of the van.[285] He accepted that this was a standard direction that they would want to achieve but that this situation did not allow for that to happen because they had already commenced their engagement. LSC Dods stated that this direction quickly became irrelevant because Tyler produced the knives and then escalated the situation by advancing and thus he broke the cordon.

373. The observation to make about this evidence is that it is circular. That is, the instruction to cordon and contain is an instruction not to rush to engage in close quarters. It then becomes clear that once engaged, it became extremely difficult, dangerous and unrealistic to disengage.

374. AC Fontana in his review noted that it was important to re-emphasise the need for planning and endeavouring to implement a cordon and containment strategy, which included the scenarios of escalation and disengagement with a view to minimising the need for use of force.

375. In closing submissions by the four police members, it was submitted that to disengage and lose physical contact with a person who is threatening to kill could have dreadful consequences for the public and also have been a dangerous option for police as to turn and run from the subject may have left them vulnerable to attack and, therefore, not a serious option.[286]

376. The effect of the evidence provided by Victoria Police is that following the first Williams Review, together with the OPI reports of 2005 and 2009, training in cordoning and containing a subject has undergone a significant change. Since July 2009, the tactic has been re-named as "*cordon and manage*". The principles as at December 2008 of "*cordon and containment*" became generally considered as a line or circle of police to

[284] Transcript 2542.
[285] Transcript 3644.
[286] Final submission for the four members, paragraphs 50–51.

contain a subject, such as the attempted "*mobile cordon*" created by the four members in the park after Tyler ran in there.

Administering of the first foam

377. The evidence is that from the time LSC Dods and S/C Blundell drove away from Liquorland, to Tyler being sprayed with OC foam, it was about 30 seconds.[287] It was the submission of Counsel on behalf of the family that the police should have had more information at Liquorland and engaged in a less confrontational approach and endeavoured to negotiate with Tyler to minimise the need for that first use of force. In reply, it was submitted on behalf of the four members that LSC Dods acted bravely and appropriately by risking his life to confront Tyler and foam him, not only in an attempt to protect the public but also to give the best possible chance of disarming Tyler.

378. In closing submissions, it was put on behalf of the four members that the initiative taken by LSC Dods to deploy his OC foam was a sensible initiative and in accordance with police training. It was submitted that such an action had a high chance of defusing the risk to the public and enabling the police to subdue Tyler and remove the knives.[288]

379. The weight of senior police opinion was that, whilst police should attempt to communicate and negotiate and create distance as a first option, there are circumstances where immediate intervention by police will be necessary.[289] It was accepted that in a situation where a person armed with two knives is threatening to kill and moving forward, however slowly, it is a proper and reasonable response to endeavour to contain that risk by deploying OC foam. I do not disagree with that proposition.

Chasing Tyler into the park after the foaming

380. It was submitted by the family that the four members should not have run into the park after Tyler when he ran off after the foaming.

381. In the written submissions from the four police members, in response to the suggestion from Tyler's family that the police should not have run into the park after him, it was submitted that (a) this was not consistent with their training and (b) it would have been an abrogation of their duties to protect the public and left the public at risk of an armed and aggressive male running around in the park in circumstances where they would have lost sight of him.

382. Given the evidence that there were a number of people out in the park at that time and people coming and going from the shopping centre, it is not reasonable to suggest that the members should not have pursued Tyler into the park.

383. The evidence is that the four members did form up into "*a group*" in the park once Tyler stopped and turned to face them. However, there was nothing said between the members as to any strategy they had other than to react to what was happening. Indeed,

---

[287] Transcript 1268, Evidence of Mr Gregory.
[288] Written submissions for four police members, page 51.
[289] Page 3563.

the evidence of LSC Dods is that he was not aware of where C. Ferrante and C. De Propertis were at the point at which it is said they formed into a loose cordon.

The second foaming

384. Counsel for the family submitted that the police escalated the situation by foaming Tyler again when he stood in the park and it was neither reasonable nor proportionate to the threat posed. It was submitted that they should have backed off creating time and space as the public were not at threat at that time and allowed the other resources to arrive. The family also submitted LSC Dods was not able to provide a cogent reason for the second foaming. This submission was firmly rejected by Counsel for the four members.

385. Contrary to the submissions of the family, Counsel for the four police submitted LSC Dods was entitled to consider at that point that he may not have got a primary dose on Tyler or he may have wiped it off and thus it was appropriate to try again. Whilst LSC Dods conceded that the second foaming may have contributed to Tyler's focus and advance upon him, the evidence was that Tyler was still behaving in a determined and threatening manner armed with two large knives.

386. It was further submitted that the option of turning and disengaging was simply not a realistic possibility at that stage, as it left both the members and the public at risk.

387. The family submitted that the police should have known that for a minority of people, OC foam will not only be ineffective but may escalate the conflict. The problem with such a submission is that knowing that this is so, is not the same as knowing that Tyler was one of that small group.

388. Given that Tyler remained armed with the two knives at large in that public environment, it was both a reasonable and proportionate response to apply the second dose of foam. Indeed, had it been effective, it may have saved Tyler's life.

Tyler's final advance and the shooting

389. It was after the second foaming that Tyler advanced towards LSC Dods and caused him to start walking backwards without being able to look behind him. The evidence of LSC Dods was that he withdrew his firearm when Tyler was about four–five metres from him and moving towards him as he backed closer to the pathway at the edge of the skate park. LSC Dods was commanding Tyler to stop coming any closer to him.

390. All of the eyewitness accounts are consistent that Tyler continued to advance upon LSC Dods as he backed away. Not only did Tyler keep moving towards LSC Dods but the effect of all the eyewitness accounts is that Tyler was continuing to tell LSC Dods that if he did not shoot him, then Tyler would kill him. LSC Dods gave evidence that he then warned Tyler, with his firearm pointed at him, that he would shoot if he continued

towards him.[290] The evidence of LSC Dods, C. Ferrante and S/C Blundell is that Tyler kept advancing on LSC Dods as he was backing away.

391. LSC Dods stated that he formed the view that he should fire a warning shot to try and stop Tyler. He fired a shot into the ground beside Tyler but other than observing a flinching, the evidence is that it did not deter Tyler's advance upon LSC Dods. It was S/C Blundell's evidence that Tyler was within a couple of metres of LSC Dods when LSC Dods fired his warning shot.[291]

392. During the examination of witnesses, Counsel for the family raised the spectre that Tyler was not threatening in his conduct. For example, it was put to C. De Propertis that Tyler was not making threats but rather just saying "*kill me*". C. De Propertis firmly rejected this and stated she was very confident that Tyler was constantly saying three sentences that she remembers well: *"Shoot me", "kill me"* and *"I'm going to kill you".*[292] This accords with LSC Dods' account that Tyler was saying: "*You're going to have to shoot me", "I'll hurt you"* and *"I'll fucken kill you".*[293]

393. Whilst various eyewitnesses describe some variation in the words Tyler was saying, nothing can realistically turn on those variations. Given what has gone before, even if he said nothing as he walked towards LSC Dods with knives out, his actions would indicate that he was threatening to use those knives to potentially cause mortal injury to the person upon whom he was advancing.

Warning shots

394. The evidence of LSC Dods was that he aimed his warning shot into the soft ground beside Tyler to minimise the risk to the safety of the public and to try and deter Tyler without using a lethal option.

395. Counsel for the family submitted that the firing of a warning shot was outside firearms training and contrary to Victoria Police policy.

396. Senior Sergeant Miles gave evidence that police members were not taught how to fire warning shots, and force policy in 2008 was that a warning shot should not be fired.[294] However, Senior Sergeant Miles also stated that a warning shot may be an appropriate option in some circumstances.[295] The evidence is that firing a warning shot creates obvious safety considerations for the public, including the potential for a ricochet. In answer to the criticism that firing a warning shot can cause an unnecessary "chain reaction", Senior Sergeant Miles observed that that should not happen because each member is expected to make an independent assessment of the need to use his or her own firearm.[296]

---

[290] Statement of Colin Dods, Inquest Brief 372.
[291] See Statement of S/C Blundell, transcript 3802–3804.
[292] Transcript 4204.
[293] Inquest Brief 369.
[294] Transcript 3557.
[295] Transcript 3574.
[296] Transcript 3573–3577.

397. Superintendent Williams was not critical of LSC Dods for firing the warning shot, although he expressed concern about the possibility that the mistaken perceptions of other members may lead them to fire. He accepted it was LSC Dods' last attempt to get a less than lethal resolution.[297]

398. It was submitted by Counsel for the four members that there was no credible evidence that shots were fired in a "*chain reaction*". Indeed this is so. The evidence of the other three members demonstrates that each of them was making an assessment of the situation as they saw it. There is no evidence in this case, on an analysis of the members' evidence that the firing of a warning shot led to the other members firing without considering their individual positions.

Firing into the legs

399. Counsel for the family submitted that the two shots that LSC Dods fired, aimed at Tyler's legs as he continued to advance on LSC Dods, were inappropriate and likely to cause a dangerous chain reaction amongst the other members and further, it was submitted that if LSC Dods thought he could shoot to wound he could have retreated.

400. It was submitted on behalf of the four members that LSC Dods ought not to be criticised for firing at Tyler's legs in an endeavour to avoid a lethal shot into the body mass, even though this was not something the members were trained to do. It was submitted on his behalf that it was not prohibited. In fact, the training instructs members that if their life is in danger they should shoot at the middle of the largest visible mass.[298] LSC Dods' evidence made it palpably clear that he did this in an endeavour to avoid a lethal option. His evidence was that this was his "*last ditch attempt at a non-lethal resolution to what was happening. I was in fear of my life. I did not want to shoot this male in the chest; I just didn't want to kill him. The spray hadn't worked. Negotiations hadn't worked; I was out of options other than a non-lethal discharge of my firearm*".[299]

401. Senior Sergeant Miles stated that there were "*no absolute tactics*".[300] The weight of the evidence is that Tyler continued to advance after the warning shot was fired and also continued to advance after being shot in the legs.

Ultimatum (form of communication)

402. Counsel for the family submitted that in issuing an ultimatum to Tyler, telling him not to come any closer or he will be shot, was likely to have escalated the conflict if Tyler was "*hell-bent*" on self-destruction.

403. Counsel for the family submitted that the issuing of an ultimatum was likely to have escalated the conflict. Counsel for the four police members, in reply, submitted that this was not supported by the evidence in that Tyler was advancing on LSC Dods and LSC

[297] Transcript 3473.
[298] Transcript 3578, Senior Sergeant Miles.
[299] Transcript 3696.
[300] Transcript 3555; 3583.

Dods was trying to make him desist by telling him what the consequences would be if he did not stop. It was submitted on behalf of the four members that whilst issuing ultimatums was not part of their training, it was not prohibited and one could not conclude that it was wrong. Indeed, Senior Sergeant Miles did not agree that the making of an ultimatum locked police into a certain course of action.

404. Senior Sergeant Miles stated that making an ultimatum may be exactly what is needed in the particular circumstances.[301] Senior Sergeant Miles also gave evidence that whilst police are not taught to issue ultimatums, he did not accept that to do so was wrong. He did accept the complexity of this situation where somebody may be intent on harming themselves and confirmed that as at December 2008, members were not specifically trained in how to deal with a person engaged in apparent acts of self-harm.[302]

Use of resources also form part of the 10 Operational Safety Principles

Ballistic vest

405. LSC Dods gave evidence that no consideration was given to donning ballistic vests. He conceded that he was aware that Tyler was armed with knives and that the vest provided at least a higher level of protection than the shirt that he was wearing.[303] He stated that there were "*extenuating circumstances*" as to why he did not stop to consider or don the vest. He noted that the vests were lodged in one of the rear compartments of the van and it takes a minute to locate the vests and then determine which one fits you and put it on.[304]

406. AC Fontana gave evidence that ballistic vests at that time did not give protection against edged weapons[305] but that new vests have since been rolled out and that his expectation is that the members would wear a ballistic vest in circumstances such as these.

The police resources that night

407. Based on the principle of the capacity to create time and space to allow for more resources to arrive, it is worth just noting that in between the time that the call was made by police officers at the scene for an ambulance at 9.31[306] and 9.47pm (16 minutes and 18 seconds later), there were 11 police members there plus one further member with a police trained dog.[307]

---

[301] Transcript 3569.
[302] Transcript 3569.
[303] Transcript 3733.
[304] Transcript 3734.
[305] Transcript 3733.
[306] 21.31.25, Inquest Brief 2203.
[307] Acting Sergeant Goldrick, S/C Fairgrieve, LSC Matsamakis plus dog, S/C Delle-Vergini, LSC Dickinson, S/C Rooney, Senior Sergeant Jordan, S/C Wallace, S/C Signorini, S/C Leete, Acting Sergeant Gevaux and Inspector Walsh. I should add that Preston 203 came up on air at 21.37.35 as at the scene and requesting SES attend with lighting.

408. Apart from the two vans, there was Sergeant Goldrick and Fairgrieve (who arrived about two minutes after the shooting); the Canine Unit (S/C Matsamakis and his dog about two minutes after the shooting); Dickinson and Rooney, Jordan, Wallace and Signorini (left a few seconds after hearing that a male had been shot and arrived from the Northcote police station); S/C Leete from inside the Northcote police station; at 9.40pm A/S Gevaux; Inspector Walsh arrived at the scene at about 21.46, Delle-Vergini (9.42pm) and Preston 203 at 21.37 comes up at the scene requesting lighting from SES. Most of these members arrived from inside Northcote police station which was about 150 metres from this incident.

409. This evidence only serves to starkly highlight the importance of using the full range of tactical options to create time and space to enable more resources to arrive to assist.

Critical Incident Response Team (CIRT)

410. Counsel for the family drew attention to the call out criteria for CIRT and questioned why CIRT was not called. Units were available that night. As Superintendent Williams said, CIRT has a very good track record in resolving incidents to which they are called. It is worth noting that this was an issue raised during the OPI 2005 Use of Force Report. AC Fontana also noted in his review that CIRT was not considered on this occasion.

411. The value of the CIRT is predicated on the management of the incident being able to be contained until the team arrive.

412. For all of the reasons discussed above, that "*containment*" did not occur.

Management and supervision

413. Management and supervision is another recurring theme from previous reviews and reports.

414. Counsel for the family submitted that there was an air of deference to the members engaged in the incident. An example of this was submitted from the evidence of A/S Gevaux stating: *"they don't need me telling them what to do; they know what to do"*.[308]

415. Further, the evidence was that Senior Sergeant Joshua, the immediate senior officer supervising A/S Gevaux on the night, was caught up in administrative duties whilst this situation was unfolding.

416. The incident began and ended so quickly, and given the circumstances it cannot be concluded that the intervention of Senior Sergeant Joshua would have changed the outcome, but the lack of senior oversight and intervention in a critical incident of this nature must cause Victoria Police to reflect on its critical incident management structure.

---

[308] Transcript 2193.

SHORTFALLS IN TRAINING AS AT 2008

Recurrent features of police shootings identified

417. Various inquiries into the Victoria Police use of force, conducted over the past two decades including previous coronial inquiries, Office of Police Integrity (OPI) inquiries and internally commissioned inquiries, both into a collection of fatal police shootings in Victoria and into the shooting of Tyler were produced, referred to and relied upon in various parts by various interested parties to the Inquest.[309] Some time was spent on the issue of the production and publication of the internal reviews of Victoria Police, the release of which eventually became the subject of a ruling published on 18 November 2010.[310]

418. In so far as they are relevant to this Inquest, Superintendent Williams' findings in his February 2009 review of 11 shootings by police were that:

a. the majority of people shot by police were rendered vulnerable by their psychological state or their use of drugs and alcohol;
b. forms of communication, presumptions of rationality, when dealing with obviously irrational people and forms of communication that may inflame the situation were recurring features such as the constant yelling of commands at an irrational person;
c. opting to engage with the subject too quickly, resulting in the armed subject advancing on the police and breaking the cordon and not allowing the creating of time to garner more resources to help manage the situation;
d. failure to make use of all available information to inform risk assessment and method of approach;
e. lack of planning to create time to better determine a course of action which can be communicated to the other members, rather than reacting independently of each other;
f. the more tactical and planned a critical incident is, the better chance to reduce resorting to lethal force; and
g. despite five of the incidents reviewed being classified as "*suicide by cop*", members are not specifically trained to deal with this.

---

[309] Australian Centre for Police Research – National guidelines compendium Report Series number 123, 1995, Exhibit 123; Inquest touching upon the death of Colleen Richman findings and recommendations, 1996, Exhibit 123; OPI: Review of Fatal Shootings by Victoria Police (November 2005); OPI Review of the Use of Force by and Against Victoria Police, July 2009, Exhibit 123;Corporate Management Review Division, Examination of Police Critical Shooting Critical Incidents between July 2005 and December 2008, February 2009 (Report of Michael Williams Consultant) (Williams 1), Exhibit 97; Education Department, Meeting Operational Safety and Tactics Training in Critical Incident Management Training Progress Report, July 2009 by Superintendent Williams (Williams 2), Exhibit 98; Statement by Superintendent Williams for the purposes of the inquest dated 27 October 2010 (Williams 3), Exhibit 99; Further statement by Superintendent Williams (Williams 4), Exhibit 100; Ashby and Feltus, OPI review of investigation by Victoria Police of fatal shooting of Tyler Jordan Cassidy, January 2010, Exhibit 87; Fontana review; Inquest into the death of Paul Carter; Review of the investigation of deaths associated with police contact 2011; Statement of Eva Perez, Exhibit 120; Statement of Senior Sgt Miles.

[310] See Coroners Court website: **Rulings** section.

The decline in the emphasis on the 10 Operational Safety Principles

419. These Principles have been considered in previous reviews by the Office of Police Integrity (OPI – 2005 and 2009) and effectively endorsed as proper principles. No issue was taken with these Principles throughout this investigation by any Interested Party.

420. There was evidence produced during this Inquest that the intensity of the focus on the 10 Operational Safety Principles, in particular on conflict resolution and tactical communications, had been in decline inside Victoria Police over the last decade and that this decline had lead to a gradual diminution in the emphasis on the "*Beacon*" principles in Operational Safety Tactics training.

421. This evidence emerged in this Inquest from the February and July 2009[311] reviews by Superintendent Williams. One of the shootings Superintendent Williams reviewed was the shooting of Tyler Cassidy.

422. In that review, Superintendent Williams found that from 1996 onwards there had been a gradual waning in the importance of the OSTT and the 10 Operational Safety Principles with less emphasis on the development of skills and communication, conflict resolution, command and control, and cordoning and containment. He stated that martial arts techniques, defensive tactics, and the use of firearms became the "*dominant aspect*" of training during that period. He found: "*There is now very clear evidence that suggests the past decade of operational safety training has impacted adversely on the policing style of Victoria Police*". Superintendent Williams said in evidence[312] "*what I've said to the organisation is that it has lost its way and we had it right back in the 90s and this is what we need to do to bring it back on track.*"

423. After Superintendent Williams completed the February 2009 review and presented his findings to Victoria Police, the then Chief Commissioner Simon Overland made him another offer to continue as a consultant reviewing OSTT and to develop strategies to ensure that the opportunities for improvement identified by his February 2009 review found their way into training. He accepted that offer. In July 2009 he provided another report.[313]

424. Superintendent Williams gave evidence that this report was looking at the efficiency or adequacy of OSTT as it pertained to the issues identified in the first report. In that report, he found that operational safety training had lost its status in terms of organisational priority, there was a lack of effective management structure and the emphasis in training had moved to defensive tactics and firearms training.[314]

---

[311] Superintendent Williams' report was called *Corporate Management Review Division, Examination of Police Shooting Critical Incidents between July 2005 and December 2008.* It was completed in February 2009.
[312] Transcript 3345.
[313] *Education Department, Meeting Operational Safety and Tactics Training and Critical Incident Management Training Progress Report*, July 2009.
[314] Exhibit 98, page 3.

425. After the delivery of those two reports, Superintendent Williams was asked to rejoin Victoria Police, to assist in the delivery of his recommendations for change. He accepted and was re-sworn in December 2009.[315] He stated that he returned to Victoria Police very keen to embed a lot of the recommendations from his initial report (February 2009) and his review of OSTT in his second report (July 2009). He stated there was a recognition that training in tactical awareness and the ability to effectively engage with vulnerable people and cordon and containment skills needed attention.[316]

426. Senior Sergeant Miles (S/S Miles) has been a member of Victoria Police for 32 years and is currently in charge of the OSTT Unit, in the Centre for Operational Safety, Education Department of Victoria Police.[317] He has been attached to the OSTT Unit, first as a Sergeant and then Senior Sergeant for the last 19 years. His Unit has the responsibility for the statewide standardisation, coordination and management of OSTT for all operational members of Victoria Police. The unit is also required to monitor all incidents involving the use of operational safety equipment where death or serious injury has resulted and is also required to attend the scene of critical incidents involving police where loss of life has occurred, to provide advice to the investigators.

427. S/S Miles was asked whether he agreed with Superintendent Williams' opinion about the gradual change in emphasis in OSTT over the years. He gave a qualified answer stating that he agreed with aspects of what Superintendent Williams had found.[318] S/S Miles explained that it was not possible in the two days available for the ongoing OSTT for members, to include all the components so that was undertaken in a rotational way but the only parts of the training that remained constant were the skill based components of the training which were the defensive tactics and the firearms training.

428. He stated that the requirements of training were constantly being added to and it was not possible to "*teach the volume of material we had acquired continuously*". S/S Miles did "*not necessarily agree*" with Superintendent Williams that there had been a greater emphasis on firearms than in earlier years. However, it also became apparent that Senior Sergeant Miles had not been provided with a copy of Superintendent Williams' reports, despite having requested a copy internally.[319]

429. S/S Miles did agree, however, that by about 2007, there was a shift away from the "*Beacon*" based theoretical training and conflict resolution and tactical communications

---

[315] Transcript 3228.
[316] Inquest Brief 3548, Williams October 2010 Statement.
[317] According to Senior Sgt Miles, the Unit has more recently become known as the Operational Tactics and Safety and Training unit or OTST. Given that most witnesses and documents referred to OSTT, I shall continue to refer to OSTT by its best-known acronym.
[318] Transcript 3534–3535.
[319] Transcript 3538: I pause to note that given Senior Sgt Miles is in charge of the OSTT unit of Victoria Police, and given the purpose of the Williams review was to investigate why Victoria continued to have a disproportionately high number of shooting fatalities when compared to other states, this seems to be a review that would be of considerable value to the training arm of Victoria Police. On the face of it, without explanation this seems like an odd decision not to provide Senior Sgt Miles with copies of these reviews.

and all of those other skills to the point where it was just about defensive tactics and firearms.

430. In this context, he also gave evidence that by 2007 the training was reduced to just one day and there was no conflict resolution training.[320] In his statement, he specifically noted that in the period July to December 2008, the OSTT package was a single day consisting of skills based training only.[321]

431. On this topic, S/S Miles was asked by Counsel for the family: "*Do I take it that doing the best you could with the instructions that you had at the time, there was a shift away from the training in relation to the theory behind Beacon and the focus shifted to, as you were saying, hand to hand techniques, use of firearms?*"

432. S/S Miles agreed with this proposition and confirmed that this was because there were resource constraints and members were needed on the streets.[322]

433. In a follow up question, S/S Miles was asked: "*Did that disturb you that the theoretical underpinnings of the Beacon principles were no longer being taught to the members that were supposed to go out and be on the front line when it came to dealing with members of the public?*"

434. S/S Miles answered as follows: "*Yes ... yes, it does disturb you and as a trainer you want to provide the best possible training that you can provide and from that perspective we pick up and we train our people the best that we possibly can in that timeframe that we are allocated to train them. So, did it disturb me? Yes, it disturbs me.*"[323] He also agreed with the opinion of Superintendent Williams that during the 90s Victoria Police had been far better focused on "*Beacon*" principles[324] but then "*lost its way*".

435. Superintendent Williams agreed when it was put to him that the 10 Operational Safety Principles were still taught, but Superintendent Williams would not agree that the principles were "*instilled*" and preferred to describe them as being "*mentioned*" in training, but that was about as far as it went according to Superintendent Williams.[325]

436. Superintendent Williams also agreed that prior to Tyler's death there had been very little response to the 2005 OPI Report on the Use of Force. This evidence is endorsed by the report of the OPI 2009, in which the Director, Michael Strong, noted concern about the "*slow progress*" in the implementation of reforms Victoria Police endorsed from the 2005 report of the OPI.[326] The recurring theme of both the 2005 and 2009 reports was that the training provided to the members of Victoria Police did not equip them with the necessary skills to respond to individuals affected by drugs or alcohol or mental health

[320] Transcript 3540.
[321] As at July 2010, a two-day program was reinstated which consists of skills and theory-based subjects.
[322] Transcript 3540.
[323] Transcript 3531.
[324] These principles were put to Senior Sgt Miles as being focused around creating time, distance and cover.
[325] Transcript 3381–3382.
[326] *Review of the Use of Force by and against Victoria Police,* July 2009, page 12.

problems, that there was a tendency for police to feel pressed to "*resolve incidents quickly*" and that they lacked the communication skills necessary to de-escalate rather than inflame situations.[327]

IMPROVEMENTS AND DEVELOPMENTS IN OPERATIONAL SAFETY AND TACTICS TRAINING SINCE DECEMBER 2008

437. There was considerable evidence that Victoria Police are making concerted efforts to address the training issues that have been consistently identified over the last decade by a number of reviews and reports: including enhancing skills in tactical communications, cordoning and containing skills, tactics and skills in disengagement but a particular focus has been on the need to address how to give assistance to all of its operational police in improving understanding of, and response to, managing people with a range of vulnerabilities, including mental health issues.

438. As an example of the developments, Superintendent Williams gave evidence about the "*presumption of rationality*" that meant police were often repeatedly yelling demands and commands at vulnerable people and how that yelling may inflame the situation.[328] Superintendent Williams went on to give evidence that the emphasis in training has changed and, in particular, the development of the "*vulnerable persons' package*" has seen a far greater emphasis on communication strategies that should be used for people possibly suffering from mental health problems or in a highly agitated or aroused state.

Specific training to assist police deal with vulnerable people

439. This issue arose squarely on the facts in this case. Various witnesses from Victoria Police as well as Professor McGorry were asked a range of questions touching upon the area both generally and specific to the facts in Tyler's death.

440. Questions were directed at the need for Victoria Police to be able to differentiate between someone engaged in a criminal enterprise as opposed to someone who is presenting as primarily mentally unstable or unwell. The need to be able to adapt or moderate the approach to that person upon making such an assessment was also examined with Professor McGorry and Victoria Police witnesses. In 2005, the OPI report noted the pressing need for further action by Victoria Police to improve the understanding of its officers with respect to the managing of vulnerable people.

441. Professor McGorry stated that he had been involved with giving advice to Victoria Police and assisting in the development of aspects of this training. During the running of the Inquest, he was given the opportunity to look at the latest round of Victoria Police initiatives in this area. Professor McGorry was quite positive about the training package he saw during his visit to the Academy. He described the current training in relation to vulnerable persons as a genuine attempt to improve the skills of frontline police.[329]

---

[327] Ibid, page 10.
[328] Transcript 3281.
[329] Transcript 2649.

442. He also gave evidence that the introduced modules needed to be evaluated in terms of competencies to ensure that members had reached the requisite standard of skill.[330] Professor McGorry added that given how frequently mentally ill people are coming into these risky situations with police members, members should be regularly "*recertified*" to ensure that their training was effective.

443. Superintendent Williams agreed with Professor McGorry on this issue. Superintendent Williams noted that there used to be exams after OSTT but they were dropped about four years ago.[331] Superintendent Williams concurred that it would be very appropriate to have some form of examination at the end of the training.[332]

444. Superintendent Williams stated that since July 2009, the Victoria Police Mental Health Strategy Unit has delivered an additional session in the recruit course on recognising and responding to mental disorders.[333] Further, he outlined that since January 2010 there is both ongoing training and the further development of training packages that predominantly focus on identifying and managing vulnerable persons.

445. Ms Eva Perez, manager of the Mental Health Strategy Project, provided a statement.[334] The statement referred to the plan of Victoria Police to introduce training modules extending to the topic of youth mental disorders. This will involve consultation with relevant external and internal experts to facilitate this.

446. Superintendent Williams also reported positively on the progress of the implementation of the recommendations from his 2009 review and the OPI reviews on the police use of force.

Training specific to vulnerable young people

447. Professor McGorry gave evidence that after having seen the training package for vulnerable persons, there was a need to have a better understanding of skills required in relation to young people.[335] Superintendent Williams stated that at present the training package does not include the development of skills specific to dealing with young people. He acknowledged that there would be value in having a discussion around the skills required of the police to communicate with young people, stating that he would want such a package to be evidence-based.[336]

---

[330] Transcript 2657.
[331] Transcript 3380.
[332] Transcript 3381.
[333] Inquest Brief 3543.
[334] Inquest Brief 3686.
[335] Transcript 2556.
[336] Transcript 3351–3352.

Data and trend monitoring and analysis to ensure evidence-based developments in training

448. Superintendent Williams stated that since January 2010, there have been important changes in the way the OSTT program is developed and delivered, in that there has been a shift to a more evidence-based approach. The OSTT unit is not only looking at all of the reviews and literature but actively conducting its own trend analysis and research as well as consulting widely across the organisation.

449. Superintendent Williams, having identified a paucity of collected data inside Victoria Police to create evidence-based training, reported that there is now a "*Mental Disorder*" reporting process in place, which in the first six months of 2010 was averaging 500 reports a month across the state.

450. Superintendent Williams' evidence was that he was able to be confident about the improvement in police responses to critical incidents generally because he had been monitoring them daily for the past18 months. He stated that he was, thereby, able to say that he could see changes in areas such as "*the rush to resolve*" issue, and successful resolution of large numbers of incidents by tactical communications.[337] His evidence was that part of the work being done in the daily scanning of the critical incident fact sheets was not only to watch the impact of the changes to training but also to pick up the repeated themes or issues coming out of those areas and ensure that the training is tailored to those contemporaneous themes and issues.

451. He stated that the monitoring of the 200 incidents of self-harm referred to below had not been analysed for the age of those involved. He gave evidence that the data were available to be gathered but resources were needed to collate it.[338]

452. It was the submission of Counsel for VLA that Victoria Police needed to not only continue the monitoring of the effectiveness of training but to enable a form of scrutiny which identifies critical incidents involving young people to enable data to be specifically assembled to inform training and the development of the necessary skills.

Police awareness/training for "suicide by cop"

453. The term "*suicide by cop*" found its way into this inquest. Whilst it is an unfortunate term, as a descriptor, for present purposes it is practical to use it. Senior Sergeant Miles gave evidence that there was no current police training dealing specifically with "*suicide by cop*".[339] However, the evidence is there is now a specific package being developed which seeks to train members in identifying and diffusing situations of potential "*suicide by cop.*"[340]

---

[337] Transcript 3345.
[338] Transcript 3351.
[339] Transcript 3603.
[340] Transcript 3603.

454. Superintendent Williams' evidence was that Victoria Police have been monitoring this since January 2009. His evidence was that there have been at least 90 incidents of attempted "*suicide by cop*" the police have attended since the monitoring commenced and there have been 200 incidents where police have attended incidents where a person has been threatening self-harm.[341]

Conclusions as to training

455. Given that Superintendent Williams appears to have played a significant role inside Victoria Police since early 2009 in identifying the shortfalls and the lack of appropriate emphasis on the "*Beacon*" principles, his assessment is an important one about what is happening currently.

456. In his October 2010 statement, he sums it up this way: "*OST training continues to be an organisational priority for Victoria Police. ... Some work remains ongoing, but substantial efforts have already been made to ensure that gaps in training are addressed and that cultural change is forthcoming*".[342]

CONTRIBUTION: DID THE POLICE MEMBERS OR VICTORIA POLICE "CAUSE" OR "CONTRIBUTE" TO TYLER'S DEATH?

457. It was submitted by Counsel on behalf of the family that I should find that the four officers directly involved, together with Victoria Police as an organisation, so departed from their duties to adequately and effectively protect members of the community, as to amount to causing or contributing to Tyler's death within the meaning of the law as espoused in *Keown v Khan [1990] 1 VR* 69, 76. This submission was put on the basis that:

a) the OSTT at the time was inadequate both generally and with respect to young persons in crisis and there was deficient command and control of the incident
b) notwithstanding the shortfalls in training, the four members involved failed to gather adequate information from relevant witnesses, failed to adequately pre-plan, failed to cordon and contain as directed, failed to call upon specialist resources such as the critical incident response team, failed to negotiate and use de-escalating tactical communication, failed to treat Tyler as a young person in crisis, failed to communicate with each other effectively, failed to use minimum force, failed to adhere to training with regard to the use of firearms and used force disproportionate to the threat that was being posed.[343]

458. Counsel Assisting submitted that I should find that the four members involved in this incident responded to Tyler within the limitations of their training. Counsel further submitted that whilst the evidence is that the training of police members strives to keep abreast of external and internal feedback, it is clear that in this case the training as it was

[341] Transcript 3344.
[342] Inquest Brief 3562.
[343] Written submissions of the family, page 7.

in 2008 fell short of what Victoria Police should have been teaching or re-teaching its members and that Victoria Police had been put on notice about these shortcomings in previous reviews.

459. Counsel Assisting did not submit that these identifiable or identified shortcomings within training could be found to be so causally connected to Tyler's death to conclude that the shortfall in training actually caused or contributed to Tyler's death in the sense submitted for by Counsel for the family.

460. Counsel Assisting did submit, however, that there were circumstances in which Tyler's death occurred that were far from optimal. Counsel submitted that there were problematic issues relevant to training such as the lack of teamwork, deficits in command and control, cordoning strategies, and the style of communication being taught. However, it was the submission of Counsel Assisting that once that first point of engagement commenced, despite the training issues identified, it would be difficult to conclude that the outcome would have been different with the current training in place.

Conclusion on causation/contribution

461. I am satisfied that when the three police members fired at Tyler, it was at a time that LSC Dods was in immediate and perilous danger of serious injury or death.

462. LSC Dods appeared to be dedicated to his work as a member of Victoria Police and his role as a protector of the community. He left no doubt as to his level of soul searching about this tragedy and belief that he could find no other resolution after two years of reflection.[344] Each of the members seemed intent to convey that they believed they had responded to the training they had as at December 2008. The general effect of their evidence was that since the death of Tyler, they have observed that their training has given greater emphasis to tactical communications, techniques for cordoning and containing and information to assist in dealing with vulnerable people.

463. I am satisfied that the members involved responded within the limitations of the training and skills provided to them by Victoria Police as at December 2008. Those limitations and issues are set out above, together with evidence as to changes and improvements noted.

464. The evidence is that not only had Victoria Police not been responding to warnings about aspects of its training falling short of what was required, it gave members no training in how to deal with a young person like Tyler in his state. Just as we build barriers on the Westgate Bridge to be able to stop someone in their impulsive attempts to end their lives, so too do we need to have our police force able to make an informed assessment to understand, firstly, what they were looking at in this case and, secondly, to be equipped with skills and tactics to respond appropriately to the complexities such a situation poses.

---

[344] Transcript 3657.

465. Whilst I am not able to conclude that a different initial approach to Tyler or other tactical options during the engagement would have resulted in a different outcome, I am able to say that Tyler's sudden and tragic death in these shocking and bewildering circumstances, must signal an immediate and urgent need for Victoria Police to focus its training to members on developing the ability to recognise and manage vulnerable young people such as Tyler.

EMERGENCY SERVICES TELECOMMUNICATIONS AUTHORITY (ESTA)

466. In the original scope of the Inquest, issues were raised about the various communications to and from ESTA (as noted previously, also referred to throughout the course of this investigation as 000).

467. ESTA's statutory functions and obligations are set out in the *Emergency Services Telecommunications Authority Act 2004*. For the purposes of this Inquest, the relevant functions were its responsibility to take, listen to and record calls from the public or members of the police force or ambulance service and appropriately manage and respond to those calls by dispatching the appropriate services in a timely way.

468. Evidence as to the statutory functions and call taking and dispatch procedures was given by Ms Michelle Smith (Centre Manager for ESTA's central service) both in the form of a statement and in oral evidence.[345]

469. The evidence was that Victoria Police has Police Communication Liaison Officers stationed at ESTA's central headquarters at the World Trade Centre and it is only these members who are empowered to make operational decisions in relation to how police units are to respond to critical events, not ESTA staff.

470. The evidence of Ms Smith also clarified that the priority assigned to an event consistent with the Standard Operating Procedures, is the priority for dispatch of the job and does not necessarily reflect the way in which police operational units in the field will respond to their attendance at the incident dispatched by the ESTA. Assistant Commissioner Fontana agreed with this evidence from Ms Smith. Indeed, it was not contentious.

471. Whilst there were some issues raised by the family with respect to the confusion over the first call made by Lydia Firanyi to the Northcote police station about whether the police were being called to Blythe Street, Thornbury or Blyth Street, East Brunswick or Arthurton Road, Northcote, I was not persuaded that anything turned on this issue in this case. ESTA dispatched the police to Blythe Street, Thornbury, consistent with Constable Jones' instructions. Constable Jones had not clarified the location accurately from the Firanyi call, and thus the van was dispatched to the wrong location. However, given that Ms Firanyi made her call about 5–10 minutes after she saw Tyler at the bus stop, he would have been long gone inside his home had the police been dispatched to the correct location and arrived even a few minutes after the Firanyi call.

[345] Exhibit 45.

472. There was a speculative submission made that had the van been sent to the correct location in Arthurton Road, it would have been able to respond to the calls to Northcote Plaza quicker, with the inference the outcome would have been different. There is no basis in the evidence to make such a finding.

473. Other than this piece of evidence, there was no other aspect of the requirements of the agreed Standard Operating Procedures of ESTA or indeed their actions on this evening that raised any issues.

IMMEDIATE AFTERMATH OF THE INCIDENT AT THE SCENE

474. There were a number of issues raised during the course of the investigation and Inquest about how the scene was managed and how the family was managed. I have endeavoured to deal with the main issues.

Separation of the members in the wake of the shooting

475. Victoria Police Manual 104-2 covers Major scene and investigation protocols. It requires the Incident Commander to ensure that members directly involved in a police fatality are located, separated and isolated. The rationale for this is to ensure that fatalities involving Victoria Police are investigated thoroughly and transparently.

476. The weight of the evidence is that Acting Sergeant Juliann Goldrick (A/S Goldrick) was the first officer on the scene in the immediate wake of the shooting.[346] Indeed, her statement is that she left the station upon hearing the series of calls about an agitated male in the car park of Northcote Plaza armed with two knives. She stated that as she was leaving the station, she heard LSC Dods call for an ambulance as he had shot the male.[347] A/S Goldrick got into a divisional van with S/C Fairgreive and took the van out of the back gates of the station and less than about 100 metres to where the four members had parked their vans. She stated that she could hear LSC Dods yelling: "*Show me your hands, take your hands out and I'll get you some help*". She also stated that Tyler was still moving his head when she arrived.

477. According to A/S Goldrick, she asked: "*What happened?*"

> LSC Dods replied: *"We foamed him twice, it was ineffective. He was screaming to be shot. He had two knives. He ran at us. I fired a warning shot into the ground but he kept coming..."*
> A/S Goldrick then asked: "*Who has shot him?*"
> LSC Dods said: "*I did at least three shots*"
> S/C Blundell said: "*I did at least three shots"*

[346] A/S Goldrick was the section sergeant on duty that evening at Northcote police station. Northcote police station was approximately 100 metres away from the skate park. A/S Goldrick made a statement which was included on pages 420–426 of the Inquest Brief but was excused from giving evidence based on her medical condition at the time of the Inquest.
[347] Inquest Brief, page 420.

De Propertis said: "*I shot once*"
Ferrante said: "*I didn't shoot. Dods was too close*".

478. According to A/S Goldrick, after confirming to ESTA that she was present at the scene and confirming that Tyler was no longer breathing, she briefed the ambulance paramedics that she was going to ensure the scene was safe for them to enter. Once this was done she advised the members to holster their firearms and separate.

479. A/S Goldrick stated that she began directing members who were arriving to get crime scene tape and cut off the entire area. She stated that she handed the members over to Sergeant Jordan.

480. This account of A/S Goldrick is consistent with the evidence of LSC Dods who says he was separated from the others within about 60 seconds and placed in the company of Sergeant Jordan. S/C Blundell was placed in the company of S/C Signorini and C. De Propertis placed in the company of A/S Gevaux.

481. C. Ferrante's evidence was that the first person she recalls at the scene was Leading S/C Dickinson and that A/S Goldrick arrived seconds later.[348] The evidence is that C. Ferrante was not allocated into the care of anyone and remained unattended at the scene for approximately half an hour. During this time she gave evidence that she was in a bit of shock and was approached by a number of witnesses whilst she was standing still at the inside of the outer crime scene area.[349]

482. C. Ferrante made notes of these conversations and stated that she knew it was not preferable for her to be there but she continued to do her duty as she saw it.[350] Amongst other issues, this meant that she was approached by a witness who turned out to be James Wendt. C. Ferrante took down his details and passed them on but understood that "*it was not preferable*" that she be talking to witnesses. She described herself as "*in shock*" at that time but felt like the information might be important and she thought she should obtain it.[351]

483. Inspector Walsh was the Inspector in Charge of the region that night. The evidence was that she arrived at the scene shortly after 21.46 and took on the role of "*Forward Commander*". It was her evidence that when she arrived the four members were in the car park standing quite apart from each other. Inspector Walsh stated that she got a briefing from A/S Goldrick.

484. The evidence was that LSC Dods, S/C Blundell and C. De Propertis were all removed from the scene and taken into the Northcote police station but C. Ferrante was left out in the car park. Inspector Walsh accepted responsibility for this situation and

[348] Transcript 4097–4098.
[349] James Wendt, Mr Gregory, Mr Skordos and Mr Sood.
[350] Transcript 4097–4011.
[351] Transcript 4100–4125.

described it as "*not preferable at all*".[352] C. Ferrante, being the only member who had not discharged her firearm, was left standing near the skate park after the other three members were escorted into the police station. Inspector Walsh stated that her intention was to deal with C. Ferrante and she regretted that she was "*distracted by a number of other duties and did not get back to her as quickly*" as she could have.[353]

485. Inspector Walsh's evidence was that when she arrived she arranged for each member to be accompanied by another assigned member to the Northcote police station where they were required to provide their equipment belts.

Conclusion as to separation of the members

486. With the exception of the account of Sergeant Delle-Vergini, the weight of the evidence is that the members were all separated at the first opportunity at the scene. It was not unreasonable of A/S Goldrick to ask what had happened in the circumstances of the scene at which she arrived. The evidence that the members were all then separated after that short exchange in each other's hearing as outlined above, does not fall foul of the requirement for the separation of police members in the wake of a fatal incident. The rationale behind it flows from situations where members have remained together for some hours after the fatality, or travelled together to be interviewed or given considerable opportunity to collaborate. There is no evidence of that in this case. The members were separated and then remained separate and in the company of individual officers who each gave evidence of how they kept vigil over the member they were assigned.

487. Only the account of Sergeant Delle-Vergini, who heard the incident over the radio and drove to Northcote and got to the scene at approximately 9.42pm, was at odds with all of the other accounts. He gave evidence that he separated the members when he arrived. Given the weight of the evidence contrary to this, I conclude that in the predictable confusion of the scene Sergeant Delle-Vergini is mistaken about this.

488. Clearly, it was an error and not appropriate for the investigation, nor for the welfare of C. Ferrante, that she was left standing in the car park for half an hour in the wake of the shooting. It is not appropriate for the investigation because of the perception that it leaves a member involved in the incident with the opportunity to both hear accounts from witnesses of what they heard and saw before that member has been interviewed, but also has the potential for a member to interfere with potential crucial evidence to the investigation. However, there is no evidence that it did cause an actual compromise in this investigation.

489. A/S Goldrick needed to establish something about the incident to take control of the scene. In my view, she did not engage in unnecessary discussion or give the members the opportunity to discuss their respective versions of events, which is the purpose of the rules of separation.

---

[352] Transcript 2411.
[353] Transcript 2397.

Drug and alcohol testing of the four members

490. The policy requiring members involved in a critical incident to furnish samples for drug and alcohol testing was described as "*very new*" in December 2008. Up until this point, it would appear that the decision to test members for the presence of drugs or alcohol was at the discretion of the Incident Commander. This may go some way towards explaining the confusion and lack of clarity on the night.

491. Detective Sergeant Birch (DS Birch) was the lead investigator assigned on the night from the Homicide Squad. It was his evidence that under the new policy, it was the responsibility of the Operations Commander to organise the drug and alcohol testing and to ensure that it was complied with in a timely manner. The policy requires an officer of the rank of inspector or above to make the request for drug and alcohol services to attend and for the members to comply with the testing requirements. It was clear from the evidence of DS Birch that there was some confusion about how the services would be called out and who would make the request of the members.

492. He accepted it as a responsibility delegated to him on the night. It was the evidence of DS Birch that around 4.00am, a nurse did attend at the St Kilda Road Homicide Squad office to perform tests but for reasons that remain unclear, she did not arrive with the proper kit to perform the test or obtain the required samples. A nurse appropriately qualified and with the appropriate equipment finally arrived at some time after 6.00am.

493. DS Birch was completely open in his evidence that this situation was entirely unacceptable to the Cassidy family, the community and the members involved.[354] There was a lack of clarity about who was to be contacted and the machinery for an available officer to make the demand. DS Birch was unable to assist as to what service was called and what time the service was called.

494. He gave evidence that in the wake of this investigation the Homicide Squad has now developed a "*checklist*". He confirmed that the testing should be done as soon as possible and in this case should have been done at the Northcote police station.[355] DS Birch also gave evidence that if he was put in the same position today, he would at least call upon the licensed police breath testing van if there was going to be an unreasonable delay.

495. The spectre of the possibility that the members were alcohol affected was raised by Counsel for the family. It was raised in the context of the Northcote police station Christmas party having been held the night before and the possibility that LSC Dods and S/C Blundell, having been in attendance at that party, were affected by alcohol at the time of this incident.

496. Other than their attendance at the Christmas party, there is no evidence that they were affected by drugs or alcohol at the time of this incident. Each member gave evidence on the issue of their drug and alcohol intake the night before. The evidence on

[354] Transcript 4154.
[355] Transcript 4162.

this issue is that LSC Dods described having arrived at work at about 2.20pm that afternoon for a routine afternoon shift, due to commence at 3.00pm. He described the shift as "*constant*" but otherwise routine. He stated he was in a van with S/C Blundell who was driving that night. LSC Dods further stated that he had attended the work function the night before. He stated that he drove to the function, had a couple of pots of full strength beer and stopped drinking at about 9.30pm. He stated that after this time he drank only coffee and water and left the function at about 12.20pm where upon he travelled home. He was not challenged on this evidence.

497. S/C Blundell gave evidence that he drank somewhere between four to six drinks and left the function at about 1.00am.[356]

498. The members who were placed with them to oversee them, the Ethical Standards Department (ESD) member who attended, the interviewing members from Homicide were each asked whether or not they observed the effects of drugs or alcohol upon any of the four members. The evidence was from each witness that they did not observe any such signs.

499. It was submitted on behalf of the four members, consistent with their evidence, that they were disappointed with the delay in drug and alcohol testing which meant they did not have the benefit of this testing to provide corroboration of their evidence that none of them were affected by drugs or alcohol at this time.

500. It was the evidence of Detective Acting Sergeant L'Estrange that only an officer of Inspector or above could demand a member participate in a drug and alcohol test. Further, it was his evidence that the testing itself needed to be performed by a forensic or medical officer.[357] The appropriate forensic or medical officer needed to be contacted by either the Homicide Squad or ESD. The evidence revealed that there was a considerable lack of clarity on the night, around who was accountable for contacting whoever was responsible for performing the drug and alcohol testing of the members.

Conclusion

501. Whilst the delay in the testing of members was most unfortunate and not of their making, there is no evidence that any of the members involved in this incident were affected by drugs or alcohol at the time. Each of the officers assigned to sit with the four members in the immediate wake of the shooting was questioned about their observations of any signs of the effects of drugs or alcohol on the four members. Each stated that they observed no such signs.[358] Similarly, the members from the Homicide Squad who interviewed each of the four members made the same observations as did the observer

[356] Transcript 3831; see also Inquest Brief page 380–381.
[357] Transcript 2915.
[358] Detective Acting Sergeant Jordan (for Dods) – Transcript 2074, Detective Senior Constable Signorini (for Blundell) – Transcript 2803, Acting Sergeant Gevaux (for De Propertis) – Transcript 2304 and Detective Acting Sergeant Delle-Vergini (for Ferrante) – Transcript 2747 together with the observer from ESD.

from ESD, Detective Inspector Aristidou, that is nobody smelt of alcohol or appeared affected by alcohol or drugs. The testing that was performed, albeit delayed, was negative for all four members.

502. The failure to have the members tested in a timely way is a serious one, and not of their making and indeed, as stated by the members, to their detriment. It is entirely unsatisfactory that this was not performed in a timely and professional way. There is no evidence to suggest that the failure was as a result of anything other than a lack of knowledge or proper procedure.

Gunshot residue

503. The testing for gunshot residue in the immediate aftermath of the shooting arose as an issue attached to the impact in the delay of the notification to the Homicide Squad to attend at the scene.

504. Mr Harald Wrobel is a Forensics Officer at the Victoria Police Forensics Services Department. He has over 20 years' experience in the field of electronmicroscopy and gunshot residue. He holds a Masters degree of applied science (applied physics). He made a statement as to his attendance on 12 December 2008 at the Northcote police station.[359] Part of his work in the aftermath of the shooting was to sample the hands of the four police officers for the presence of gunshot residue. He found no gunshot residue particles detected on the samples taken from the hands.

505. Mr Wrobel stated that the non-detection of gunshot residue particles was consistent with "*the subject either not having discharged a firearm or the gunshot residues having been dislodged prior to sampling as a result of activity since shooting*". He went on "*gunshot residues are lost from most surfaces rapidly and, generally only a few particles may persist on the skin for 4–6 hours and on clothing for about eight hours after the discharge of a firearm*".

506. Mr Wrobel stated that he took possession of the clothing of the members involved on the night and on 19 August 2009, he received a sealed paper bag that contained Tyler's clothing which he examined to endeavour to ascertain "*the muzzle distance*".

507. Around some holes in Tyler's trousers that he examined, he found "*significant numbers of gunshot residue particles*" which would indicate an approximate distance of less than four metres from the muzzle of the gun to Tyler but not closer than three metres. However, for the majority of holes on Tyler's shirt that he examined, he found a low number of gunshot residue particles. Ultimately he concluded that this may be explained by either: (a) the firearms were discharged from a greater distance than four metres or (b) the "*thick*" blood deposits on the shirt had significantly affected the recovery of particles. In oral evidence, Mr Wrobel added that other possible explanations for the absence of particles from Tyler's shirt could be that Tyler's arm was moved by police and his shirt

[359] Inquest Brief 546.

unbuttoned by paramedics at the scene, the transfer of Tyler from the scene and the removal of his clothes for post mortem examination.

508. Mr Wrobel's ultimate conclusion was that in this case *"due to the lack of gunshot residue particles detected"* he was unable to ascertain the distance from firearm to Tyler.

509. Given the evidence of Mr Wrobel as to the need for gunshot residue to be a timely examination, there was some focus on what actually happened with respect to the calling of examiners to the scene in the wake of the shooting. Mr Wrobel gave evidence that he was not paged to attend the scene until 1.30am, that was almost four hours after the incident. Mr Wrobel stated he did not commence sampling the officers until approximately two hours after that, about 3.30am.

510. Mr Wrobel stated that it was not just the delay but perhaps, more critically, what activity occurs during the lapse of time between the shooting and the examination.[360] In this case, the four police officers had been requested to remove their clothes for the purposes of testing but, according to Mr Wrobel, given the volatility of GSR (gunshot residue) particles, it would have been preferable if they remained in their clothes.[361]

511. The evidence was that the delay in contacting the GSR services in a timely way was due to a *"double delay"*. There was first a delay in contacting the Homicide Squad to attend at the scene, and then a further delay in the lead investigator for the Homicide Squad, DS Birch in calling for the GSR services.

512. DS Birch took responsibility for the delay in contacting the forensic services to attend. He gave evidence that when he contacted the Major Crime Desk and asked for the attendance of ballistics and forensic services, he believed that would extend to GSR services.[362]

513. It was submitted on behalf of the four members, that any inadequacy in the GSR testing of the members was inconsequential as there was ample evidence as to who had fired and how many rounds each member had fired.

514. In my view, the investigation was not lacking in probity as a consequence. Whilst it is always preferable to perform the GSR testing as soon as possible, and DS Birch accepted his misunderstanding lead to a further delay, in this particular instance, instant GSR testing would have added nothing. It was not a situation where it was unclear whether or not shots had been fired and who fired them.

Delay in contacting the Homicide Squad

515. The current requirement in the wake of a police shooting fatality is that the Homicide Squad must be immediately notified. The evidence is that there was at least an hour's delay in advising the Homicide Squad of Tyler's death in the wake of the call to

[360] Transcript 3021
[361] Transcript 3022
[362] Transcript 4147-8

ESTA for an ambulance. AC Fontana, both in evidence and in his report, stated that there was confusion as to who was responsible for calling out the services. The evidence is that whilst an ambulance was called via ESTA after Tyler was shot, this did not translate into a notification to ESTA that a person had died as a result of a police shooting. At the time the ambulance was called for via ESTA, Tyler was still alive. ESTA was not re-contacted and notified that Tyler had died, nor was the Victoria Police Crime Desk notified of the death for at least an hour.[363]

516. It would appear the process is that the Police Communications Liaison Officer stationed at ESTA should notify the Major Crime Desk, and then the Major Crime Desk is thereafter responsible for calling out the services, in consultation with the Homicide Squad.

517. Both AC Fontana and DS Birch stated that the first detectives at the scene should have contacted the Major Crime Desk directly.[364] It was their responsibility, according to AC Fontana in the model, as it was at that time they should have assessed suitability for the call out of resources by the Major Crime Desk. AC Fontana, at page 26 of his internal review stated that *"in such clear cut cases, time is of the essence... In serious critical incidents such as this, the assessment should not be delayed and relevant services should be notified immediately".*

518. DS Birch stated that, in his view, the delay in contacting the Homicide Squad on the night was significant, as it delayed the notification of all the other forensic services required to attend the scene.[365]

519. According to the evidence of DS Birch, since 21 August 2009 there is now an obligation upon the Police Communication Liaison Officer at ESTA to notify the Major Crime Desk immediately upon becoming aware of the fatal police shooting or a death involving police contact.[366]

Contact with the Cassidy family/dealing with the family at the scene and in the immediate aftermath

520. During the course of the Inquest some attention was given to the intense unhappiness felt and expressed by the Cassidy family about their treatment at the scene and on the night of the shooting generally. Following are several issues raised in that context.

Restraint of Blake

521. Constables Simon Doherty (C. Doherty) and Constable Meredith Grisold (C. Grisold) were performing traffic duties together in the Preston area on the night of 11 December 2008. According to the statement of C. Doherty, at approximately 9.29pm they received information from ESTA to assist at Northcote Plaza to a report of an armed male with two knives. A few minutes later, they arrived at the eastern side of All Nations Park,

[363] AC Fontana Review, Inquest Brief 2321.
[364] Inquest Brief 2321.
[365] Transcript 4145–4147.
[366] Transcript 4208.