having heard en route that the male had been shot and, although conscious and breathing, urgently required an ambulance.

522. They were directed by A/S Goldrick to set up a road block at the southern entrance to the Plaza. In the course of doing so, C. Doherty stated that he saw a male about 17 years old get out of a car that had pulled up at the scene and run towards the crime scene.

523. He told the male he could not go in there as it was a crime scene and the male said: "*It's my brother*".[367] C. Doherty stated that he "grabbed the male ... to stop him from entering the crime scene".

524. C. Doherty stated that the male said: "*I just want to see my brother.*" C. Doherty further stated that the male was very aggressive and crying and appeared very emotional. C. Doherty stated that he said: "*If you don't stop, you'll be under arrest for hindering police*".

525. He also stated that the male continued to try and break free so he and C. Grisold detained the male for his own safety as they were unsure if the crime scene had been made safe at that stage and also to preserve the crime scene. That male was Blake, Tyler's brother who had been receiving increasingly more disturbing messages from his brother as he frantically searched for him that night.

526. C. Grisold provided a statement consistent with the account from C. Doherty. She added that after Blake was warned by C. Doherty, despite them trying to hold him each by an arm, he continued to struggle and tried to break away, so he was handcuffed "*for his own welfare, and that of police*".[368]

527. C. Doherty and C. Grisold both agreed that Mrs Cassidy and Mr Taylor approached them after Blake had been handcuffed, identified themselves as Blake's family and were told to go and sit in their car and they would be spoken to soon.

528. Blake's evidence was that when he arrived at the scene and saw police lights in the car park, he knew it was Tyler because of the call he had received from Tyler about the police shooting him. Blake stated that he got out of the car to run through the car park to see Tyler, but he was stopped by the police. He stated "*I asked them to see my brother and they told me I couldn't do anything at this time*".[369]

529. Blake stated that he did try and run past the police and they "*quickly tackled me down*" and thereafter put him in handcuffs for about half an hour sitting under a tree.[370]

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[367] Inquest Brief 472, Statement of Doherty.
[368] Inquest Brief 503.
[369] Inquest Brief 193.
[370] Transcript 578.

530. Counsel Assisting expressed in closing submissions that whilst it was clear that a crime scene needed to be preserved, the treatment of Blake in all of the circumstances, given what the police knew, "*is troubling for us as a community and worthy of redress by Victoria Police through its consideration of engaging suitable persons to deal with the welfare of families affected in this and like situations*".

531. I agree.

Delivery of the death message

532. Another area of considerable unhappiness felt and expressed by the Cassidy family was the way in which the notification or "*death message*" was delivered to the family on the night.

533. The police were aware of the presence of Mrs Cassidy, Mr Taylor and Blake at the scene by about 10.00pm.

534. Detective Acting Sergeant Sadler (DAS Sadler) and Detective Senior Constable Cole (DSC Cole) were directed by Inspector Walsh to approach the family, initially to assess what had brought the family there and why they thought that something had transpired with their son at this location. It was the evidence of Inspector Walsh that at the time she gave that direction to DAS Sadler and DSC Cole, there had been no positive identification of Tyler and thus she would not have given directions for the detectives to inform the family of Tyler's death.[371]

535. DAS Sadler and DSC Cole arrived at the scene at 22.08.[372] DSC Cole gave evidence that A/S Goldrick had informed both of them of Tyler's identity.[373] DAS Sadler gave evidence that in her view the identification was only tentative. However, by 10.30pm both members were apparently sufficiently satisfied with the identification of Tyler that DAS Sadler and DSC Cole approached Mrs Cassidy who was standing with Mr Taylor and Blake.

536. Both members asked Mrs Cassidy to accompany them to a police vehicle away from where Mr Taylor and Blake were standing. Once Mrs Cassidy was seated alone in the police vehicle with DAS Sadler and DSC Cole, Mrs Cassidy was told that Tyler had passed away.

537. Mrs Cassidy remained extremely unhappy with the way in which the death notification was delivered in that she was separated from her partner and son in the manner described above.

538. Both members were questioned about this at Inquest. DSC Cole gave evidence that the rationale for separating Mrs Cassidy from her family for the purpose of delivering the death message was because Mrs Cassidy was Tyler's "*natural*" mother and Mr Taylor

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[371] Transcript 2396.
[372] Transcript 1944.
[373] Transcript 1973.

was her fiancé but not Tyler's father. DSC Cole added in his evidence that a further reason was that Blake had become quite agitated and he "*just wanted to let Mrs Cassidy know on her own*".[374]

539. DAS Sadler gave evidence that they separated Mrs Cassidy from her family for reasons of privacy, respect and based on the assumption that Mrs Cassidy would want to have this conversation in the absence of Blake and Mr Taylor.[375]

540. In hindsight, DSC Cole acknowledged in evidence that there may have been some value in allowing Mrs Cassidy to have the support of her fiancé and son at the time they delivered the traumatic news to her. However, he believed that he and DAS Sadler had made the right decision to inform her on her own. DSC Cole gave evidence that he had not had any specific training from Victoria Police in relation to delivering death notifications, but stated that it was something that one learned from experience.

541. After DSC Cole had completed his evidence, the current training given to recruits on the subject of "*death notification*" was provided by a statement from Acting Senior Sergeant Paul Henry (ASS Henry) of the Centre for Law and Policy, People (Education) Department within Victoria Police. With his statement, he produced a copy of the current syllabus notes. His evidence was that this module was originally inserted into the training in 1998, the latest revision occurring 19 April 2010. However, ASS Henry added that he believed training in death notification dated back to at least 1987.

542. The notes for the current syllabus give sensible guidance to members engaged in this difficult task, including a strongly worded piece of advice as follows[376] "*...you must carry out the task in a professional, dignified, and sympathetic manner, remembering that the* ***receiver*** *for the remainder of his or her life will recall this occasion*". Further, under the heading General points at paragraph 3.3 of the syllabus notes, the following can be found:

> *Death notification should be delivered with dignity and understanding, and with others present, if possible.*

Conclusion:

543. The evidence is that the delivery of the death notification to Mrs Cassidy lacked sympathy and understanding and fell short of the current police training and advice to members. The two members involved seemed unable to reflect on the possible shortcomings of their actions on the evening.

[374] Transcript 1949.
[375] Transcript 2338.

[376] Page 1, paragraph 2.

Making a statement that night back at Preston police station

544. On the night of Tyler's death, Mrs Cassidy, Mr Taylor and Blake were requested by police to attend at the Preston police station for the purpose of making statements that night. They complied with this request and did attend and make statements.

545. Counsel for the family submitted that the family felt deeply aggrieved by having to attend in such circumstances and without any support, legal or welfare, and that the family should have been offered independent support before, during and for the purpose of taking those statements and should not have been taken back to the Preston police station where two members involved in the shooting were stationed.

546. The explanation given for why the family was requested to attend Preston is that it was the nearest police station to Northcote and given Northcote was being heavily used that night, it seemed appropriate.

547. As to the timing, the explanation was given that it is the experience of investigators that the best evidence is always obtained closest to the time of the events in question.

548. The response lacked understanding and a willingness to be flexible about the family's needs at that time.

549. In my view, this situation was handled inadequately by Victoria Police.

Media interaction

550. On this issue, there were three aspects of police/media interaction which were of significance. The first two were issues raised by the family about the timing of contact with the media and the release of information about Tyler, including his name. The third issue was about public communication by the police generally in the wake of a "*police contact*" fatality which the police will then investigate on behalf of the Coroner.

551. Assistant Commissioner Cartwright (A/C Cartwright) was responsible for Region 3 on this evening. Northcote is part of that region. He was the most senior officer to attend in response to the shooting. He had been in this position for one month at the time. After he was notified of Tyler's death on this night, he travelled to the scene and got a briefing. He then provided a briefing to the assembled media at 11.45pm. A/C Cartwright stated that at that time the identity of Tyler had not been confirmed. He confirmed that he authorised a media release at around 1.00am on the morning of 12 December 2008.[377]

552. He met with Mrs Cassidy at around 2.00am on 12 December at Preston police station. He travelled to Preston police station to speak with the family. It was a matter of considerable distress and unhappiness to the family that Assistant Commissioner Cartwright briefed the media prior to speaking with the family.[378] It was submitted on

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[377] Exhibit 72.

[378] Transcript 2440.

behalf of the family that the making of public statements and participating in media interviews prior to meeting with and speaking to the family was simply wrong and unthinking. A/C Cartwright stated that he had no particular reason not to speak to the family before the media briefing.[379]

553. The family also expressed distress that the police made representations to them that they would not release Tyler's name without consultation with the family, but by early the next day Tyler's name was in the public domain; and further, there was a great deal of information about Tyler that was thereafter in the public domain. The family asserted that the police gave negative information about Tyler to the media. This was strongly denied by each police witness it was put to and there was no evidence to support the family's assertion that the police gave out information about Tyler.

554. A/C Cartwright stated that he only commenced referring to Tyler by name after his identity made its way into the public domain but denied that Victoria Police were responsible for releasing his name, in breach of their undertaking to the family.

555. There was no evidence as to how Tyler's name got into the public domain. On the issue of talking to the media before talking to the family, it was the submission of Counsel for the family that it was unthinking to do so.

556. I agree.

557. Of a more broad nature, the evidence raised the issue of police statements to the media generally in the wake of a police contact related death, which the police will be investigating on behalf of the Coroner. This issue is not a new one.

558. Difficulties surrounding perceptions of independence and the appropriateness of police making detailed public statements when investigating incidents on behalf of the Coroner is an issue that has been highlighted in this jurisdiction in the past. It has been the subject of previous comment and recommendation in the coronial jurisdiction and indeed most recently by the OPI in its 2009 report.

559. In December 2000, the former State Coroner Graeme Johnstone, in his Finding into the police shooting of John Stuart McConnell recommended that there be a protocol developed between police and the Coroner for fatal police shooting incidents. This recommendation was addressed through the development and implementation of "*Media protocols for incidents involving police and the Coroner*" in July 2003. The police manual was updated to include it at 208-2 (7.3) (copy attached). The protocol emphasises that the investigation is for the Coroner and that it is "*imperative that any comment released to the media must be made in consultation with the Coroner's Office*".

560. A/C Cartwright gave evidence that he had not been made aware by the police media unit of the protocol between the Coroner and Victoria Police.

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379 Transcript 2441.

561. A/C Cartwright gave evidence that he not only participated in the two media conferences referred to above, but also to a number of radio interviews the following morning and two filmed interviews during the day of 12 December 2008. At no stage during any of these contacts with the media was any consultation sought with the Coroner as per the existing protocol.

562. After the Inquest closed, I was provided with a copy of a document through the media officer of the Court headed "*Cover Sheet*" dated 26 October 2010 with the name Acting Senior Sergeant Carla Coslovich as the apparent author of the document. I was advised that the document arose as a result of exchanges between the Court's media officer and the police media unit in relation to the status of the 2003 protocol referred to above. The document states as follows:

> "*There was no formal decision to repeal or revoke the protocols however the media unit has moved away from the protocols which are not complied with at this time. Whilst the protocols were developed and implemented in good faith, the conditions within the instructions are restrictive and limit the release of information that at times is vital to the reputation of the Victoria Police and the members involved in the incident. The requirement to await the permission of the coroner to release information creates delays in the timely dissemination of information.*"

563. The document goes on to recommend that the current protocols are repealed and new protocols should be written by appointed members from the Victoria Police media unit and the Court's media officer.

564. Until this document was produced, no indication or communication had been provided to the Court's media officer or any Coroners Court staff advising that the protocol had been abandoned by the Victoria Police media unit. However, it may explain why A/C Cartwright was not given advice about the existence of the protocol by the Victoria Police media unit. I add that given this document only emerged after the close of the Inquest, Victoria Police has not had the opportunity to comment upon it or respond to it.

565. The evidence is that the media releases did not contain exculpatory statements, a practice that has been roundly criticised by both Coroners and the OPI in its 2011 report.

THE INVESTIGATION

Adequacy of investigation by police

566. Before turning to this aspect of the inquiry, it is necessary to reflect on submissions made, on the one hand, by Counsel on behalf of the Chief Commissioner and, on the other hand, by Counsel for the Human Rights Law Resource Centre (HRLRC) about the issue of both this police investigation and the general model of police investigating police in "police contact related" deaths.

567. Counsel for the Chief Commissioner appeared to be submitting that a Coroner could not engage in an examination of the nature, competency and conduct of the police investigators who attended the scene; directed the collection of evidence and examination of witnesses; and the compilation and delivery of the Brief, unless it could be shown that their actions compromised the quality of the evidence or their actions were demonstrably lacking in impartiality or were, in fact, corrupt.

568. Alternatively, it was the position of the HRLRC that this Court should engage in a fulsome examination of the current model of police investigating police to come to a view about whether or not the current model is in breach of the Victorian Charter of Human Rights, which it submitted, in fact, was the case.

569. It was also put in a broad ranging submission by Counsel for the Chief Commissioner that this Court could not examine the structure of the way in which "*police contact related*" deaths were investigated as it was beyond the power of the Coroner; it was a duplication of the work of other agencies whose responsibility it was to do it, it would take up too much time and it would not reduce deaths.[380]

Model of investigating police contact related deaths

570. I shall deal first and very briefly, at this juncture, with the issue which was raised in this Inquest of the examination of the current way in which "*police contact related*" deaths are and should be dealt with in the coronial jurisdiction.

571. I do not propose to go to the legal arguments raised by any of the Interested Parties on this issue as I do not consider it necessary for the following reason. In November 2009, the Director of the OPI announced his intention to conduct an inquiry into the model of how police contact related deaths are investigated, which would include investigating both nationally and internationally what existed and what was considered best practice in the context of the coronial jurisdiction and more generally.

572. It was indicated in the early stages of this Inquest that there would not be a stand alone examination of the current model or models of how police related fatalities are investigated in this state. I confirmed that I would look at the aspects of the facts in this particular investigation that raised issues about how the police behaved or investigated this death that touched upon competency, adequacy or impartiality in how evidence was collected, obtained or compromised as it was produced.

573. The OPI made clear its intention to construct a consultation which would include representatives of each of the relevant interested parties in this inquiry. This invitation included representatives of this Court. It was also clear that the results of the inquiry would be published and indeed now have been.[381]

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[380] Final written submissions of the CCP.

[381] Review of the investigative process following a death associated with police contact, Office of Police Integrity, tabled in Parliament, June 2011.

574. In coming to the decision not to further the issue of the model of "*police investigating police*" in "*police contact related*" deaths, I relied upon section 7 of the *Coroners Act 2008* containing the responsibility of the Court to liaise with other investigative authorities where appropriate. I also relied upon the need to take into account the resources of this Court. Putting to one side any jurisdictional argument, given the expertise and terms of reference of the OPI, it would be a duplication of a contemporaneous inquiry being conducted by another investigative agency on the exact issue. Not only would this be a duplication of the State's resources, it would be likely to significantly lengthen already protracted proceedings contrary to the intention of section 8 of the *Coroners Act 2008*.

575. Having said that, I do not resile at all from the need for a Coroner to be ever vigilant about the investigative work that is provided to the Court by the collection of agencies that provide investigative support to the Coroner. These include entities such as WorkSafe, Office of Correctional Services Review, Civil Aviation Safety Authority, the Australian Safety and Transport Bureau, the Department of Defence Investigative Service and Victoria Police. None of these bodies are immune from the Coroner's scrutiny if the actions taken by the investigators are considered inappropriate. The Court remains independent of all of these agencies and importantly so.

576. That independence (embedded in the Act by the Preamble) and the necessary vigilance come from an understanding of our own recent history and the findings and recommendations from one of the most important Royal Commissions for Coroners in Australia. That is, the Royal Commission into Aboriginal Deaths in Custody (RCIADIC), two decades ago.

577. The RCIADIC found that the form, style and competency of the police investigation often indicated the capacity of the coronial jurisdiction to do its work. Many of RCIADIC's recommendations have been at the heart of coronial reform across the nation over the past two decades. The RCIADIC has been described at its "*highpoint*" in highlighting the impact of the shortcomings of police investigations on the capacity of the coronial jurisdiction to do its work.[382]

578. The RCIADIC concluded that competent and rigorous investigations for Coroners assist the Coroner to make rigorous findings about what did or did not happen and may, where appropriate, enable issues to be identified which may assist in the development of recommendations which are aimed at preventing future deaths in similar circumstances.

579. Right from the outset of this investigation, issues were raised by the family as to the conduct of the members of the Homicide Squad who were investigating this death, alleging an inadequate and less than partial investigation had and was being conducted.

[382] The Hon. Hal Wooten QC, Presentation at the Asia Pacific Coroners Conference, Noosa, November 2011.

580. This was reflected in final written submissions on behalf of the family.[383] The allegation that the investigation lacked impartiality and independence was raised by some of the other Interested Parties.

581. I shall return to the issue in the comments section following. I turn now to the issues raised as to the adequacy and competency of the investigation in this case.

CRIME SCENE EXAMINATION

Recovery of bullets

582. Ten shots were fired that night by three police firearms. No bullets were recovered. It was the strong view of the family, that this was either a conspiracy on the part of the police to ensure that it was not possible to discover which bullet was fired from which gun and thus endeavour to discover who fired the fatal shot, or complete incompetence on the part of the crime scene examiners.

583. On this issue, evidence came from LSC Vincent who was at the time attached to the Ballistics Unit at the Forensic Science Centre.[384] He gave evidence in relation to the scene search conducted for the bullets and also as to the assistance they may have been able to give the Court had the bullets been recovered.

584. He stated:

> *...we might have been able to work out what gun it was fired from, for starters, and if we were able to work that out, we may be able to work out which direction the shot is fired from and we may, with a little bit of luck and without any help from anybody else, we may be able to position the shooter, at the time.*[385]

585. LSC Vincent identified one of the difficulties facing them, in their search for the bullets, was that much of the grassed area of All Nations Park was reclaimed tip and thus searching for metal fragments was very difficult.

586. During the course of the evidence, it emerged that the "*searchers*" may not have been as well-briefed as they should have been about the areas to be searched. LSC Vincent left the impression that he was not as clear as he would have liked to be about the details of who was standing where when shots were fired and, thus, the possible trajectory of bullets for the purposes of searching were not as clear as they should have been.

587. LSC Vincent also gave evidence about the change in the type of bullet issued to police that occurred in the mid 90s and resulted in it being more likely that the bullet fired would not lodge in the subject.

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[383] See paragraph 58 of final written submissions of family.
[384] Exhibit 91, transcript 3133.
[385] Transcript 3140.

588. Given that 10 bullets were fired from three separate firearms, from members standing reasonably close to each other, even though in open surroundings, the evidence as to the lack of recovery of bullets from the scene was left in an unsatisfactory state, perhaps at least in part explained by less than adequate briefings given to the crime scene examiners, compounded by there being no contemporaneous reconstruction, the bullets being discharged in the open and in an area that is full of metal fragments as a result of being a reclaimed tip.

No reconstruction

589. No reconstruction of the incident took place throughout the police investigation into Tyler's shooting. This was the subject of concerted criticism from the family directed at Victoria Police. It was submitted on behalf of the family that the failure to do so resulted in the loss of vital information that would have assisted the inquiry, including better information provided to the ballistics team who were searching for the bullet.

590. DS Birch, when asked questions about the value of a reconstruction, rejected the idea stating he was not in favour of a re-enactment or reconstruction.

591. It was his view that there were major failings with both reconstructions and re-enactments and they often caused more issues than they resolved. DS Birch stated that, in his view, a reconstruction can taint the memory of a witness because they then "*try and reconcile their memory with the circumstances, adjust accordingly and they make mistakes doing that*". DS Birch made it clear that this is why he had concerns about the reliability of a reconstruction. He went on to explain that he also had difficulty with the concept of a reconstruction as multiple eyewitnesses will ordinarily have multiple and varying recollections of places and distances and this creates a difficulty for a reconstruction in that it is not proper for an investigator to choose one account over another for the purpose of the reconstruction.[386]

592. However, acknowledging the investigative experience of DS Birch, C. De Propertis stated in her evidence that on returning to the scene in 2010, it assisted her memory of events[387] and, in fact, caused her to make a second statement altering some of her estimates of distance as a result of that visit.

593. I accept the investigative experience of DS Birch and his coherent reasoning for why he did not engage in a reconstruction. Perhaps what is learned is the value to a witness, once having completed their statement of returning to a scene to satisfy him or herself of their recollection and the accuracy of the contents of their statements.

Conclusion

594. Given the complexity and rapidity of this situation, a reconstruction as soon as possible after the events would have been very helpful, not only to me but on the evidence, at least to some of the members involved. The evidence is that the

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[386] Transcript 4236.
[387] Transcript 4049.

discrepancies in the estimates of distances given by the four members were caused in part by not having the opportunity to walk back through their steps as soon as possible after the events.

595. I note that the OPI Review[388] 2011 concluded that as soon as practicable a scene "*walk through*" or reconstruction should occur and should be audio-visually recorded.

EXAMINATION OF TYLER'S COMPUTER AND MOBILE PHONE

596. Tyler's computer was collected hours after his death to enable an examination of it to obtain any information which may assist in shedding light on the circumstances in which his death occurred, including who he was contacting immediately before he left the house that night and what information was available as to the content of any of those communications. The family raised the issue of the MSN chat history from Tyler's computer not being recovered from the computer and why that had not been achieved, submitting that it was a lack of competency on the part of the investigators to fail to recover the contents of the MSN chat history. It was also submitted on behalf of the family that there was a failure to endeavour to retrieve outgoing text messages from Tyler's mobile phone.

597. The evidence is that Tyler had an exchange with Daniel Chowne by way of the instant messaging facility on MSN available on his computer immediately before he left his home and headed to Northcote Plaza that night. Daniel Chowne was unable to remember the contents of that chat room conversation he had with Tyler. The only other possibility of obtaining evidence as to the conversation was to obtain a record of it from the MSN chat history.

598. The evidence of DS Birch stated that the computer was not examined until some days after it was collected from the Cassidy home and this resulted in the chat history being lost. DS Birch gave evidence that he was unaware that the "*chat history*" could be lost if not recovered in the first couple of days.[389]

599. Detective Senior Constable Barry gave evidence that unless the user of the computer had the MSN program set to "*record*" the chat session, none of the communications would be captured. The evidence was that Tyler's computer had not been set to record the chat session and thus it was not able to be extracted from the computer.[390]

Conclusion

600. An examination of the MSN chat history may have produced some further communications from Tyler to others. Daniel Chowne gave evidence that whilst he could not remember the exact detail of the exchange he had with Tyler, he could not recall anything out of the ordinary about the communication. DS Birch gave evidence that he

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[388] Page 63, OPI Review 2011.
[389] Transcript 4273.
[390] See Exhibit 82.

now understands that unless the system is set up to record the exchanges, they will be lost unless retrieved within a day or two. Whilst it is always preferable to have as much information as is possible to obtain in circumstances as complex as these, there is no evidentiary basis to conclude other than this was a lack of understanding on the part of DS Birch that time was of the essence when it came to the possibility of recovery of any detail.

601. The outgoing text messages on Tyler's mobile phone could not be retrieved from the phone. The evidence stated that this was because it was not supported by the software used by ECrime Unit of Victoria Police.[391]

TAKING OF STATEMENTS FROM MEMBERS INVOLVED IN THE INCIDENT

602. The issue of how statements are taken from police members involved in shooting or a critical incident has been the subject of much discussion over the years in this jurisdiction, and various other places including the OPI Review referred to previously. In this particular investigation, the method of statement taking came under a considerable amount of scrutiny and was the subject of a number of submissions for recommended change.

603. The current method engaged by the Homicide Squad for members involved in a fatal shooting, is to request of the member that he or she participate in an audio and video recorded interview in the wake of the fatality. If the member declines to do so, a written statement will be taken.

604. The evidence in this case is that each of the four members was requested to participate in an audio and video recorded interview. All four members declined to participate in this way.[392] All four members made written statements via a process whereby they were interviewed by a Homicide Squad detective with a member of ESD sitting in on that interview. It was submitted on their behalf that after receiving advice from the Police Association, each member elected to make a written statement rather than participate in a recorded interview. All four members, when giving evidence, expressed the view that they felt this was the best way in which they could give an efficient and ordered account of events.[393]

[391] Exhibit 120, statement of K Barnett (3rd statement); see also evidence of DSC Barry transcript 2896.
[392] LSC Dods gave evidence that he considered that a written statement would provide a clearer picture as he had the time to put everything on paper and review, edit and add to the circumstances and thus it would be more fulsome (Transcript 3716). C. De Propertis was of the same view although she accepted that there could be benefits in having the statements recorded (T4104). S/C Blundell expressed the view that only suspects were audio recorded and he had not considered himself a suspect (T3901). C. Ferrante also expressed the view that only suspects were audio recorded. She added that she thought having the written statement was easier to follow (T4103). C. Ferrante did add, however, that she accepted the video would show how she was feeling and that was worth considering.
[393] Written submissions for the four police members 81.

605. A range of views were expressed during the course of the inquest as to the appropriateness and format of the taking of statements from members involved in a fatal incident. It was submitted on behalf of Tyler's family that the best evidence would have been for the police officers directly involved to provide video and audio recorded statements.

606. Mr Feltus, an investigator from the OPI, gave evidence that the police ought not to be treated differently than members of the public. It was his view that the statements should have been video and audio recorded.[394]

607. DS Birch gave evidence that in his opinion the benefits of a video recorded statement are that it will be quicker (which is a relevant matter when considering the welfare of the member being interviewed), it will be more accurate and that the process is far more transparent.[395] DS Birch acknowledged that there was a stigma attached to video recording statements of police members involved in critical incidents, because it implied that the member was a suspect as this was the method police used to interview suspects.

Conclusion

608. There was no evidence that anything improper occurred during the process of the Homicide Squad taking statements from the four members.

609. However, whilst police remain the investigators in police related fatalities, the concern about the perception of a lack of transparency[396] as to the nature of the investigation will not abate.

FAILURE TO CALL FOR WITNESSES AND EVIDENCE

610. The evidence was that there was not a general call for witnesses in the wake of Tyler's death. It was submitted by Counsel on behalf of the family that this was a failure in the investigation.

611. There clearly was at least one extra eyewitness account which had not been obtained and that was from Mr Chen in the milk bar opposite Alphington station. It would be a long bow to draw to assume that Mr Chen would have responded to a call for witnesses. However, he did respond to the door knock and gave evidence, which was helpful in filling in some of the gaps in Tyler's journey home.

[394] Transcript 2693.
[395] Transcript 4171–4231.
[396] See the OPI Review 2011 wherein the issue of the perception of the lack of transparency was addressed.

Conclusion

612. I do not conclude that this investigation was compromised by a failure to make a general call for witnesses. Tyler's death happened in a public place and a number of people gave accounts of what they saw and heard. Further, the evidence is that there was a considerable amount of public attention given to Tyler's death at the time in a range of media outlets. There was evidence that witnesses did make contact with the investigating police to give accounts.

COVERT RECORDINGS MADE BY THE INVESTIGATORS OF THEIR ATTENDANCES ON THE FAMILY

613. After the final Directions Hearing fixing the scope of the Inquest had been completed, and the hearing days had been confirmed, in the course of confirming that all relevant material held by Victoria Police had been provided, the lead investigating member from the Homicide Squad, DS Birch advised the solicitors appointed to Counsel Assisting, of recordings he held of various attendances upon the family at their home in the weeks following Tyler's death. He confirmed that these recordings had been made without the knowledge of the family and this had happened on more than one occasion. He was directed to produce the recordings to the Coroner with a statement explaining how and why this covert recording of the family had happened and why he had not produced the recordings to date.

614. He did produce a statement.[397]

615. Not surprisingly, the family expressed considerable shock and distress upon learning that these attendances of police in the family home had been covertly recorded.

616. DS Birch's statement set out that when he attended upon the family on 13 December 2008, in company with DSC Barry, he had decided to record the meeting to have a confirmation of the information given to the family.

617. On 16 December 2008, Detective Senior Constable Chapman (DSC Chapman) and DS Birch attended again upon the Cassidy household and again covertly recorded the exchanges between the family and themselves. On 2 January 2009, Detective Acting Sergeant L'Estrange (DAS L'Estrange) attended with his supervisor Detective Senior Sergeant Legge (DSS Legge), at the direction of DS Birch and covertly recorded that exchange. On 20 January 2009, DAS L'Estrange and DSC Chapman attended the Cassidy household and again covertly recorded the exchange.

618. It was maintained in evidence by each of the Homicide Squad investigators that engaged in this recording that the purpose of the visit was to *give* information to the family and not *obtain* information.

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[397] Exhibit 114 (statement dated 28 August 2010).

619. DSC Barry gave evidence that the reason for the taping was there had been *"some discrepancy or conjecture about what information was told... And what exactly was said"* and that the purpose of the recording was so that *"there was an accurate account of... what the content of the conversations were"*.[398]

620. DS Birch made clear that he was given no direction by any person to engage in such an action and that he had not provided copies of the recordings to any person except a copy of the recordings to Inspector Lanyon from ESD on 7 April 2009. The purpose of doing so was because ESD were investigating a complaint by Mrs Cassidy about police conduct connected to Tyler's death. A copy of the recording on CD was provided to Inspector Lanyon for that purpose.[399]

621. DS Birch gave evidence that he was interviewed by Inspector Lanyon in relation to a complaint by the Cassidy family about a lack of information being provided to them about the investigation including non-provision of statements, CCTV footage and the like. It was in the course of being interviewed, that he advised Inspector Lanyon of the existence of that recording which he then provided on 7 April 2009.

622. When giving evidence on this issue, the Homicide Squad investigators endeavoured to draw a distinction between the investigation into the death of Tyler for the Coroner, as opposed to having contact with the family for the sole purpose of briefing them in relation to the investigation into the death, which, it was stated, fell outside the jurisdiction of the Coroner's investigation.

623. The distinction was lost on me.

624. Indeed the evidence of DS Birch demonstrated the circularity of the position that the Homicide Squad detectives endeavoured to sit behind. That is, DS Birch[400] in the course of answering a question from Counsel Assisting as to whether the covert recordings were part of his investigation, stated *" ... I would not have been at the Cassidy household if it weren't for the fact that I was investigating the matter... But it wasn't in the course of investigating the matter that I attended there. It was to provide information. I wasn't asking any questions, probing for information; I actually anticipated doing that later on with the Cassidy family, clarifying a few things"*.

625. DS Birch was adamant that he was not "*advancing the investigation*" when he attended the family home and recorded conversations. DS Birch indicated that he did not want to take notes because he felt that would cause the conversation to be "*stilted*". DS Birch, when asked whether or not in hindsight it may have been better to advise the family that he was recording the conversation to ensure an accurate account of what took place between them, indicated *"if I had placed a recorder on the table and said that I'm going to record what I say in this conversation, I think any hope of establishing a rapport*

[398] Transcript 2856–2857.
[399] Transcript 4195.
[400] Transcript 4205.

with the Cassidy family would be lost".[401] DS Birch went on to say *"it was never intended by me that the recordings would surface anywhere if there was not a need for my... what I said, to be scrutinised".*

626. All of the police involved in doing this gave evidence that they had not done so before in a coronial investigation although it was described as a well-accepted investigative tool to use covert recordings. It demonstrated the difficulty of the position the investigators strived to maintain about the covert taping as an investigative tool on the one hand, but then stated that they were not involved in investigating anything at that point but rather "*information giving*".

627. This issue of the covert recording assumed a significance beyond the distress to the family. Counsel Assisting drew attention to the apparent tension for Homicide Squad investigators in these circumstances. That is, even in the circumstances where the investigators conclude that the death will not be a criminal prosecution and, therefore, the investigation is for the Coroner only, the terrain for the investigators may nonetheless remain unclear. This tension is well-illustrated by the evidence of DS Birch on this issue as follows:

> *"...it will be an inquest brief but it's a ...still a Victoria Police force investigating the matter and to report to the coroner with an inquest brief. I didn't actually think I was solely working for your Honour, that wasn't my mindset... My mindset is that I do whatever I can to assist your Honour and I'm still accountable to the Victoria Police force".*

628. DS Birch went on to say that he saw himself as a Victoria Police officer at the Homicide Squad assisting the Coroner with the investigation.[402]

629. Indeed, what appeared to emerge from DS Birch's evidence is some distinction between the time before the Inquest Brief is submitted to the Coroner as opposed to after the Brief is submitted. That is, I understood DS Birch to be stating that this "*first stage*" of the investigation is the Homicide Squad investigator using his or her skills as a senior and trained investigator to put together the Brief, using his or her own discretion, and then once submitted, it was accepted that the Coroner could then direct further, different or additional parts to the investigation.

Conclusion

630. It became clear from the evidence that the reason for the taping of the family was a concern that the family may complain about what they were or were not told or how they were treated. This issue appears to have arisen very early into the investigation from a complaint made by the family about the information they were given from AC Cartwright on the initial night that he met with them.

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[401] Transcript 4193–4194.

[402] Transcript 4183–4184.

631. The covert recording of the family in this way, and at this time, was not consistent with the perception of an impartial investigation. The attempts to explain it did not hold up to scrutiny as any proper part of an investigation on behalf of the Coroner.

632. Counsel Assisting submitted that there is no evidence that the fact of the covert recordings interfered with the investigation. However, Counsel Assisting submitted that there is a *"real possibility that the perception, both in the community and certainly for the family, was that there was a lack of parity, by reason of the covert recordings, in the treatment of the family as compared with other witnesses to this investigation.*"

633. I accept that submission. I also accept that it was very distressing for the family to learn of this activity on the part of the investigating police.

COMMENTS

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

Youth mental health services

634. At various points, the Inquest touched upon the issue of the availability of youth mental health services and their nature and type. The circumstances surrounding Tyler's death did not raise the issue of the availability of youth specific mental health services in the immediate sense of Tyler not being able to access a service, or a suitable one. Indeed, Tyler was completely resistant to any sense that there was anything wrong with him. Mrs Cassidy wanted Tyler seen as a "*normal boy*" with normal teenage problems. Blake's evidence was that Tyler wanted that too.

635. However, the evidence is that part of Tyler's resistance to attendance upon any sort of mental health service was most likely the stigma attached to it. Professor McGorry's evidence was that this was not an uncommon feature of young people exhibiting signs of mental health problems. His evidence was that youth mental health services must be properly tailored to the needs of youth, including an understanding that for a number of young people, the traditional model of service delivery will fail to engage them. It was not a matter that was explored in this Inquest, but it is an important issue worthy of comment.

Previous reviews and commentary on police use of force

636. We demand a considerable amount of our police force and its individual members in an ever more complex community. We look to the police to enforce and uphold the law and act as the protectors of all of us in our community. The major focus of the police force is to police and enforce adherence to the laws which govern us and in that way to provide comfort, safety and protection to us. The police force endeavours to intervene in potential or actual criminal or unlawful acts to prevent, detect or prosecute the commission of those unlawful acts. We give police a range of operational equipment including firearms to perform this role for us, with strict rules about when and how these lethal weapons can be used.

637. The legislative guidance for the police use of force sits inside the *Crimes Act 1958* (Vic). In the Victoria Police Manual under the section headed "Operational Safety and Equipment" the first sub-heading is "Context". Under it reads the following:

> *"Police members are expected to protect themselves and the public while fulfilling their duties and, to do this effectively, they may need to use force. However, any force used by a member must be in line with section 462A, Crimes Act 1958, which states: "A person may use such force not disproportionate to the objective as he believes on reasonable grounds to be necessary to prevent the commission, continuance or completion of an indictable offence or to effect or assist in effecting the lawful arrest of a person committing or suspected of committing any offence."*

638. That is, the focus of the police force, when its members are required to use force to perform their role is framed in the context of dealing with criminal offending. Dealing with those who may be acting in breach of the law, such as Tyler, but driven by mental anguish, illness, instability or disorder is a complex challenge for a modern police force.

639. The evidence during the inquest was that Victoria Police better understand this and is endeavouring to respond to the need to train members to identify and respond to this group who may be acting in breach of the law but are not driven by criminal intent.

640. As stated above, previous inquiries and reviews have identified the need for Victoria Police to address the issues of dealing with people with a range of vulnerabilities.

641. The evidence that emerged in this Inquest, as to the wane in emphasis on tactical communication skills, conflict resolution skills, planning, cordon and containing has been responded to by Victoria Police with a considerable amount of effort and activity aimed at improving training and skills development in these areas. However, a system which ensures vigilance such that no such "*waning*" occurs again must be put in place. **(Recommendation)**

642. The evidence also highlighted that even with the current renewed focus inside Victoria Police on developing and instilling tactical skills to deal with vulnerable people, it does not have a youth specific component to the training. Given the evidence of Professor McGorry about the need to adopt a different tactical approach and style with a vulnerable young person, this situation cannot continue. (**Recommendation**)

Command and control

643. This issue has been a recurrent feature of previous reviews. In this case, the senior supervising officer on the night, S/S Joshua, did not provide any assistance, supervision or command and control in a timely way. S/S Joshua's evidence was that he was caught up with administrative duties on the night and missed the heart of the exchange.

644. A considerable amount of thought and work apparently goes into developing chains of command and supervisory structures inside Victoria Police. It would be hoped that a proper internal reflection for Victoria Police would be to consider whether or not senior officers should have been expected to take a more commanding and immediate role and if so, how is that going to be best achieved inside the current model of responding to critical incidents.

Evaluation of the effectiveness of OSTT for individual members

645. Professor McGorry stated that such is the importance of the need for police members to be properly equipped with the skills required to deal with vulnerable people, it cannot be assumed that the Operational Safety and Tactics Training (OSTT) has been absorbed and that members should be tested. Superintendent Williams agreed with Professor McGorry on this issue. In fact, Superintendent Williams noted that there used to be exams after OSTT but they were dropped about four years ago.[403] Superintendent Williams agreed that it would be very appropriate to have some form of examination at the end of the training.[404] **(Recommendation)**

Delays in notification

646. The public confidence necessary to be maintained in an investigation of this nature is enhanced by a perception of competency and transparency of the investigation. Delays in the calling out of specialist forensics services do nothing to enhance either the perception of competency or transparency.

647. 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 a fatal police shooting or a death involving police contact.[405]

648. This is a positive development. However, it is also worth noting that a "*safety net*" system should be maintained. That is, because it is preferable for the Major Crime Desk to get two or even three calls requiring Homicide to be notified, rather than no calls.

649. On this night, the evidence is that the communications between the scene and the Police Communication Liaison Officer did not lead to that officer knowing that the person shot by police had died, and thus it contributed to the delay in the call to Homicide. The detectives at the scene did not make an immediate notification to the Major Crime Desk. Hence, the "*safety net*" approach is recommended, which imposes obligations upon more rather than less members.

Attendance of forensic services in a timely way

650. DS Birch, despite being a Homicide Squad investigator of considerable experience, was not clear about how to call out all the services required at the scene in a timely way. His evidence was that the Homicide Squad has now developed a "*checklist*" to assist

[403] Transcript 3380.
[404] Transcript 3381.
[405] Transcript 4208.

members in identifying which services are to be contacted in relation to particular incidents and by whom.[406] This is a very sensible initiative.

651. DS Birch readily conceded, in evidence, that the delay in the drug and alcohol testing of the members involved in this incident meant that not only did the members involved in the shooting miss the opportunity to confirm their evidence as to their drug and alcohol status,[407] but the community at large missed the right to have the testing done in a far more timely fashion than was achieved on this evening.[408]

652. The only further comment necessary, however, is that the "*checklist*" must be kept constantly up to date and accurate. Such a checklist for an organisation of the size and complexity of Victoria Police will only be of genuine value if it is regularly monitored and updated. **(Recommendation)**

Public call for witnesses

653. Whilst I did not conclude in this investigation that it was compromised by a failure to make a general call for eyewitnesses, as a matter of principle, in a situation such as this, members of the public with information should be requested to provide it to a designated member or contact number. It is done regularly for police investigations generally and to do any less for an investigation of this nature appears unbalanced. This is a matter that can be addressed in the Coroner's Guidelines discussed below.

Family welfare issues

654. There were a number of instances of poor or insensitive practices noted in the body of the Finding resulting in additional distress, shock and confusion for the family, both on the night and in the wake of Tyler's death. An example of this was requiring the family to attend the Preston police station in the hours after Tyler's death. It is accepted that the best account is usually obtained closest to the timing of the events, but it is also true that some compassion and sense must prevail to the circumstances in which the family were in on this night.

655. In this day and age, in circumstances such as these, given that the family lived close by, it does not seem unreasonable that they should at least have been offered the option of being in their own home and that interviewing members could have attended with laptops to obtain statements. It is understandable why the family have expressed such unhappiness about being directed to the police station that in their eyes owed allegiance to two of the police involved in the death of Tyler.

656. It is understandable that the family felt overwhelmed and had no knowledge of what they could expect or indeed how to navigate their way through the array of decisions they had to make. They lacked a sense of someone they felt was focused on giving them assistance on the night and in the days afterwards. **(Recommendation)**

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[406] Transcript 4156.

[407] LSC Dods gave evidence that he was "disappointed" there was no scientific evidence to attest to the physical state he was in (Transcript 4273).

[408] Transcript 4154–4155.

Delivery of the death message

657. I was provided with a copy of the advice and guidance in the current syllabus notes. I endorse the contents of those notes. It is the unhappy task of members of Victoria Police that from time to time they may be required to deliver the terrible news of the loss of a family member. Every assistance must be given to members to ensure that they are equipped with not just the words but also an understanding of how to manage that task.

Model of police investigating police for the Coroner

658. As stated above in November 2009, the OPI commissioned a review under the *Police Integrity Act 2008* that examined the Victoria Police policies and processes for investigating deaths associated with police contact. The review also examined the relevant legislative framework for conducting investigations into deaths associated with police contact.

659. The OPI review noted that the context for commencing the work was concern raised, in the wake of the shooting of Tyler Cassidy, about the role and involvement of Victoria Police in coronial investigations when the death is associated with police contact, whilst also making clear that the review was not conducting an examination of the role of the investigating police in this particular death.[409]

660. The OPI review resulted in a report published as "*Review of the Investigative Process following a death associated with police contact*", June 2011(the OPI review).

661. The OPI review consulted at a state and national level as well as internationally. The review team hosted a range of forums and workshops, called for and received submissions and conducted its own research.

662. The review summarised the issues that were raised about the concerns with the current model as:

a. That the police have a conflict of interest (real or perceived)[410] when investigating their own and to maintain public confidence, where the death is associated with the special powers granted to the police (i.e. the power to carry and use firearms), an enhanced investigation with the "highest levels of rigour, scrutiny and accountability"[411] must be conducted.
b. That the current model is not compliant with the *right to life* obligations contained in the *Victorian Charter of Human Rights and Responsibilities Act 2006.*

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[409] The OPI review 2011, page 11.

[410] This conflict can be summarised as one in which the necessary rigour needed to search for the truth may conflict with the interests of the investigating members in protecting the reputation of Victoria Police or the individual members or be contaminated by the investigating member's sympathy for or sense of loyalty to another police member or members.

[411] Ibid, page 11.

663. The OPI review set out the range of views expressed about these issues. It noted that some believed the current system, with further improvements would best provide the expertise and timeliness needed, taking into account the imposition on the public purse of setting up a new stand alone system, to the other end of the spectrum who believed that human rights principles would be paramount and, therefore, demand a "*hierarchically and institutionally*"[412] independent investigation which necessitates it being done independently of Victoria Police.

664. The OPI review made a series of recommended improvements to the current process,[413] noting that it was ultimately a matter for Government to consider the competing views and determine what, if any, policy and/or legislative changes may be appropriate.

665. However, the OPI review concluded that, as a result of the process of review itself, Victoria Police had developed a more consistent procedure for the investigation of deaths associated with police contact.

666. The OPI review concluded that "*the current legislative framework for the investigation and oversight of deaths associated with police contact is not optimal*".[414]

667. Given this, the OPI review looked at a range of systems and models both nationally and internationally. It concluded that the current framework which supports the investigation of deaths associated with police contact is "*underdeveloped*"[415] and noted that monitoring the progress of the newly proposed (but not yet operational) Queensland model of coronial investigation of police related deaths may provide "*useful insight into any alternate framework*".[416]

668. The OPI review concluded that both the community and the police involved in the death need to have confidence in the competence and integrity of the investigation. Emphasis was put on confidence being enhanced by the investigative process being exposed to public scrutiny.[417]

669. The OPI review concluded that in the short and medium term the Homicide Squad and the Major Collision Investigation unit investigators were "*the best placed experts*" to continue to conduct the primary investigation for the assistance of the Coroner.[418]

670. The OPI review considered that a number of changes and improvements could be made to the current system and indeed noted that some had already been agreed to and put into practice, including the OPI itself resolving to adopt a more active oversight role of the police management of the investigation into the death. This incorporated

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[412] This is the language of the European and UK human rights Coroners' cases.
[413] OPI Review 2011, page 45.
[414] Ibid page 25.
[415] Ibid page 62.
[416] Ibid page 63.
[417] OPI Review page 41–42.
[418] Ibid page 47

monitoring the work of Victoria Police "*to ensure a consistent approach to integrity standards as they apply to investigations into police related deaths*".[419]

671. A list of changes to current processes and developments underway are set out at page 46 of the OPI review including such developments as raising a Conflict of Interest Declaration Form, the development of oversight checklists, the development of investigator guidelines and the introduction of "*table top*" exercises.

672. ESD have agreed to routinely provide a statement to the Coroner as to their oversight of the investigation and conclusions as to the integrity of the investigation.

673. The OPI review contains a number of valuable suggestions for enhancement to the rigour, competency, consistency and transparency to the system of police investigating police contact related deaths.

674. I note that in NSW, the Coroner and the police have a set of coronial "*Critical Incident Guidelines/Protocols*" which are used as soon as a death in police custody/contact occurs. These protocols set out the Coroner's requirements as to a range of aspects of the investigation, including notifications to the Coroner and requirements at the scene.

675. Taking into account what is contained in the OPI Review, and to enhance consistency and standards of these investigations and accountability, I intend, after consultation with Victoria Police and the OPI, to proceed to develop and publish a set of Coroner's guidelines for coronial investigations into police contact related deaths. Whilst I have singled out some aspects of the investigation for specific comment or recommendation, all issues relevant to the Coroner's investigation should ultimately become part of the Coroner's guidelines for police investigating "*police contact related*" deaths.

Taking of police statements

676. Counsel Assisting submitted that there was a sufficient basis on the evidence for the Court to make a recommendation that the taking of audio/video statements of police by police in incidents such as this should be the strongly preferred option.

677. The OPI review 2011 considered this issue and found that "*transparency and accountability are increased if investigators audio and visually record a 'free narrative' account given by the police involved*", concluding that it "*increases transparency by eliminating potential allegations of collusion or bias in the taking of the statement*".[420]

678. The OPI recommended that, in the absence of any suspicion as to possible criminal conduct and where practicable, investigators should "*audio and visually record a 'free narrative' account of what happened by police involved in any incident involving the*

[419] Ibid page 45.
[420] OPI Review page 50.

deaths associated with police contact as soon as possible after the incident has occurred".

679. This recommendation was accompanied with a recommendation that a review be conducted two years post implementation of this recommendation to assess whether or not accountability and transparency have, indeed, been increased and also, at that point, consider whether or not a legislative amendment may be needed to ensure the best possible account of the police version of events is obtained.

680. The evidence in this investigation was that each member was invited by the investigator to give an audio and video recorded '*free narrative*'. Each declined to do so. In evidence, each member stated that he or she wished to give the best, clearest and most comprehensive account of what happened as soon as possible after the event.

681. The police members gave evidence that they felt this would best be achieved if they had the time and space to properly consider all of the facts and details that should be provided. The evidence was that the members would feel constrained and hampered by being audio and video recorded whilst undergoing that process. I accepted that evidence.

682. It leaves the unsatisfactory position of the findings of the OPI review as to the public perception or suspicion that police may be colluding behind closed doors to "*look after their own*", set in the context of the evidence in this case, that the accounts the member would provide to the Coroner may well be less fulsome, coherent and helpful if audio and video recorded.

683. In my view, there is a course which should be adopted to meet both of these issues. That is, to allay suspicions, allegations, perceptions and concerns about collusion and bias without compromising the detail and coherence of the account given by the member being interviewed, an institutionally independent, legally trained person should be present to observe the entire interview process being conducted in "*police contact related*" deaths. That appointed person should be required to provide a statement for the Inquest Brief as to their observations and be available to give evidence and be examined in Court about their observations. **(Recommendation)**

684. The OPI Review grappled with the definition of a "*police contact related death*". In my view, that definition should include any death where there has been a police use of force, a police pursuit, in police custody or in the course of being taken into custody by police.

Control of the Coroner's investigation/timeliness of the delivery of the Brief

685. There was evidence which emerged in this investigation that raised the issue of a lack of clarity about the role of the police investigator vis a vis the Coroner.

686. Counsel for the family made submissions critical of the time it took the investigating police to deliver the Brief to the Court. In this context, Counsel for the family also submitted that the family should have been provided with statements of key

witnesses as they were collected. Counsel for the family submitted that a recommendation directed to the "*preliminary disclosure*" of key witness statements should be made. I understood this recommendation to be directed at the investigating police being instructed to provide such statements to the family.

687. There are a couple of separate issues contained in this submission. The first is timelines attached to the delivery of the Inquest Brief. As at the time of this investigation commencing, there was no process in place for setting the timing for the delivery of the Inquest Brief, or the Court taking control of the process at an early stage. This situation has now been addressed by Practice Direction 8 of 2011, which is contained in Appendix 2.

688. The operation of this Practice Direction allows the investigating Coroner, within 14 days of the report of the death, to set the timing for the delivery of the Inquest Brief, and make any other directions considered appropriate at that time. These directions will happen in Court and on the record. The family will be notified of this Hearing and able to attend.

689. The second aspect of the submission raised a separate matter about the provision of statements to the family or any interested party part way through the process of preparing the Inquest Brief for the Coroner. I assume the submission is based on an interpretation of s. 8 (d) of the *Coroners Act 2008* which requires family, where appropriate to be kept informed of the particulars and progress of the investigation.

690. It was not clear if the submission was directed to the police providing such statements to the family, but I assume that was the intent of the submission. If that is so, it would not be appropriate for the police, preparing a Brief for the Coroner to commence providing statements contained in the Brief to any person or interested party, family included, before that Brief has been delivered to the Coroner. The Coroner controls the coronial investigation. It is a matter for the Coroner to decide who the "*key*" witnesses are and this cannot be done until the Brief has been delivered (as per the new Practice Direction process).

691. S. 115 of the Act is also relevant in that it is clear that Parliament has addressed the requirement to provide a copy of the Inquest Brief to interested parties. The section sets up a process and provides a definition of the Inquest Brief. However, the section also makes clear that the provision of the Inquest Brief is not mandatory in that the Coroner retains power not to provide the Inquest Brief. Further, s. 115 (7) (c) and (d) make clear that the contents of the Inquest Brief in so far as it contains statements and reports are those the Coroner "*believes are relevant to the inquest*".

Police statements to media

692. The OPI review noted that whilst police maintain it is important to demonstrate public support for its members in the wake of a police related fatality, the police must understand that in providing this support, it can shake public confidence in the

impartiality of the investigation, if it commences with an exculpatory statement hours after the death, and before the investigation has properly commenced.[421]

693. The OPI Review noted that "*this not only pre-empts the outcome of the investigation, it invites perceptions of bias and stereotypes police as 'looking after their own' while undermining the integrity of the investigation and the coronial process*".

694. The OPI Review noted that "*public confidence in the process demands accountability and a thorough, objective search for the truth. It is understandable that police want to support each other, but premature statements pre-empt the investigation findings and diminish community confidence in the integrity of the process and with it any chance of legitimate exoneration. Ultimately the best support police can give each other is by ensuring public confidence in the integrity of the investigation and the validity of its findings*" (p.15).

695. After reviewing six recent deaths associated with police contact, the OPI concluded that police statements to the media in the wake of a police related death should be "*limited to the bare facts*" (p. 53) and went on to recommend amendments to current police/media protocols (p. 55) about what sorts of issues could be touched upon in such statements.

696. I endorse the findings and comments of the OPI report as to the extreme sensitivity that surrounds such a situation for the police and the community and, indeed, the Coroner. The protocol recommended by the former State Coroner and entered into in 2003 with the former State Coroner was not formally rescinded or revoked with any consultation with the Court. Given the contents of the OPI review and material which emerged in this investigation, the current protocol will be revisited during the consultation with Victoria Police to develop the Coroner's Guidelines discussed above.

[421] See page 15, OPI review 2011.

RECOMMENDATIONS

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

Youth specific component to Operational Safety and Tactics Training

1. To equip Victoria Police members to safely and effectively manage vulnerable youth that come to the attention of the police, I recommend that Victoria Police develop and incorporate a youth specific component to the Operational Safety and Tactics Training (OSTT) with particular focus on youth specific skills for risk assessment and tactical communications and conflict resolution.

Police use of force with vulnerable people

2. To assist Victoria Police members to safely manage people who may be in crisis or possibly intent on bringing about their own death at the hands of police, I recommend that Victoria Police urgently provide a component in OSTT to assist police to identify and respond to such people.

Maintenance of the system of Operational Safety and Tactics Training

3. To ensure that OSTT is able to be constantly receptive to the needs of operational members responding to critical incidents, I recommend that Victoria Police ensure the data collected from the critical incident review sheets be analysed and incorporated into OSTT where appropriate.

4. I recommend that Victoria Police develop a structure to ensure that adherence to the 10 Operational Safety Principles is vigilantly maintained in order to prevent over reliance on operational equipment.

Evaluation of the effectiveness of OSTT for individual members

5. To ensure that Victoria Police members are equipped with the skills required to safely manage vulnerable people, police members should demonstrate competency in operational safety and tactics. I recommend that Victoria Police reintroduce some form of assessment following the completion of OSTT.

Attendance of forensic services in a timely way

6. To ensure the timely attendance at the scene of a police contact related death to receive immediate and appropriate assistance from the necessary services (including forensic services), I recommend that Victoria Police ensure that the "*Homicide Squad Checklist*" be immediately accessible to all members and be annually reviewed and updated as required.

Family welfare issues

7. To ensure the immediate and ongoing welfare of the family of the deceased in a police contact related death and to guide the timing and need for the family to proceed to make an immediate statement, I recommend that Victoria Police arrange for a suitable welfare person to attend and assist the family at the scene and be available to them thereafter.

Taking of police statements

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

Signature:

Judge Jennifer Coate
State Coroner
23 November 2011

DISTRIBUTION

I direct that a copy of this Finding be distributed to the following parties for their action:

1. The Chief Commissioner of Police
2. The Secretary of the Department of Justice

I also direct that this Finding be distributed to the following parties for their information:

1. Mrs Shani Cassidy (Galbally & O'Bryan, Solicitors)
2. Leading Senior Constable Colin Dods (Russell Kennedy, Solicitors)
3. Senior Constable Richard Blundell (Russell Kennedy, Solicitors)
4. Constable Antonia Ferrante (Russell Kennedy, Solicitors)
5. Constable Nicole De Propertis (Russell Kennedy, Solicitors)
6. Austin Health (Minter Ellison, Solicitors)
7. Human Rights Law Resource Centre (Allens Arthur Robinson, Solicitors)
8. Victoria Legal Aid
9. Emergency Services Telecommunication Authority (Gadens Lawyers, Solicitors)
10. Professor Patrick McGorry
11. Detective Sergeant Birch
12. Superintendent Michael Williams
13. Director, Office of Police Integrity