IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court reference: COR 2017 0325
COR 2017 0327
COR 2017 0328
COR 2017 0329
COR 2017 0343
COR 2017 0465

INQUEST INTO THE DEATHS OF MATTHEW POH CHUAN SI, THALIA HAKIN, YOSUKE KANNO, JESS MUDIE, ZACHARY MATTHEW BRYANT AND BHAVITA PATEL

RULING NO. 2

BACKGROUND

1. The hearings in the inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel are scheduled to commence on Monday, 18 November 2019 and continue until Friday, 20 December 2019. It is anticipated that the evidence to be given in the course of the inquest will be of intense interest to the Victorian public.

2. On 28 March 2019, the Court distributed to the interested parties a draft scope of the issues to be canvassed during the course of the inquest (**draft scope**).

3. The draft scope identified the following broad issues to be explored at inquest:

    1. *Out of sessions bail hearing of* [the offender] *on 14 January 2017*

        (a) *The conduct of the bail/remand application on 14 January 2017, including what information the police provided to the Bail Justice.*

        (b) *Information, training, policies and procedures related to out-of-sessions bail/remand hearings.*

(c) *Any post-incident review/changes by or for Department of Justice and Community Safety [DOJCS], the Victorian Government or Victoria Police.*

(d) *Any prevention opportunities for DOJCS, the Victorian Government or Victoria Police.*

The inquest will not consider the correctness of the Bail Justice's decision.

2. *Victoria Police Response between 14 – 20 January 2017*

(a) *The conduct of the bail/remand application on 14 January 2017, including what information the police provided to the Bail Justice.*

(b) *The police response to the grant of bail, including monitoring of* [the offender's] *bail conditions.*

(c) *The co-ordination and effectiveness of the Victoria Police response to the circumstances leading up to the 20 January 2017 events:*

(i) *Police response to information concerning* [the offender's] *escalation of behaviour from 14 January 2017;*

(ii) *Police offender profile, risk assessment and management practices;*

(iii) *Police investigation and response to the stabbing of Angelo Gargasoulas by* [the offender] *including: command and control, planning, strategy and co-ordination of the police response;*

(iv) *Strategic and tactical options available to Victoria Police;*

(v) *Victoria Police communications in circumstances of significant operations and critical incidents;*

(vi) *Police pursuits;*

(vii) *Criteria for Location Based Services requests, CIRT, SSU and SOG involvement; and*

(viii) *Relevant Victoria Police Manuals, policies and procedures.*

3. *Identification of remedial changes that have been implemented by Victoria Police and other relevant remedial changes in response to the events from 14 to 20 January 2017.*

4. *Policing practices in respect of the use of vehicles as weapons.*

5. *Identification of further prevention opportunities.*

4. On 29 March 2019, the Court distributed a draft index of the coronial brief and a list of 46 witnesses proposed to be called to give oral evidence.

5. On that same day, the Court received correspondence from the Chief Commissioner of Police (**Chief Commissioner**) foreshadowing to the Court that he would make an application based in claims of public interest immunity or for a suppression order in respect to parts of the coronial brief, including (but not limited to) the contents of the Victoria Police Operation Titan Critical Incident Review prepared by Assistant Commissioner Stephen Fontana.

6. On 2 April 2019, a directions hearing was held to provide an update to the interested parties, consider the scope of the inquest, propose witnesses and provide a timeline to the parties for the conduct of the inquest.[1]

7. Counsel Assisting indicated that it was anticipated that the coronial brief would be prepared by 30 April 2019.[2] A timetable of orders was made to accommodate that indication, with a view to any such application being heard by me on 14 August 2019.[3]

8. Counsel Assisting noted that the offender had been found guilty by a Supreme Court jury of, among other things, the murders of the six people named in this inquest. It was noted that the sentencing remarks of the trial judge, his Honour Justice Weinberg, were to be included in the coronial brief. It was submitted by Counsel Assisting that in light of the criminal proceeding, some of the circumstances required to be determined by me pursuant to the *Coroners Act 2008* (Vic) (**Coroners Act**) would be broadly uncontroversial, particularly the events canvassed by the criminal proceedings including when the offender drove his vehicle up Swanston Street and thereafter along Bourke Street.[4]

9. I indicated to the interested parties that the focus of my investigation would be upon the six days leading up to the intersection of Swanston and Flinders Street and not thereafter.[5]

---

[1] Transcript of directions hearing dated 2 April 2019, page (**p**) 2.
[2] Transcript of directions hearing dated 2 April 2019, p 8.
[3] Order dated 2 April 2019, Inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel.
[4] Transcript of directions hearing dated 2 April 2019, pages (**pp**) 4-5.
[5] Transcript of directions hearing dated 2 April 2019, pp 16-17.

10. Senior Counsel for the families of the deceased indicated that they were unable to comment on the draft scope at that time as they had not yet had the benefit of reviewing the coronial brief, and in effect, reserved their position with respect to the scope of the inquest, the contents of the coronial brief and the proposed list of witnesses to be called to give evidence.[6]

11. On 10 May 2019, the first version of the coronial brief was provided to the Chief Commissioner.

12. On 14 May 2019, an amended version **(second version)** of the coronial brief was provided to the Chief Commissioner.

13. On 31 May 2019, the Chief Commissioner gave notice of an application for the making of a proceeding suppression order sought pursuant to section 18(2) of the *Open Courts Act 2013* (Vic) **(Open Courts Act)** over specified parts of the coronial brief and made application for pseudonym orders to protect the identities of members of the Special Operations Group **(SOG)** and the State Surveillance Unit **(SSU)**.

14. The Court prepared a third version of the coronial brief for distribution to the interested parties which was in substance the same as the second version of the coronial brief with:

    (a) the suppression order areas identified and highlighted;

    (b) replacement of the identities of SOG and SSU members throughout the brief with their respective operator numbers; and

    (c) redacted personal information of third parties.

15. On 7 June 2019, the Court provided the third version of the coronial brief to the interested parties.

16. On 13 June 2019, the Court provided additional materials to the coronial brief to the interested parties.

[6] Transcript of directions hearing dated 2 April 2019, p 17.

17. Pending the hearing and determination of the Chief Commissioner's application, I made interim suppression orders pursuant to section 20(1) of the Open Courts Act, specifically without determining the merits of the underlying application.

18. On 5 August 2019, the Court received correspondence from the legal representatives of the families of the deceased (**families' letter**) in which they requested to address the following issues with the Court at the Directions Hearing on 14 August 2019:

    (a) that the families considered it preferable that James Gargasoulas (**individual**) be referred to as 'the offender' during the inquest (**first limb**);

    (b) that the families were concerned that the inquest's scope did not propose to examine what occurred once the offender turned into Bourke Street. The families suggested that it would be appropriate for the Court to explore whether there were possibilities for intervention or apprehension of the offender in Bourke Street. Accordingly, the families proposed to insert a further line at paragraph 3(d) of the scope of the inquest as follows:

        > *The co-ordination and effectiveness of the Victoria Police response to the events on 20 January 2017 from the time the offender entered the Melbourne CBD until his arrest* (**second limb**); and

    (c) that a number of the families of the deceased had raised concerns about their experiences with Victoria Police and other emergency services in the aftermath of the Bourke Street event, including:

        (i) the identification of victims;

        (ii) the access of family members to victims at the scene;

        (iii) the provision of information to family members at the scene; and

        (iv) the subsequent provision of information to family members (**third limb**).

19. On 9 August 2019, a copy of the families' letter was provided to the interested parties.[7]

20. On 14 August 2019, a directions hearing was held to hear the Chief Commissioner's applications for proceeding suppression orders. Submissions were heard from the interested parties and a separate ruling deals with these issues.[8] Following the Chief Commissioner's application, Senior Counsel for the families of the deceased addressed me in relation to the issues identified in the families' letter.

THE FAMILIES' APPLICATION

First limb – References to 'the offender'

21. Senior Counsel for the families stated that any person representing the families before the inquest will refer to the individual as 'the offender'. It was explained that the preference of the families was that the inquest itself would follow the same protocol as a matter of formality but indicated the request did not extend to removing references to the name of the offender from the coronial brief.[9]

22. Senior Counsel for the families recognised that they could not commit other representatives at the Bar Table to follow suit, but requested that other parties at the Bar Table adopt a similar approach out of courtesy to the six families.[10]

23. No other party provided submissions in response to the first limb of the families' application.

Second limb – Opportunities for intervention on Bourke Street

24. Senior Counsel for the families submitted that it was insufficient to terminate the coronial investigation at the point where the offender was performing 'doughnuts' at the intersection of Swanston and Flinders Streets. It was submitted that there were legitimate investigations and enquiries regarding the possibilities for intervention and

---

[7] I note that former Victoria Police officer, Mr Frank Caridi, who in July 2019 was granted leave to appear as an interested party, has not been provided with this families' letter (or the coronial brief) as he is currently unrepresented.

[8] Ruling No 1, Inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel dated 23 August 2019.

[9] Transcript of directions hearing dated 14 August 2019, p 74.

[10] Transcript of directions hearing dated 14 August 2019, p 74.

apprehension of the offender that existed after the offender turned left into Bourke Street.[11]

25. Counsel Assisting informed me that the practical consequence of extending the scope as proposed had the capacity to add substantial material to the coronial brief, comprising the statements of some 758 witnesses (being some 3,252 pages) and a significant volume of video and other data. It was also noted that additional parties including emergency responders may seek leave to appear as interested parties which may have impacts upon the future conduct of the inquest.[12]

26. Senior Counsel for the families submitted in response that the prospect of considerable additional material, additional interested parties and/or additional hearing days are factors that do not constitute a legitimate reason upon which to determine not to investigate, nor do they impact upon the obligations of a coroner to properly conduct a coronial investigation.[13]

27. Senior Counsel for the families clarified that their application was not directed to the manner in which the offender drove his car or the manner in which he injured or killed the victims (which I note have already been determined as facts in the criminal proceedings), but rather to the possibilities for intervention and apprehension that existed after the offender's vehicle turned into Bourke Street and the possible "*opportunities that were lost*".[14]

28. It was clarified that the families were not seeking to include eyewitness accounts from every possible witness to the events following the intersection of Swanston and Flinders Street.[15] It was submitted that it is important to consider what the police were being commanded and directed to do and whether there were opportunities for police members to come from another direction in order to apprehend the offender prior to the events of Bourke Street.[16] To this end, it was noted that the coronial brief already contains material, including statements from police members in various divisions of the police force, that deals with the events that occurred after the intersection of

[11] Transcript of directions hearing dated 14 August 2019, pp 66-67.
[12] Transcript of directions hearing dated 14 August 2019, p 65.
[13] Transcript of directions hearing dated 14 August 2019, pp 65, 68.
[14] Transcript of directions hearing dated 14 August 2019, pp 66-68.
[15] Transcript of directions hearing dated 14 August 2019, p 67.
[16] Transcript of directions hearing dated 14 August 2019, pp 67-68.

Swanston and Flinders Street and prior to the offender's arrest at the intersection of Bourke Street and William Street.[17]

29. Senior Counsel for the families made formal application to expand the scope of the inquest to include a further sub-paragraph at 3(d) of the draft scope of the inquest:

> *The co-ordination and effectiveness of the Victorian Police response to the events on 20 January 2017 from the time the offender entered the Melbourne CBD until his arrest.*[18]

30. At this juncture, I note that in both the families' letter and oral submissions, it was requested that the proposed sub-paragraph be inserted at 3(d). However, having reviewed the draft scope provided to the interested parties on 28 March 2019, it appears that a more appropriate placement for the proposed sub-paragraph would be at 2(d).

31. The Chief Commissioner did not make any submissions in response to the families' request to broaden the scope in respect of the coordination and effectiveness of the police response. No other party provided submissions in response to the second limb of the families' application.

Third limb – Emergency Management Response

32. Senior counsel for the families referred to the third limb of their application as "*the response of trauma emergency services*".[19] It was explained that this response starts at the Bourke Street scene and involves emergency services such as Ambulance Victoria, Victoria Police and other emergency responders.[20]

33. Senior Counsel for the families indicated that they had received instructions to the effect that Jess Mudie was originally misidentified, and that it had taken some time for her to be properly identified. It was explained that this occurrence caused the Mudie family considerable and understandable distress.

34. Senior Counsel for the families submitted that the question of access of family members to victims at the scene ought to be construed as part of the circumstances in

---

[17] Transcript of directions hearing dated 14 August 2019, p 67.
[18] Transcript of directions hearing dated 14 August 2019, p 68.
[19] Transcript of directions hearing dated 14 August 2019, p 69.
[20] Transcript of directions hearing dated 14 August 2019, p 69.

which the deaths occurred. I was informed that Mr Tony Hakin, the father of Thalia Hakin, had instructed his legal representatives that it is his belief that his daughter was still alive when he arrived at the accident scene and that "*he was prevented from going to her*".[21] Senior Counsel for the families stated that Mr Hakin "*firmly believes that he may have been able to save his daughter's life. No father should live with that doubt and no father should be left wondering about that. So that's why we say it's an important matter*".[22]

35. Senior Counsel for the families stated that the provision of information to family members at the scene seemed "*disjointed and distracted*" and that some of the information subsequently provided to family members "*sent some of them in the wrong direction or they were not informed as to where their loved ones had been taken*"".[23] The families submitted that these are matters that are "*...directly concerning or connected with the death*".[24]

36. Senior Counsel for the families also queried whether there was a proper response by the emergency services to the Bourke Street event and whether the *Emergency Management Act 2013* (Vic) and State Emergency Response Plan[25] were adhered to.[26] It was indicated that the families do not currently know whether there was an Incident Commander or Emergency Management Coordinator or Controller appointed to manage the scene.[27] The family submitted that this aspect is "*important*", and that public safety was "*clearly in the minds of the police throughout when we look at the inquest brief and the material that they have produced so far. The statements, that they're very concerned about public safety, both before and after the turn into Bourke*

---

[21] Transcript of the directions hearing dated 14 August 2019, p 69.
[22] Transcript of the directions hearing dated 14 August 2019, p 69. I note that Mr Hakin was unable to inform his legal representatives of the identity of the person(s) who prevented him for accessing his daughter, whether it was a member of Victoria Police, Ambulance Victoria or this like; Transcript of the directions hearing dated 14 August 2019, p 73.
[23] Transcript of directions hearing dated 14 August 2019, p 70.
[24] Transcript of directions hearing dated 14 August 2019, p 70.
[25] The State Emergency Response Plan is the primary document for emergency response in Victoria. It outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in emergency response.
[26] Transcript of directions hearing dated 14 August 2019, p 70.
[27] Transcript of the directions hearing dated 14 August 2019, p 70.

Street".[28] It was submitted that the response of the emergency services is and should be a legitimate part of what ought to be included in the scope of the coronial inquest.[29]

37. Senior Counsel for the families submitted that a similar approach to that taken at the 'Kerang inquest'[30] should be adopted in respect of examining the emergency services response in the present inquest. The families submitted that these issues raise "*significant public health and safety issues, confidence issues and also, obviously significant concerns for the family.*"[31]

38. Senior Counsel for the families submitted that my power to comment on any matter connected with the deaths, including matters relating to public health and safety or the administration of justice[32] is not restricted to matters occurring prior to the death(s). It was submitted that the words of this provision are sufficiently broad to encompass the matters that they have raised.[33]

39. Senior Counsel for the Chief Commissioner submitted in respect of the third limb that generally the approach of coroners is to confine their investigations to matters anterior to death in interpreting the notion of circumstances of death and to "*leave to other process analysis of responses and post incident issues*".[34]

40. Senior Counsel for the Chief Commissioner also invited the legal representatives for the families to identify the issues and concerns family members may have about matters such as police enabling access to the crime scene. It was indicated the Chief Commissioner would ensure there was "*a suitable response and communication to them*" and assist in "*explaining what happens after a terrible homicide such as this and there are ways in which perhaps that information could be provided*".[35] I commend the Chief Commissioner's offer of assistance in that regard.

RELEVANT PRINCIPLES

Coronial Jurisdiction

---

[28] Transcript of directions hearing dated 14 August 2019, p 70.
[29] Transcript of directions hearing dated 14 August 2019, pp 70-71.
[30] COR 2002 3174 and Ors.
[31] Transcript of directions hearing dated 14 August 2019, p 71.
[32] *Coroners Act 2008* s 67(3).
[33] Transcript of directions hearing dated 14 August 2019, p 73.
[34] Transcript of directions hearing dated 14 August 2019, pp 71-72.
[35] Transcript of directions hearing dated 14 August 2019, p 72.

41. The coronial jurisdiction plays an important role in Victorian society. That role involves the independent investigation of deaths for the purpose of finding the cause of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice.[36] It is established as a specialist inquisitorial court with powers given to coroners to effectively investigate deaths without the coronial jurisdiction becoming too adversarial.[37] I note that in accordance with the Coroners Act, the coronial system should operate in a fair and efficient manner.[38]

42. In exercising my functions pursuant to the Coroners Act, I must have regard, as far as possible in the circumstances, to matters including the desirability of promoting public health and safety and the administration of justice.[39]

43. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[40]

44. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

45. The circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

46. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as 'the prevention role'.

---

[36] *Coroners Act*, preamble, s 1(a)-(c).
[37] *Coroners Act 2008* (Vic) second reading speech.
[38] *Coroners Act 2008* (Vic) s 9.
[39] *Coroners Act 2008* (Vic) s 8(f).
[40] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

47. Coroners are also empowered to:

(a) report to the Attorney-General on a death;

(b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

48. These powers are the vehicles by which the prevention role may be advanced.

49. The coronial system should operate in a fair and efficient manner.[41] When exercising a function under the Coroners Act, coroners are to have regard, as far as possible in the circumstances, to the notion that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[42]

50. I am mindful of what was said by Nathan J in *Harmsworth v The State Coroner*.[43] His Honour referred to the extent of coroners' powers, noting that power is not "*free ranging*" and must be restricted to issues sufficiently connected with the death being investigated. His Honour noted that if not so constrained, an inquest could become wide, prolix and indeterminate. His Honour stated the Coroners Act does *not* provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions or individuals. Significantly he added:

> *Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.*[44]

---

[41] *Coroners Act 2008* (Vic) s 9.
[42] The Coroners Act s 8.
[43] (1989) VR 989.
[44] (1989) VR 989.

51. The principle was restated in *R v Doogan*,[45] where the court commented that the scope of the coronial inquiry does not extend to the resolution of collateral issues.[46]

52. I further note Justice Muir's comments in *Doomadgee & Anor v Deputy State Coroner Clements*,[47] that Coroners are not '*roving Royal Commissioners*'. His Honour added:

> *It is significant also that rules of evidence do not bind a Coroners Court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The evidence relied on by the Coroner must be relevant to the matters within the scope of the coronial inquiry.*[48]

53. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[49] the scope of a coroner's inquiry and the issues that may be considered at an inquest were described as being limited. As there is no rule that can be applied to clearly delineate those limits, rather, 'common sense' should be applied. In this case, Chief Justice Higgins noted that:

> *It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry...[i]t may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry.*

54. Chief Justice Higgins also provided a helpful example of the limits of a coroner's inquiry, suggesting that factual questions related to cause[50] will generally be within the scope of the inquest.

55. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is not a universal test that is readily available to a coroner.

56. The power to comment, arises as a consequence of the obligation to make findings. It is not free-ranging. It must be a comment 'on any matter connected with the death'. The powers to comment and also to make recommendations are inextricably connected with, but not independent of, the power to enquire into a death or fire for

---

[45] [2005] ACTSC 74, 162.
[46] [2005] ACTSC 74, 27.
[47] (2005) QSC 357.
[48] (2005) QSC 357, paragraph 35
[49] [2009] ACTSC 40.
[50] I note that in that matter, Chief Justice Higgins was referring to the cause of a fire, however, I consider this analogous to the cause of death.

the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[51]

57. I refer to the words of Justice Nathan in *Harmsworth*:

> *An inquest into particular deaths in a prison, is not and should not be permitted to become an investigation into prisons in which deaths may occur. A comment on the particular deaths may be pertinent, especially so if the prison facilities were found to be inadequate. It could even be that a comment could have general application, and so much is envisaged by the Act which gives commentary and recommendatory powers in matters of public safety. But the power to comment is incidental and subordinate to the mandatory power to make findings relating to how the deaths occurred their causes and the identity of any contributory persons.*[52]

ANALYSIS AND DETERMINATION OF THE APPLICATION

58. I will now determine each limb of the families' application.

References to 'the offender'

59. I do not think it is practical or appropriate to make a specific order or direction requiring all court attendees to refer to the individual in every instance as 'the offender'. Given the volume of material that predates the families' application, a large proportion of which will be referred to in oral evidence, it would be unworkable to expect every reference to the individual to conform with the families' request.

60. However, I consider it respectful and reasonable that all counsel involved in the inquest make every effort to adopt the protocol of referring to the individual as 'the offender' throughout the inquest and in any further correspondence with the court, where it is possible to do so. Consequently, I will refer to the families' request in the orders as a matter of courtesy and to draw the attention of interested parties to the families' request.

Opportunities for intervention on Bourke Street

61. I accept the families' submissions that there are legitimate investigations and enquiries regarding the possibilities for intervention and apprehension of the offender

---

[51] *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[52] *Harmsworth v The State Coroner* [1989] VR 989 at 996, emphasis added.

between the intersection of Swanston and Flinders Street and the offender's eventual apprehension at the intersection of Bourke Street and William Street. As identified by Senior Counsel for the families, the coronial brief already contains material, including statements from police members, that deals with these issues.

62. Having regard to my duties under the Coroners Act and in particular the broader purpose of coronial investigations to contribute to a reduction in the number of preventable deaths, I consider it is appropriate and warranted to expand the scope of the coronial inquest to include the following proposed paragraph:

> *The co-ordination and effectiveness of the Victorian Police response to the events on 20 January 2017 from the time the offender entered the Melbourne CBD until his arrest.*

63. To give effect to this, I have directed court staff to review the criminal brief with a view to identifying any additional police witness statements that may assist my inquiry into the co-ordination and effectiveness of the Victoria Police response from the time the offender entered the Melbourne central business district until his arrest.

Emergency Management Response

64. I am conscious that in part, Senior Counsel for the families relied on the inclusion of the emergency response in the scope of the Kerang level crossing collision inquest as part of their present application. I note that the issues identified as within the scope of the Kerang level crossing collision inquest are substantially different to the issues presently raised. The Kerang inquest examined the emergency response to the Kerang level crossing collision in relation to issues such as:

(a) Ambulance Victoria and Air Ambulance Victoria's consideration of the risks of tension pneumothoraces when triaging trauma patients for transfer by fixed air wing without Mobile Intensive Care Ambulance support;

(b) the availability of first aid supplies on regional trains; and

(c) V/Line's management arrangements with respect to training V/Line Rail Incident Controllers and the proximity of such controllers to all Victorian regional level crossings.

65. I also note that a number of deaths that occurred as a result of the Kerang level crossing collision were found *not* to be influenced by the emergency response as their:

(a) deaths occurred immediately following the collision; or

(b) unresponsiveness occurred very soon after the collision; or

(c) their prognoses were poor following the collision.

66. The emergency response was rather examined to explore the possibility that decisions made as part of the emergency response might have impacted upon individual's chances of survival.[53]

67. On the evidence currently before me, I see no situations comparable in the present matter.

68. In relation to Mr Hakin's concerns as detailed at paragraph 34 above, it is clear that the reality of a parent living with the belief that they could have done something to save their child's life is utterly devastating and must be treated with a high level of sensitivity and compassion. I agree that no parent should live in the shadow of doubt over whether they could have saved their child.

69. To this end, I have directed Court staff to enquire as to whether there is evidence contained in the criminal brief that could be presented to Mr Hakin to address his concerns. I am informed that there is evidence relevant to Mr Hakin's concerns that will hopefully provide Mr Hakin and his family some level of peace in this respect. I am informed that in the evidence presently reviewed, there does not appear to have been any opportunity for Mr Hakin to have saved his daughter's life. The evidence indicates that Thalia Hakin was almost immediately assisted by first responders, including an off-duty nurse, an off-duty ear nose and throat surgeon and a police officer, who undertook cardiopulmonary resuscitation until the arrival of a Mobile Intensive Care Ambulance paramedic who confirmed that she was deceased. The evidence indicates that Thalia Hakin had died prior to the arrival of Mr Hakin and does not give any cause to suspect that her injuries were survivable.

---

[53] I note in this respect that there are some circumstances where it is appropriate to examine similar matters, such as the inquest into the deaths of those who died following the 2016 Victorian Thunderstorm Asthma event. This inquest also differs from the present matter in that the Thunderstorm Asthma inquest examined, among other things, the impact of an unprecedented surge event upon Victoria's emergency service providers' ability to respond to medical emergencies in a timely manner. There again is no suggestion that such a situation arose after the offender was arrested in the present matter. In the current evidence, there does not appear to be an issue of delay in the emergency response or a question arising between the possible relationship of any such delay and the deaths occurring.

70. I have asked court staff to facilitate provision of this material to Mr Hakin's legal representatives. In addition, court staff have indicated that should Mr Hakin be amenable to such a proposal, a meeting could be arranged between Thalia Hakin's family, a Victorian Institute of Forensic Medicine Forensic Pathologist, a Coroners Court of Victoria Family Liaison Officer and Coroners Court of Victoria Solicitor to assist in addressing any concerns raised by this material. It would be a great privilege to assist Mr Hakin with his concerns and it is regrettable that an opportunity to do so did not arise sooner.

71. That being said, I do not consider that a public inquest is the appropriate forum to address Mr Hakin's concerns. I will return to this notion in due course.

72. In regard to access to the victims in general, due to the nature of the event, a crime scene was quickly established over a large geographical area along Bourke Street. I note the importance of crime scene preservation to permit Victoria Police Forensic Services staff to attend and thoroughly examine the scene. The results obtained by such Forensic Services crime scene examination significantly aid the criminal justice system and the courts.

73. I note that there is currently no evidence before me, nor did the legal representatives of the families take me to any evidence that directly pertains to the preventability of the deaths following the offender's arrest. There is nothing before me to suggest that emergency responders, and the Victorian community at large, did anything but earnestly try their hardest to assist those injured in the 2017 Bourke Street event. There is no current suggestion that a timelier response to the deceased would or could have altered the tragic outcome of the six lives lost.

74. I note that there were no issues raised by the families such as significant delays in the attendances of emergency services that impacted upon the deceased's chances of survival. The evidence contained in the criminal brief and in the Victorian Institute of Forensic Medicine's medical examination reports in respect of the deceased indicate that the six deceased sustained sudden, life-threatening injuries that proved to be almost immediately fatal in most cases. There is no apparent evidence that had emergency services arrived sooner, or acted in a different manner, that the deaths could have been prevented.

75. The families' concerns with reference to police and other emergency services separately and together have, or have the capacity to, cause great and understandable distress to them. This however does not in itself determine these matters to be those that ought to be properly included in the scope of inquest. The 2017 Bourke Street event is one that has left an indelible mark on the wider Victorian community, with no one affected more than the families of those who lives were tragically taken from them. I recognise the families' enduring grief.

76. Having carefully considered all of the relevant material, I do not consider, based on the evidence currently before me, that the families' application to broaden the inquest's scope to include the response of trauma emergency services should be accepted, as I have not identified a legitimate coronial purpose to be served by so doing. However, I intend on providing the legal representatives of the families with a PDF version of the criminal brief of evidence so that they can review it and thereafter draw my attention to any material that supports the view that the emergency management response should be included in the scope of the inquest and therefore be provided with an opportunity to make further submissions in relation to this at a later date.

ORDERS

(a) I make no direction concerning the reference to the offender, but note that I consider it reasonable and appropriate for all counsel involved in the inquest to make every effort to adopt the families' requested protocol of referring to the individual as 'the offender' throughout the inquest and in any further correspondence with the court, where it is possible to do so;

(b) I order that the scope of the inquest be amended to insert at paragraph 2(d) "*The co-ordination and effectiveness of the Victorian Police response to the events on 20 January 2017 from the time the offender entered the Melbourne CBD until his arrest*"; and

(c) I direct that the legal representatives of the families be provided with a copy of a PDF version of the criminal brief of evidence (excluding multimedia and photograph books) to provide them with an opportunity to identify evidence that might give further substance to their application to broaden the scope of the inquest to include the emergency management response. The legal representatives of the families are then to correspond with the Court by 27 September 2019 to:

(i) identify any further witness statements they seek to be included in the coronial brief of evidence;

(ii) identify any further witnesses they seek to be called to give oral evidence at inquest; and

(iii) detail the assistance that the proposed additional material and/or witnesses would provide to me in the execution of my coronial duties.

Signature:

JACQUI HAWKINS
CORONER
Date: 23 August 2019