Coroners Court of Victoria

Coronial Inquest into the deaths of

Matthew Poh Chuan Si

Thalia Hakin

Yosuke Kanno

Jess Mudie

Zachary Matthew Bryant

Bhavita Patel

Coroner Jacqui Hawkins

19 November 2020

Coroners Court of Victoria
at Melbourne

Inquest into the deaths of

Matthew Poh Chuan Si

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Bourke Street Coronial Finding
Executive Summary

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1. On 20 January 2017, the Offender deliberately drove a stolen maroon-coloured Holden Commodore through crowds of pedestrians along the Bourke Street Mall, causing the deaths of six innocent young people—Matthew Poh Chuan Si, Thalia Hakin, Yosuke, Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel—and seriously injuring scores of others.

2. The cause of, and moral culpability for, the deaths of the six victims lies solely with the Offender, who was found guilty on 13 November 2018 of the murders of Matthew, Thalia, Yosuke, Jess, Zachary and Bhavita, as well as an additional 27 charges of reckless conduct endangering life. He was sentenced to life imprisonment with a non-parole period of 46 years.

3. My role as coroner is to independently examine, through a prevention-focused lens, the relevant circumstances of reportable deaths to establish the facts and identify any systemic gaps or failures in processes or responses with a view to making recommendations designed to contribute to the reduction of preventable deaths and promote public health and safety and the administration of justice.

4. Pursuant to s. 67(1) of the *Coroners Act 2008* (Vic), I am required to make formal findings as to the identity of the deceased, cause of death and circumstances in which the deaths occurred.

5. The facts surrounding the events immediately proximate to the deaths of Matthew, Thalia, Yosuke, Jess, Zachary and Bhavita were uncontroversial. The path of the Offender's vehicle along the Bourke Street Mall was captured by video footage from numerous angles and is described in the uncontested statements of hundreds of eyewitnesses.

6. However, although the immediate circumstances were not in dispute, it was apparent that the events leading up to the Bourke Street incident gave rise to community concern about aspects of the administration of justice and issues relating to public health and safety. These issues warranted further investigation to:

    a. ascertain how a recidivist criminal, prone to extreme forms of violence with escalating behaviour immediately prior to 20 January 2017, was able to murder six innocent people and seriously injure scores of others

    b. understand the environment that allowed the Offender to operate and navigate his way around the criminal justice system

    c. learn from the deaths of Matthew, Thalia, Yosuke, Jess, Zachary and Bhavita to reduce the risk of such an event reoccurring and to ensure that our community is better able to anticipate and respond when confronted with similar circumstances.

7. I have thoroughly and forensically analysed the salient facts and issues associated with the Offender's behaviour and his interaction with police, from the bail application on 14 January 2017 to the catastrophic events in Bourke Street on 20 January 2017 that resulted in the deaths of six innocent young people.

8. I have had the benefit of examining thousands of pages of evidence, policies and procedures, viewing CCTV footage, listening to the audio of police communications and hearing the evidence of witnesses and the submissions of highly skilled counsel. This confers upon me a significant advantage: to examine in detail the totality of the circumstances, which I acknowledge was not an advantage available to police on the day.

9. By its very nature, a coronial inquiry is wholly retrospective. This carries with it an implicit danger for the court to prospectively evaluate events through the optics of hindsight. That is, it can be easy or seductive to conclude that what did occur was always going to occur, and from that conclusion to view the actions or inactions of those involved more critically, and as if the outcome was obvious and should have been foreseen. In writing this Finding, I have remained cognisant of the potential intrusion of hindsight bias.

10. The Offender's behaviour in the lead up to 20 January 2017 was consistently dangerous, violent and unpredictable. While on bail for a number of serious offences, he committed two violent assaults, firstly against Gavin Wilson on the evening of 18 January 2017 and secondly against his brother, Angelo, in the early hours of 20 January 2017. Although the precise events of Bourke Street were unforeseeable, the Offender had an extensive and known history of baiting police and driving dangerously to evade police with a complete disregard for the safety of others. It is agonising that, despite the escalating events of the previous days and the scores of police members actively engaged in attempting to stop him, such a violent, drug-fuelled, psychotic and delusional criminal was able to slip through the cracks and evade interception by police over several hours on 20 January 2017.

11. In this context, a remarkable confluence of events emerged in favour of the Offender, including a set of systemic deficiencies in the response of Victoria Police that permitted manipulation by a single dangerous and unpredictable offender. These deficiencies included poor planning, a lack of assertive leadership, supervision and coordinated command and control, a lack of adequate resources, inadequate communications between units across police radio channels, a failure to follow-up and action essential inquiries and resources, inflexible attitudes and policies, a staunch belief that negotiating with a delusional person was the best chance of bringing the incident to a conclusion, a loss of objectivity and, ultimately, a reluctance to act assertively for fear of recrimination. Each of these factors contributed to a perfect storm.

12. However, I am unable to conclude that had any of these responses been different, the catastrophic outcome could have been avoided.

13. My investigation starkly exposed the significant practical challenges of stopping a moving vehicle. Finding an appropriate means to neutralise offenders who use vehicles as a weapon is incredibly difficult and options are limited. It is clear that, once the Offender had reached the CBD, there were few, if any, options available to the responding police units to stop the Offender without causing injury to other people, including innocent bystanders.

14. I find that the police officers involved in the events leading up to Bourke Street acted in good faith in their efforts to apprehend the Offender. The evidence revealed many examples of excellent policing, including the active identification and pinging of the Offender's phone in the early morning, the attempted intercept on Wurundjeri Way when CIRT officers came agonisingly close to apprehending the Offender, assertive leadership by supervising police in the northwestern region and the response by police to the events on Bourke Street, including their efforts to warn pedestrians, facilitate the arrest of the Offender and render aid to the many victims.

15. To prevent something like this from reoccurring, the systems and processes need to be robust and flexible enough to address a dynamic situation. When an individual is able to act recklessly, dangerously, with wilful intent and with a blatant disregard for authority and public order, our police system needs to be able and equipped to rapidly and assertively respond. Leadership, command and control, clear and established roles and responsibilities, detailed plans, objectivity and a recognition of an unfolding escalation of events are all essential.

16. When an incident as significant as this one occurs, it is important for key agencies and stakeholders to reflect on lessons learned to identify and implement solutions as part of a process of continual improvement. The tragic events of 20 January 2017 have been a catalyst for significant reforms.

17. Victoria Police has done much soul searching to ensure it is better equipped, and to provide individual officers with the support of the police command to be more decisive and able to respond differently if this kind of incident were to present itself again. Enormous work has been undertaken by Victoria Police and other government agencies and departments to develop and implement practical, focused and effective solutions designed to prevent a similar event from occurring. I find that work was responsive, appropriate and conducted in a timely manner. This has reduced the need for me to make many substantial recommendations. I hope the families of the deceased may find some comfort in this knowledge.

18. Even though many changes have been made, this forensic process has identified some remaining gaps and areas of improvement. Accordingly, I have made nine recommendations:

Recommendation One:

That Victoria Police, in consultation with the DJCS, investigates the feasibility of Victoria Police-issued body-worn cameras being used to record all out-of-sessions bail/remand hearings.

Recommendation Two:

That Victoria Police reviews its training and supervision of members involved in bail/remand proceedings to improve members' skills and knowledge concerning:

a. proper preparation of the bail/remand brief
b. identification of the available grounds upon which to oppose bail
c. identification and presentation of the evidence relevant to opposing bail
d. information about obtaining all relevant information and seeking an adjournment if necessary
e. information about the circumstances around when and how to appeal a decision to grant bail.

Recommendation Three:

That Victoria Police develops force-wide policies and procedures to:

a. ensure that notifications of failure to report on bail are forwarded to a Position-Based Email Account, such as the Officer-in-Charge of the police station, in addition to the informant

b. provide guidance on the actions to be taken by the informant and Officer-in-Charge upon receipt of such notification.

Recommendation Four:

That Victoria Police reviews its training, policies and procedures on bail and remand with respect to high-risk recidivist offenders to ensure members:

a. conduct a timely risk analysis using the ROPT, POINTER or similar tool

b. consider the need for and, if appropriate, implement a Priority Target Management Plan or Offender Management Plan within the meaning of Victoria Police Manual *Tasking and Coordination* or other suitable oversight plan designed to detect and disrupt further offending while on bail.

Recommendation Five:

That Victoria Police reviews its training, policies and procedures that govern the roles, responsibilities and coordination between the criminal investigation units and other supervisory units to eliminate role confusion and ambiguities concerning operational command in all areas, including criminal investigations, incident response and planned operations.

Recommendation Six:

That Victoria Police conducts a review of its policies, procedures, training and infrastructure in respect of the management of critical incidents or emerging critical incidents and the proper and effective use of police communications, so that:

a. there is, to the maximum extent possible, continuity of command in planned operations and critical incidents, particularly in circumstances where:

   i. the operation or incident crosses Divisional or Regional boundaries and may involve a change of radio channel

   ii. the operation or incident may involve the use of dedicated (TAC) radio channels.

b. there is, to the maximum extent possible, continuity of involvement of police communications personnel performing the role of channel operator during a critical incident or emerging critical incident

c. all police members that may be impacted or become involved in an operation or incident are afforded the best possible situational awareness and clarity of command, plans, roles and responsibilities.

Recommendation Seven:

That Victoria Police reviews its criminal investigator and investigator management training program with a view to incorporating a curriculum on risk evaluation, transition to incident management and the identification and management of critical incidents. Such training should incorporate an immersive, interactive training environment to support decision-making in critical incidents and emerging critical incidents.

Recommendation Eight:

That Victoria Police Professional Development Command develops and implements appropriate operational safety training on hostile vehicles and vehicle-borne attacks that incorporates simulation or Hydra experience training to enhance the skills and operational decision-making of frontline operational members (including uniform, criminal investigation units and the Critical Incident Response Teams) who may be called upon to act in response to a hostile vehicle or vehicle-borne attack.

Recommendation Nine:

That Victoria Police Professional Development Command incorporates regular annual or biennial refresher training on the Victoria Police Manual *Hostile Vehicle Policy* and on vehicle-borne attacks to ensure members' knowledge and skills remain up to date.

19. I acknowledge the devastating loss of life and the physical and psychological injuries suffered due the Offender's actions by an untold number of victims, first responders and witnesses.

20. I particularly extend my sincere and heartfelt condolences to the families of Matthew, Thalia, Yosuke, Jess, Zachary and Bhavita. I acknowledge the absolute grief and utter devastation that you have endured as a result of your respective losses. I am grateful to have had the benefit of your considered and thoughtful comments at the beginning and at the end of the Inquest hearings and have reflected on these when approaching my task.