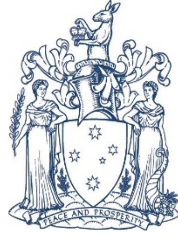

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 3809

FINDING INTO DEATH AFTER INQUEST OF GABRIEL MESSO
Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	State Coroner Judge John Cain
Delivered on:	1 December 2022

Paragraph 365 amended pursuant to s76(c) *Coroners Act 2008* on 19 January 2023

Delivered at:	Coroners Court of Victoria
Inquest Dates:	19-29 July 2022
Counsel Assisting:	Ben Ihle KC of Counsel Anna Martin of Counsel instructed by In-House Legal Service Coroners Court of Victoria
Family of Gabriel Messo:	Fiona Ryan KC of Counsel James Anderson of Counsel instructed by Robinson Gill
Chief Commissioner of Police:	Catherine Boston of Counsel instructed by MinterEllison
Senior Constable Lucy Verplak:	Andrew Imrie of Counsel instructed by the VGSO
Melbourne Health:	Paul Halley of Counsel instructed by K&L Gates
Northern Health:	Tamir Katz of Counsel instructed by In-House Legal

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BACKGROUND

1. Gabriel Messo (hereinafter referred to as Gabriel) was born on 27 October 1989. He was 30 years of age when he died on 16 July 2020 at John Coutts Reserve in Gladstone Park from gunshot wounds to the chest inflicted by a Victoria Police officer.

2. Gabriel was the much-loved son of Lilla and Fuat Messo, and older brother to Chris and Mary. Gabriel initially attended West Meadows Primary School and then St Mary's Orthodox Coptic College for both Primary and High School. The Messo Family came from an Assyrian heritage and initially grew up in West Meadows and then Tullamarine.[1] During Gabriel's upbringing, the family regularly attended the Syrian Orthodox Church.

3. Gabriel was described by his father as being an intelligent and cheeky child who grew up to be an outgoing, active and energetic man who just liked to enjoy life.[2] David Haddad was his best friend.[3]

4. Gabriel left school after Year 10 and commenced employment at Kentucky Fried Chicken for approximately an 18-month period, however he left his job after receiving some burns to his leg. He also worked in the family business for a period (a small nut and middle eastern grocery store) and was heavily involved in indoor soccer refereeing.[4]

5. Gabriel's father states that '*Gabby was a good kid growing up. He respected the elderly and the community. He didn't have a criminal record. He had respect with me but he didn't always agree with me. He got along with his siblings. He used to love Mary and he always went to his mother. They had a great relationship. There was never any real issues with any of the family until he got sick'*.[5]

6. Around 2010 when Gabriel was in his early-20's he travelled to Thailand with members of his community. Whilst he was over there he met and fell in love with a Thai woman and maintained contact with her upon his return. He returned for a second trip however it is understood that the relationship did not go well and upon his return the relationship ended. In August 2013, Gabriel travelled to Malaysia to play in a number of poker tournaments. He stayed there until his return to Melbourne on 2 January 2014.[6]

[1] Statement of Fuat Messo, CB 119; statement of Chris Messo, CB 132.
[2] Statement of Fuat Messo, CB 119-120.
[3] Statement of Fuat Messo, CB 120; statement of David Haddad, CB 156.
[4] Statement of Fuat Messo, CB 119-120.
[5] Statement of Fuat Messo, CB 120.
[6] Statement of Chris Messo, CB 133-134.

7. On his return from Malaysia, Lilla was concerned Gabriel was using drugs. Chris then approached Gabriel expecting him to deny he was using marijuana, however Gabriel '*admitted to me that he was using it and said that it was good for you and spoke about the general health benefits*'. In Chris' opinion at that time, '*Gabriel was still quite well and spent most of his time in his room playing poker or playing video games. He also spent a lot of time with his mates and the drug use didn't appear to impact him. Gabriel was always in good shape and liked to work out a lot and during this period he maintained shape even though he was using drugs*.'[7]

8. In January 2015, Gabriel met Phatsawan Rukitinderm. Phatsawan had just arrived in Melbourne from Thailand on a working holiday visa. On 11 March 2015, Gabriel and Ms Rukitinderm moved in together into an apartment on Flinders Street and on 4 July 2015 they married at the Registry Office in Spring Street with just members of the Messo family present. They ended up separating in December 2017 with Gabriel moving back in with his family and Ms Rukitinderm relocating interstate to Brisbane.[8]

9. At the time of his death, Gabriel lived in a share house in Gladstone Park. He moved there three weeks prior to his death. Before that, Gabriel had lived with his parents in the family home.

Psychiatric history

10. Gabriel experienced his first episode of psychosis in July 2014.[9] He was subsequently diagnosed with bipolar affective disorder. A short history of his mental illness included being subject to a number of orders under the *Mental Health Act 2014* (**Mental Health Act**), including:

    10.1. Inpatient Temporary Treatment Order (**TTO**) between 6 and 29 July 2014. His care required periods in the section reserved for the most unwell psychiatric patients and periods of time in seclusion.[10]

    10.2. Inpatient TTO between 28 September 2016 and 11 October 2016. This TTO was varied so that Gabriel could reside in the community. On 21 October 2016, the TTO was revoked and replaced with a Community Treatment Order (**CTO**).[11]

    10.3. On 9 May 2017, Gabriel was discharged from the CTO early as he was declining psychiatric treatment and refusing to attend appointments or take medication.[12]

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[7] Statement of Chris Messo, CB 134-135.
[8] Statement of Phatsawan Rukitinderm, CB 162-164.
[9] Exhibit 80: NWAMHS medical notes, p 8.
[10] Statement of Dr Devapriya Rudolph, CB 190-191; Exhibit 80: NWAMHS medical notes, pp 18, 29.
[11] Statement of Dr Devapriya Rudolph, CB 192; Exhibit 80: NWAMHS medical notes, pp 20, 27, 30.
[12] Exhibit 80: NWAMHS medical notes, p 27.

10.4. Another Inpatient TTO was made 9 February 2018. Upon Gabriel's application to the Mental Health Tribunal to revoke that TTO, a full treatment order was granted by the Tribunal on 22 February 2018. Gabriel remained in hospital between 8 February 2018 and 7 March 2018, and the treatment order was varied to a CTO on 8 March 2018.[13]

10.5. A further 12-month CTO was granted by the Mental Health Tribunal on 20 August 2018.[14]

10.6. North West Area Mental Health Service (**NWAMHS**) applied to have a second 12-month CTO granted by the Mental Health Tribunal on 31 July 2019. However, on 12 August 2019 the Mental Health Tribunal discharged Gabriel from compulsory status, as it was the Tribunal's opinion that he did not fulfil the criteria as a compulsory patient under the Mental Health Act.[15]

11. Dr Devapriva Rudolph, Deputy Director of Clinical Services at NWAMHS, summarised Gabriel's clinical position as follows:

> *'Mr Messo presented with repeated relapses of Bipolar Affective Disorder. Since his initial presentation, he had four episodes of a severe relapse in context of non-adherence with medications and substance use. Each time he required an admission to the hospital (admitted to PARC on one occasion) to manage his relapse due to his severe symptoms. In each of his relapses, Mr Messo responded well to the treatment but subsequently discontinued his medications due to poor understanding about his illness despite repeated attempts to engage him. He also stopped engaging with the treating team leading to a discharge. There were extensive attempts to enhance his understanding about his illness and need to adhere to treatment. During the course of treatment several meetings were held with his family to provide information and education about Mr Messo's illness, treatment options and early warning signs'.*[16]

12. Between late January 2018 and early February 2018, Gabriel's family and friends recognised a deterioration in Gabriel's mental health. During this period, his family were fearful of what Gabriel might do. They attempted but were unsuccessful in engaging him in treatment and assessment via s 351 of the Mental Health Act on two occasions.[17]

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[13] Statement of Dr Devapriya Rudolph, CB 192; Exhibit 80: NWAMHS medical notes, pp 20, 25, 76.
[14] Exhibit 80: NWAMHS medical notes, pp 75, 133.
[15] Statement of Dr Devapriya Rudolph, CB 193; Exhibit 80: NWAMHS medical notes, pp 33, 78, 132.
[16] Statement of Dr Devapriya Rudolph, CB 193.
[17] Statement of Fuat Messo, CB 122-123; statement of Chris Messo, CB 136-137; statement of Mary Messo, CB 143-144; statement of Banibal Messo, CB 151; statement of David Haddad, CB 157-158.

13. Gabriel had stopped taking medication. He was experiencing delusions and suffering psychosis. He stated that he believed he was on a mission from God and had to 'cull people'. He regarded a staff member who worked at his friend's restaurant was a witch and needed to be killed.[18]

14. Following Gabriel's involvement in a high-speed car accident on 5 February 2018, Gabriel made his way to Sydney. Although Fuat booked a return flight for him, Gabriel was driven back to Melbourne by a family friend after Gabriel mentioned blowing up the plane.[19]

15. On 8 February 2018, on the third attempt, a medical assessment was conducted pursuant to ss 351 and 30 of the Mental Health Act.[20] This resulted in the TTO of 9 February 2018 (referred to above) being made.

Deterioration of mental health in months leading up to Gabriel's death

16. Throughout the first half of 2020, leading up to 16 July 2020, Gabriel's friends and family saw his mental health deteriorating again. Gabriel reported that he was not taking medication.[21]

17. Between 4 May and 16 July 2020, Fuat made 21 phone calls to mental health services regarding Gabriel.[22] He was desperate to get Gabriel the help that he needed.[23]

18. On 14 May 2020, Gabriel was referred by GP Dr Rahman to Psychologist Kathy Carrozza for six sessions of counselling under a Mental Health Care Plan. Gabriel attended three initial sessions on 26 May, 3 June and 19 June 2020 and had a fourth session booked for 17 July 2020.[24]

19. Throughout June and early July 2020, Gabriel's friend David Haddad saw Gabriel every day. Mr Haddad described this period as the darkest time of Gabriel's life.[25]

20. On 15 June 2020, Gabriel's family contacted Corina Cleur and Christina Borromeo from ABC Aged and Disability Services to assist Gabriel with his mental health. ABC Aged and Disability Services is a provider under the National Disability Insurance Scheme (**NDIS**). During the first meeting with Fuat and Lilla, Ms Cleur formed a view that Gabriel's parents were 'triggers' for Gabriel and that he needed to be removed from the family home.[26]

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[18] Exhibit 80: NWAMHS medical notes, p 10.
[19] Statement of Fuat Messo, CB 122.
[20] Exhibit 80: NWAMHS medical notes, p 976.
[21] Statement of Fuat Messo, CB 123-124; statement of Chris Messo, CB 137-138; statement of Mary Messo, CB 145; statement of Banibal Messo, CB 152; statement of David Haddad, CB 158-159; statement of Sam Aygur, CB 197-198.
[22] Statement of Fuat Messo, CB 124; CCRs of Fuat Messo, CB 1386.
[23] Evidence of Fuat Messo, T 47-48.
[24] Referral to Kathy Carrozza and mental health care plan, CB 825-828; Consultation notes of Kathy Carrozza, CB 829-838.
[25] Statement of David Haddad, CB 158.
[26] Statement of Sam Aygur, CB 196; statement of Corina Cleur, CB 210-211.

21. On 17 June 2020, Ms Cleur and Ms Borromeo attended the Messo family home to meet Gabriel. At this meeting, Gabriel exhibited signs of delusions and was erratic. Ms Cleur believed that Gabriel might hurt someone or himself and they needed to get him out of the house.[27]

22. Following an argument he had with Chris and Lilla Messo on the evening of 17 June 2020, Gabriel spent the night at a hotel.[28]

23. On 18 June 2020, Fuat telephoned NWAMHS about Gabriel. A file note of that contact reads:

> *Phone call received from his father (Frank) who told the writer that they believe that Gabriel's mental health has relapsed. They believe that he potentially* [sic] *a risk to himself and others and as a result they had to remove him from the family home last night and purchased a night at the Guest Hotel in Tullamarine…*
>
> *He also said that [Gabriel] has no insight into his mental illness and does not believe that he needs medication or support.*
>
> *Whilst at home the family observed that his sleeping pattern had deteriorated and he was becoming verbally aggressive towards family members and has been punching holes in the wall at the family home.*
>
> *Frank also said that if [Gabriel] is exposed to a busy noisy environment he will display challenging behaviour that they are unable to manage and they are no longer able to have been return [sic] to the family home as he presents a risk to the safety of the family.*[29]

24. The clinician who spoke with Fuat advised him that if Gabriel was located, they should take him to the emergency department and if he refused to go, Fuat needed to contact Triage for assistance if it was out of hours.

25. Gabriel continued to stay at a hotel until 23 June 2020.[30] He continued to spend a considerable amount of time with, and was supported by, his friend Mr Haddad and Sabri (Sam) Aygur who were also helping Gabriel to find suitable long-term accommodation.[31]

[27] Statement of Christina Borromeo, CB 205-206; statement of Corina Cleur, CB 211-212.
[28] Statement of Sam Aygur, CB 196-197; statement of Chris Messo, CB 137-138; statement of Fuat Messo, CB 124.
[29] Annexure A to Exhibit 80: NWAMHS medical notes, p 17. See also, statement of Sam Aygur, CB 196-198.
[30] Statement of Sam Aygur, CB 196-197; statement of Chris Messo, CB 137-138; statement of Fuat Messo, CB 124.
[31] Statement of David Haddad, CB 158.

26. On 22 June 2020, Gabriel sent the following text message to Ms Cleur:

> *Indeed it's not worth it.*
> *But if I force the police to kill my body.*
> *I will free of pain.*
> *Yes that is the easy way out.*
> *Yes I wont kill anyone.*
> *But I will make sure they kill me.*
> *So I can have relief in the spirit world.*[32]

27. Other than replying to Gabriel, Ms Cleur did not recall taking any action in response to this message.[33]

28. On 23 June 2020, Gabriel signed a rental agreement to move into a share house in Gladstone Park with the assistance of Ms Cleur.[34]

29. On 25 June 2020, Gabriel spoke graphically to his friend, Mr Haddad, about wanting to hurt his brother. Mr Haddad decided he needed to keep Gabriel away from his brother and put him somewhere safe. Mr Haddad took Gabriel to a hotel and paid for him to stay there until 30 June 2020.[35]

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[32] Messages between Corina Cleur and Gabriel Messo, CB 1003.
[33] Evidence of Ms Cleur, T 120:17 – T 123:20.
[34] Statement of Corina Cleur, CB 212-213; statement of Sam Aygur, CB 198.
[35] Statement of David Haddad, CB 158.

CORONIAL INVESTIGATION

Jurisdiction

30. Gabriel's death constituted a 'reportable death' pursuant to s 4(2)(c) of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and immediately before his death, Gabriel was a person placed in custody (being a person who a police officer was attempting to take into custody or who passed away from injuries sustained when a police officer attempted to take the person into custody). Accordingly, pursuant to s 52(2)(b) of the Coroners Act, an inquest was mandatory.

Purpose of the Coronial jurisdiction

31. The jurisdiction of the Coroners Court of Victoria (Coroners Court) is inquisitorial.[36] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[37]

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

33. The circumstances in which the 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.

34. 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.

35. Coroners are empowered to:

    35.1. report to the Attorney-General on a death;

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

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[36] Section 89(4) Coroners Act.
[37] Preamble and s 67 Coroners Act.

35.3. make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[38]

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

36. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[39] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[40] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death.[41]

Standard of proof

37. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[42] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[43]

38. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[44] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

39. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[45] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[46]

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[38] Sections 67(3), 72(1) and (2) of the Coroners Act.
[39] Section 69(1) of the Coroners Act.
[40] *Keown v Khan* (1999) 1 VR 69.
[41] See ss 69(2) and 49(1) of the Coroners Act.
[42] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[43] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[44] (1938) 60 CLR 336.
[45] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[46] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

Scope of the inquest

40. Following a Directions Hearing on 28 April 2022, the Inquest Scope was determined, pursuant to s 64(b) of the Coroners Act, as follows:

    1. *Examination of the mental health interventions that were attempted, and assessments that were conducted, in the two days prior to Gabriel's death, including examination of the applicable training, policies, procedures and practices which applied to the following events and circumstances:*

        a. *Gabriel and Lilla's attendance at Broadmeadows Community Mental Health Service on 14 July 2020;*

        b. *Gabriel's telephone call to North Western Mental Health on 14 July 2020;*

        c. *Gabriel's section 351 transfer to Royal Melbourne Hospital on 15 July 2020;*

        d. *Gabriel's attendance at Royal Melbourne Hospital on 15 July 2020, including the nature and adequacy of the assessments and/or treatments he received whilst there;*

        e. *Gabriel's assessment for fitness to be interviewed by the FMO on 15 July 2020.*

    2. *Examination of the conduct of Victoria Police at John Coutts Reserve on 16 July 2020 and the reasons for that conduct, including examination of the applicable training, policies, procedures and practices which applied to the following events and circumstances:*

        a. *the use and level of force used by Constable Andrew; and*

        b. *the non-activation of body worn cameras by both Constable Andrew and FC Churcher prior to the shooting of Gabriel; and*

        c. *the training and directions that were given to police as to use of force and activation of BWCs.*

    3. *Examination of the applicable training, policies, procedures and practices in respect of organisations registered under the NDIS regarding:*

        a. *mandatory reporting obligations or responses to behaviour of clients, or potential clients, which could reasonably indicate concerns of significant risk of harm.*

    4. *Any relevant changes in the policies, procedures and practices referred to in 1, 2 and/or 3 above since June-July 2020.*

41. The inquest was conducted over nine sitting days, taking evidence from 16 witnesses in July 2022, with submissions by interested parties heard on 14 September 2022. The Chief Commissioner of Police and police members, First Constable Lucy Verplak, Northern Health, Melbourne Health and Gabriel's family were represented by counsel.

42. Gabriel's father, sister and brother personally attended the hearing whilst Gabriel's mother viewed proceedings remotely. Gabriel's sister, Mary and father, Fuat, both made family impact statements at the conclusion of the hearing. Both statements were deeply moving and emphasised the significant and ongoing impact this tragic event has had on the family. Despite their overwhelming grief, Fuat to his great credit, on behalf of his family, expressed forgiveness that police had in his words '*done their best in the circumstances*'. This showed great strength of character on his part, and he has my admiration and respect for doing so. I acknowledge and thank Gabriel's family and friends for their assistance and contribution to the inquest, in what were very challenging and difficult circumstances.

43. This finding draws on the totality of the material obtained in the coronial investigation of Gabriel's death: the coronial brief prepared by Detective Sergeant David Woolfe of the Homicide Squad; further material obtained by the Court; transcript of the evidence adduced and exhibits tendered at the inquest; and the closing submissions of counsel.

44. On 16 July 2020 following notification of the incident, I attended the scene at John Coutts Reserve in Gladstone Park with police as part of my investigation.

45. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

46. With an investigation of this magnitude, it is appropriate that I acknowledge the significant work of all who were involved in assisting me.

47. I thank Detective Sergeant David Woolfe of the Homicide Squad who was appointed the Coroner's Investigator in this investigation and compiled a comprehensive Coronial Brief that was of great assistance.

48. I thank Counsel Assisting, Mr Ben Ihle KC and Ms Anna Martin, and the counsel and solicitors who represented the interested parties, for their work and comprehensive submissions.

49. I also acknowledge Mr Lindsay Spence, Principal In-House Solicitor at the Coroners Court of Victoria, who has worked diligently and provided me with invaluable assistance throughout the entirety of this investigation.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased: s 67(1)(a) of the Coroners Act

50. On 20 July 2020, Gabriel was identified through visual identification by his close friend, Sabri (Sam) Aygur, as per the Statement of Identification of the same date. Gabriel's identity was not in dispute and required no further investigation.

Cause of death: s 67(1)(b) of the Coroners Act

51. On 17 July 2020, Professor Woodford, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy upon Gabriel's body.

52. In an Autopsy Report dated 29 October 2020, Professor Woodford identified three gunshot entry wounds and made the following findings:

    52.1. the cause of death was gunshot wounds to the chest; and

    52.2. the mechanism of death related to severe blood loss (haemorrhagic shock); and

    52.3. while none of the gunshot wounds were judged to be immediately incapacitating, one of the wounds was associated with significant trauma to the heart and is likely to have been associated with collapse within seconds.[47]

53. Post-mortem toxicology did not detect the presence of alcohol or other commonly encountered drugs or toxins.

[47] Autopsy Report, CB 573.

Circumstances in which the death occurred: s 67(1)(c) of the Coroners Act

Victoria's Mental Health system

54. Gabriel and his family's interaction with Victoria's mental health system was a significant focus of this inquest. There is no question, the system is under significant pressure and is notoriously strained. The Royal Commission into Victoria's Mental Health System examined in considerable detail the challenges faced by individuals, and family members on behalf of a loved one, accessing timely and appropriate support and treatment. The Royal Commission's Final Report was tabled in the Victorian Parliament on 2 March 2021 and made 65 recommendations in addition to the nine recommendations contained in the interim report. Many of these recommendations address issues directly relevant to timely access to mental health services. Some of these recommendations have been implemented but many remain a work in progress and the Government has committed to implementing all the recommendations in full.

55. Section 7 of the Coroners Act requires that I avoid unnecessary duplication of inquiries and investigations. Many of the findings of the Royal Commission echo the experience of Gabriel and his family's interactions with the mental health system, particularly in the days immediately prior to Gabriel's passing. There is clearly significant room for improvement in the mental health system. Within this Finding I have avoided duplicating the Royal Commission's inquiries and investigations, but acknowledge that implementation of the recommendations remains ongoing, and is intended to address the identical issues experienced by Gabriel and his family.

The events of 2-9 July 2020

56. On 2 July 2020, Fuat was concerned about Gabriel's mental state and contacted NWAMHS requesting a face-to-face review with Gabriel's previous treating team. As set out in the background above, that request followed on from a number of calls made by Fuat in the preceding weeks. Fuat did not want Gabriel to know he had called as he feared it would cause conflict. A file note of this call records:

    Gabriel is not living at home… is not taking any medication…

    Concerned that Gabriel is becoming unwell. Gabriel visited their home last week, incident where brother changed the TV channel, resulting in Gabriel going to the shed and punching holes in the wall. Does not want to call police as Gabriel will present well and nothing will occur. Worried that Gabriel's mental state will further decline.

    Author advised that above will be relayed to [Gabriel's] past [treatment team at Hume Community Team] and plan will be formulated.

57. On 3 July 2020, Gabriel's previous treating psychiatrist, Dr Rao, was consulted. A plan was made to have Gabriel assessed within days and resulted in a referral to the acute crisis team. It was considered too urgent to simply refer him back to his treating team.[48]

58. NWAMHS was unable to achieve a face-to-face review or assessment of Gabriel because they did not have his new address and did not know where he was.[49]

59. On 8 July 2020, a clinician of NWAMHS telephoned Fuat. A file note of the conversation records the following:

> *P/C to Frank. He reports that his son is currently living at NDIS accommodation, and the accommodation is not disclosed and he doesn't know the exact address. [Fuat] reports that he spoke to NDIS support worker today that Gab is doing alright and nil concern; NDIS support worker advised Frank that if there is concern, they will make contact.*
>
> *Frank said Gab is doing well with others but not with family. He advised that he would like to withdraw the referral now and if he has new info and wants to re-refer him, he will contact triage.*[50]

60. Fuat had no recollection of the call on 8 July 2020 and inquiries have not revealed the identity of the NDIS support worker to whom Fuat was referring.[51]

61. However, Fuat's request was discussed at a clinical review meeting on 9 July 2020.[52] There is no record of the meeting, such as where it occurred, who attended, what was discussed, what was taken into account, or the clinical justification for the ultimate decision to withdraw the referral which was made by Dr Sekharan.[53] The only record is a brief note:

> *Father initially referred due to concern of relapse*
>
> *Not sure about the address*
>
> *Referral withdrawn – advised to re-refer once he makes contact.*[54]

---

[48] Evidence of Dr Lokesh Sekharan, T 254:17 – T 257:22; Statement of Dr Lokesh Sekharan, CB 1724-5; NWMH screening register notes, 3-7 July 2020, Annexure A to Exhibit 80 of the CB, pp 12-16.
[49] Evidence of Dr Lokesh Sekharan, T 257:19 – T 258:8.
[50] NWMH screening register notes, 8 July 2020, Ex 80, p 491.
[51] Evidence of Fuat Messo, T 54 – T 58; evidence of Corina Cleur, T 110:23 – T 112:22.
[52] NWMH screening register notes, 8-9 July 2020, Annexure A to Ex 80 of the CB, p 12; Evidence of Dr Lokesh Sekharan, T 260:1 – T 264:17.
[53] Evidence of Dr Lokesh Sekharan, T 261:18-27.
[54] NWMH screening register note, 9 July 2020, Annexure A to Ex 80 of CB, p 12.

62. As will be seen below, Gabriel himself contacted NWAMHS on 14 July 2020 in an attempt to re-commence medication. He spoke to duty clinician, Michelle Millen, and was triaged. Clinic psychiatrists Dr Sekharan and Dr Rudolph gave evidence that, had the referral of 3 July 2020 to the acute crisis team not been withdrawn, Gabriel would have been dealt with differently when he contacted the Clinic himself on 14 July 2020 as there would have been no need to triage him and it is likely he would have been seen as a matter of urgency.[55]

Submissions

63. Melbourne Health submitted that the suggestion that Gabriel would have been dealt with differently when he contacted NWAMHS on 14 July 2020, had the referral not been withdrawn, was speculative and not put directly to Ms Millen, who received Gabriel's call on that day. It was accepted, however, that there would have been no need to triage Gabriel in those circumstances.

64. Counsel appearing on behalf of Gabriel's family submitted that Dr Sekharan's withdrawal of the referral was made without adequate knowledge of Gabriel's history and, had the referral not been withdrawn, it is more likely than not that Gabriel would have been seen face-to-face on 14 July 2020 when he contacted NWAMHS.

Comments

65. Fuat was very concerned about Gabriel's deteriorating mental health when he contacted NWAMHS on 2 July 2020. His referral was actioned promptly being reviewed by Dr Rao on 3 July 2020. Dr Rao made the decision to refer Gabriel to the acute crisis team which reflected the concern for Gabriel's wellbeing. Contact by the acute crisis team was frustrated by not having a current address for Gabriel which led to the call to Fuat on 8 July where he made the request that the referral be withdrawn. Although Fuat does not recall the telephone call, I accept that the call occurred and that he made the request that the referral be withdrawn. This request was discussed at the clinical review meeting on 9 July 2020.

66. Ultimately it was Dr Sekharan who decided that the referral should be withdrawn, and I find that this decision was reasonable. I am however concerned about the absence of records or notes that summarise the clinical basis for this decision. The three lines that are recorded '*Father initially referred due to concerns of relapse. Not sure about the address. Referral withdrawn – advised to re-refer once the makes contact*' provides no clinical information justifying the decision. I do not underestimate the demands placed on medical and mental health staff arising from the volume of cases they deal with daily. Nevertheless, the information recorded in relation to this withdrawal of referral is entirely inadequate.

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[55] Evidence of Dr Devapriya Rudolph, T 361:27-31; evidence of Dr Lokesh Sekharan, T 269:3 – T 270:22.

67. A more complete explanation contained in the notes from Dr Sekharan may well have been helpful to Ms Millen when she spoke with Gabriel on 14 July 2020. She would, at a minimum, have had a better understanding of the recent history and the management decision that had been made, in particular the basis for the recommendation by Dr Sekharan to '*re-refer once he makes contact*'

68. Whilst I accept that the withdrawal of the referral was reasonable, I acknowledge that if the referral had not been withdrawn, then it is likely that Gabriel would have been dealt with differently on 14 July 2020. The urgency of assessment identified by Dr Rao may have resulted in Gabriel being seen face-to-face by Ms Millen, at the very least there would have been no need to triage Gabriel.

14 July 2020: Gabriel and Lilla's attendance at Broadmeadows Community Mental Health Clinic

69. On 13 and 14 July 2020, Gabriel indicated to family and friends that he had accepted that he needed help and was willing to accept treatment for his mental health including by re-commencing medication.[56] It is clear from the background outlined above and the evidence heard before this Court, that willingness was unusual for Gabriel.[57]

70. On 13 July 2020, Gabriel disclosed to Mr Aygur that '*his condition had deteriorated and it was getting to a point where he wasn't going to be able to help or control himself, not be himself. He said, brother I'm putting up my hand, I need some help, help me.*'[58] Mr Aygur subsequently spoke to Fuat and Lilla and told them Gabriel wanted to get treatment and he was willing to accept medication. Fuat described this as being '*good news*'.[59]

71. On 14 July 2020, Lilla and Mr Aygur met Gabriel at his house in Gladstone Park and they confirmed with Gabriel that he was ready to receive mental health treatment. Due to the COVID-19 restrictions in force at the time, Mr Aygur was unable to accompany them and therefore, Lilla drove Gabriel to the Broadmeadows Hospital in order to have Gabriel seen by staff at the Broadmeadows Community Mental Health Clinic ('**the Clinic**').[60] This is a location Lilla and Gabriel had attended many times before for the purposes of Gabriel receiving medication and mental health treatment.[61]

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[56] Statement of Sam Aygur, CB 198; Statement of Fuat Messo, CB 125.
[57] Statement of Fuat Messo, CB 122; evidence of Fuat Messo, T 48:24 – T 49:18, T 62:15-24; statement of Corina Cleur, CB 1356; evidence of Corina Cleur, T 96:14-18, T 114:17-25; NWMH screening register detail, 18 June 2020, Annexure A to Ex 80.
[58] Statement of Sam Aygur, CB 198.
[59] Statement of Fuat Messo, CB 125.
[60] Statement of Sabri Aygur, CB 198; statement of Fuat Messo, CB 125.
[61] Evidence of Fuat Messo, T 34:31 – T 35:22; statement of Fuat Messo, CB 2104.

72. Records of attendances that day show that Gabriel and Lilla Messo did **not** attend the Clinic in person on 14 July 2020.[62] The following evidence supports a finding that they attempted to do so:

72.1. Fuat Messo gave evidence that he spoke to Lilla on the phone while she was at Broadmeadows Hospital. His telephone records indicate he spoke to Lilla on five occasions between 11.46am and 4.53pm on 14 July 2020, including three phone calls at 2.16pm, 2.24pm and 2.41pm.[63] Fuat recalled Lilla '*saying something along the lines of "nobody is letting us in because of Covid." She said that they went inside the foyer and there was a desk with two women. The women would not allow them in. She said "Gabby's now on the phone to the mental health section".'*[64] In evidence Fuat also recalled '*[Lilla] said to me we went inside, like in the front door. There was, I think, two ladies she said there, they wouldn't let them go to the mental health, which was – was probably only, I don't know, 30-40 metres away, to approach them to get medication.'* Fuat also recalled Lilla telling him that while Gabriel went outside the Hospital to speak on the phone to '*someone from the mental health'* Lilla sat down, but she was also told she had to leave and '*they kicked her out of the foyer.'*[65] Although Fuat could not recall which phone call it was, he was under the impression Lilla and Gabriel were still at the hospital during at least one of the conversations on 14 July 2020, and had been waiting for an hour or hour and a half, after which Fuat also tried to call the Clinic.[66]

72.2. The evidence of Mr Aygur about Gabriel's intention to seek treatment (as noted above) as well as Mr Aygur's evidence that '*[Lilla] ended up taking [Gabriel] on her own… She spent quite some time there where they were unsuccessful in getting Gabriel through the door. From memory, Fuat was on the phone for a very long time. He was also unsuccessful on getting him in*.' Mr Aygur also stated that on the evening of 14 July 2020, he went to see Gabriel who '*was really frustrated that they wouldn't take him in*'.[67]

[62] Hume Wellness and Recovery Team Daily Client Log, 14 July 2020, CB 1951; evidence of Michelle Millen, T 155:14-16; T 185:24 – T 186:27.
[63] Statement of Fuat Messo, CB 125, 129; statement of Fuat Messo, CB 2104; CCRs, CB 1386a; evidence of Fuat Messo, T 35:1-4, T 59:15 – T 64:8.
[64] Statement of Fuat Messo, CB 2104.
[65] Evidence of Fuat Messo, T 59:15 – T 60:3.
[66] Evidence of Fuat Messo, T 62:7 – T 63:23; statement of Fuat Messo, CB 125.
[67] Statement of Sabri Aygur, CB 198.

72.3. Ambulance Victoria records note that Gabriel told paramedics on 15 July 2020 the following: '*30yom reports insomnia and increase in bipolar symptoms recent/y. Pt attempted to contact BHS for assistance with mental health yesterday however was unsuccessful*.'[68] Gabriel relaying this information is also captured on Victoria Police body worn camera (**BWC**) footage on 15 July 2020.[69]

72.4. Gabriel advised a Forensic Medical Officer on 15 July 2020 that he had attended the Clinic with a family member in order to get some help for his current symptoms.[70]

73. It is appropriate at this juncture to explain that the Clinic is in fact located within the Broadmeadows Hospital. At the time, the Clinic was operated by Melbourne Health, while Broadmeadows Hospital was operated by Northern Health. The Court heard the following evidence about the impact of COVID-19 restrictions in force on access to the Clinic and Broadmeadows Hospital on 14 July 2020:

73.1. There was screening conducted by Broadmeadows Hospital staff at the entrance to the hospital to identify (i) visitors who were not permitted to enter the hospital and (ii) patients or persons seeking treatment, including mental health services, who were permitted to enter. The screening at the entrance to the hospital for persons permitted to enter included COVID-19 screening with respect to temperature checks, face mask, and checking generally for COVID-19 symptoms.[71]

73.2. Clients wishing to access the Clinic were triaged in the dome on immediate entry to the Broadmeadows Hospital by the hospital's concierge. There was no record of attendances through this entry. If a client was agitated at the door, concierge staff would not challenge them and allow them to make their way to the Clinic, sometimes calling the Clinic to let them know a client was on their way.[72]

73.3. Northern Health had two staff members sitting at the front entrance of the Broadmeadows Hospital COVID-screening everybody. The entrance was described by Clinic staff as involving two sets of automatic doors: one set of automatic doors, a small breezeway, and then a second set of automatic doors, behind which was where the Northern Health staff were seated. Although no one was allowed to walk beyond them without completing a COVID screen, someone seeking access to the Clinic should have been allowed through the Northern Health desk with or without an appointment.[73]

[68] Statement of Alexandra Smith, CB 1351; statement of Megan Waldhuter, CB 1394.
[69] BWC footage of F/C Ryan, Ex 9 within CB at 23:20.
[70] VIFM Forensic Medical Examination Record Fitness for Interview (Dr Romey Giles), CB 665; evidence of Dr Romey Giles, T 781:12 – T 782:7.
[71] Statement of Awash Prasad, Exh 8 [4]-[5].
[72] Statement of Joy Barrowman, CB 1947 [3.1].
[73] Evidence of Michelle Millen, T 149:28 – T 150:19; T 152:5-30; T 185; evidence of Dr Devapriya Rudolph, T 338.

73.4. The doors to the Clinic were closed. The Clinic was open between 10am and 4pm but closed for one hour from 12.30pm, but the Clinic would always see walk-in clients and never turn someone away all hours.[74] The Clinic's phones were operational as per usual so the Clinic could take calls from 9am to 5pm.[75]

73.5. This evidence is to be contrasted with the statement provided by Richard Buck, nurse and casual employee of the Clinic on 14 July 2020. Mr Buck stated that at this time, '*people were not able to access the building without an appointment due to COVID-19 restrictions in place.*'[76]

73.6. Patients seeking access to the Clinic were not able to bring a family member or friend with them.[77]

Submissions

74. At the conclusion of the inquest, Melbourne Health submitted that it was open to find that Gabriel and Lilla Messo attended Broadmeadows Health Service on 14 July 2020 but the evidence was not conclusive. Submissions made on behalf Northern Health noted the lack of direct evidence as to whether or not Gabriel was actually refused entry to Broadmeadows Hospital or, if so, what the cause of that was. Northern Health submitted that it was speculative to find Lilla and Gabriel were not permitted entry to Broadmeadows Hospital, or believed they were not permitted to enter.

75. Counsel Assisting submitted that the evidence of Gabriel and Lilla's attendance at Broadmeadows Hospital on 14 July 2020 was compelling, reference being made to the evidence of conversations that Gabriel and Lilla had that preceded, were contemporaneous with, and post-dated that attendance (as set out at paragraphs 72.1 to 72.4 above). Counsel assisting also referred to the fact that Fuat Messo was not challenged in respect of his evidence and no suggestion was made by any interested party that he was mistaken or misremembered the contents of his conversations with Lilla on 14 July 2020. Similarly, there was no application by any interested party for Mr Aygur to be called as a witness and his statement was tendered without challenge or dispute.

76. Counsel Assisting submitted the evidence demonstrated that, due to COVID-19 restrictions, Gabriel and Lilla Messo were denied entry into, *or at least believed* they were unable to enter, the Broadmeadows Hospital. The evidence in support of this does not result in an exercise of speculation because it arises from the evidence of what was said by Lilla to Fuat Messo and the timing and circumstances in which it was said make

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[74] Statement of Joy Barrowman, CB 1947 [3.1]-[3.10]; evidence of Dr Lokesh Sekharan, T 265:26-31; evidence of Dr Devapriya Rudolph, T 335:4-9.
[75] Evidence of Michelle Millen, T 151:1-3, 23-29.
[76] Statement of Richard Buck, CB 1728 [1.13].
[77] Evidence of Michelle Millen, T 152:21-27.

it highly probable that it was true. While the evidence may be indirect in the sense that it is hearsay, statements of intention and those made contemporaneously with their attendance at the hospital are probative of their intention, purpose, location, and circumstances during the course of that afternoon.

77. Counsel Assisting also submitted that some Broadmeadows Hospital and Clinic staff did not understand the applicable COVID-19 restrictions and how they applied to attendees at the Clinic, but there was insufficient evidence for the Court to make a positive finding that any particular person or organisation can be identified as the reason why they were not able to physically access the Clinic on 14 July 2020. At its highest, the evidence suggests misunderstanding - not malfeasance - on behalf of Northern Hospital staff.

78. Melbourne Health and Northern Health both submitted that there was no evidence Gabriel and Lilla Messo were denied access to the Clinic on the basis of a misapprehension of policies. Melbourne Health noted in particular that Mr Buck (whose evidence is referred to at paragraph 73.5 above) was a causal employee of the Clinic and this, the passage of time, and the early stage of COVID-19 restrictions would explain his apparent confusion. Northern Health submitted there were a number of alternative explanations for their lack of attendance, including Gabriel losing patience, or a valid reason for preventing his access under COVID-19 protocols.

<u>Comments</u>

79. I am satisfied that Lilla and Gabriel attended at the Broadmeadows Hospital on 14 July 2020 with the intention of attending the Broadmeadows Community Mental Health Clinic. Further I am satisfied that neither Lilla nor Gabriel gained access to the Clinic although the evidence does not allow me to determine the reason(s) why. A number of possibilities exist, including but not limited to:

    79.1. Lilla and Gabriel were denied access at the entry to the Broadmeadows Hospital due to the COVID-19 protocols in force at the time (either being correctly applied or alternatively there being a misapprehension of the policies); or

    79.2. Lilla and Gabriel believed, incorrectly, that they had been denied entry to the Broadmeadows Hospital to access the Clinic; or

    79.3. There being some confusion regarding Gabriel's status as a 'patient', and Lilla's status as a 'visitor', resulting in them being denied entry to the Broadmeadows Hospital to access the Clinic;

    79.4. Gabriel became frustrated by the changed arrangements for access and did not persist in attempting to gain access to the Broadmeadows Hospital to access the Clinic.

80. The state of the evidence does not enable me to make a finding as to the reason(s) why Gabriel did not access the Clinic on 14 July 2020.

81. Regardless community mental health services need to be readily accessible to those in need, and whilst in July 2020 COVID-19 restrictions may have created confusion and misunderstanding, individuals and families of those suffering mental health conditions must be able to access services easily, and in a timely way. Management of mental health facilities must be diligent in ensuring that the introduction of new policies and procedures, whether driven public health issues such as COVID-19, or for some other reason, are not creating barriers to access services.

Gabriel's telephone call to NWAMHS on 14 July 2020

82. On 14 July 2020, Michelle Millen was the Duty Clinician for the Hume Community Team at the Clinic. At approximately 2pm, she received a call from Gabriel who was put through to her by the Clinic's reception staff. The initial phone line was poor so Ms Millen advised Gabriel she would end the call and call him back immediately in order to get a clearer line.[78]

83. During that time, Ms Millen accessed Gabriel's file which included the following information:

    83.1. Gabriel's long history of Bipolar Affective Disorder and cannabis use, including multiple hospital admissions;

    83.2. Gabriel had ceased all psychotropic medications when he was discharged off the CTO in 2019;

    83.3. discharge summary from 9 January 2020 which outlined Gabriel's clinical history and case management with the Clinic's Hume Community Team;

    83.4. Gabriel's history of poor engagement with mental health services;

    83.5. Gabriel's symptoms when unwell including impulsivity, risk-taking behaviour, aggression, and substance use among other things; and

    83.6. medical records on the Client Management Information (**CMI**) system which included notes from Fuat's contact with the Clinic between 2-9 July 2020 (referred to at paragraphs 56 to 61 above), a referral to Gabriel's previous treating team and the withdrawal of that referral.[79]

[78] Statement of Michelle Millen, CB 1643 [2.14].
[79] Statement of Michelle Millen, CB 1643-1644 [2.15]-[2.19]; evidence of Michelle Millen, T 188:2 – T 191:26.

84. Ms Millen could not recall reading the record of Fuat's call to the NWAMHS on 18 June 2020 (referred to at paragraph 23 above) which noted concerns about Gabriel being potentially a risk to himself and others and they had to remove him from the family home. She was not aware that the circumstances surrounding Gabriel moving out of home involved concerns about his family's safety.[80]

85. During the telephone call, Gabriel told Ms Millen that he was calling to see whether he could re-start anti-psychotic treatment but expressed concern about being placed back on a treatment order. He reported he did not sleep at all the previous night and was feeling a bit irritable and agitated as a result. He confirmed he had not been on any medication since January 2020. He denied the following: using substances; experiencing paranoid thoughts; suicidal ideation or self harm. All of these matters are recorded in Ms Millen's notes.[81]

86. Although it is not referred to in her notes, Ms Millen gave evidence that she did specifically ask Gabriel about his risk in relation to thoughts of harm to others. She was confident of this based on her invariable practice and had an independent memory of doing so.[82] Ms Millen's evidence was that Gabriel denied any risk to himself or others.[83]

87. Ms Millen also noted that Gabriel sounded a little guarded in his responses to questions about his mental state and answered these questions somewhat abruptly. Ms Millen considered that Gabriel sounded quite agitated and with some mild pressure of speech.[84]

88. Armed with this information, Ms Millen gave evidence that she performed a screening mental state assessment which included a risk assessment. She assessed Gabriel to be a category D on the triage scale which required a 'semi-urgent mental health response' to be provided within 72 hours (category C required urgent contact within 8 hours while category E required a response within seven days). Her reasons for this included the fact Gabriel was showing insight and seeking help, he had only experienced one night of disturbed sleep, he was showing only mild pressure of speech but otherwise articulated a clear thought stream, that he was living away from his family,[85] and his history of quick relapse.[86]

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[80] Evidence of Michelle Millen, T 193:28 – T 195:25; T 228:21 – T 229.
[81] NWAMHS Screening Register Detail, CB 1718.
[82] Statement of Michelle Millen, CB 1647 [4.14]; evidence of Michelle Millen, T 203:2-29.
[83] Statement of Michelle Millen, CB 1644 [2.30].
[84] Statement of Michelle Millen, CB 1644 [2.28], [2.32]; NWAMHS Screening Register Detail, CB 1718.
[85] It is noted that Ms Millen viewed Gabriel living away from his family as a risk factor in circumstances where she knew his family were a great source of support and was not aware of the circumstances of Gabriel moving out: T 204:3-19.
[86] Statement of Michelle Millen, CB 1644 [4.3]-[4.13].

89. Ms Millen's evidence was that the computerised system used by NWAMHS to record triage risk assessments was not the most user-friendly system. Despite this, and despite there not being one centralised place setting out all of the factors to consider as part of as triage risk assessment, Ms Millen considered that her knowledge and experience in conducting such assessments ensured she covered all of the relevant considerations.[87]

90. At the conclusion of the call with Gabriel, Ms Millen arranged a referral to the Hume Brief intervention team for follow-up and provided a written and verbal handover.

91. Ms Millen gave evidence that she was not aware that Gabriel was, or had been, physically in attendance at Broadmeadows Hospital, or that Lilla was with him.[88] She did not ask him where he was when they spoke on the phone. Her evidence was that she would have invited him into the Clinic if she had known he was there, however, Gabriel was not seeking an immediate face-to-face assessment and he agreed to a plan for that to occur in the next few days. Despite it not being in her notes, Ms Millen's evidence was that she asked Gabriel how soon he wanted to be seen and 'put it on the table' that he could come in that day.[89]

92. Had Ms Millen known Gabriel was at Broadmeadows Hospital when she took his call, she also would have conducted a face-to-face mental state examination and taken the opportunity to speak to Lilla with Gabriel's consent (noting Lilla would not have been able to attend the Clinic at the same time as Gabriel due to the above mentioned COVID-19 restrictions), but Ms Millen could not speculate how these factors might have influenced her triage assessment.[90]

93. Evidence from both Ms Millen and Dr Sekharan was that if Gabriel had attended the Clinic in person on 14 July 2020, he would likely have been examined and, given his long-term and recent mental health history, he would likely have received assistance.[91] Dr Sekharan was present at the Clinic on the afternoon of 14 July 2020 but he had some doubt as to whether he or a consultant psychiatrist would have been available to see Gabriel had he presented in person. However, Dr Sekharan agreed in evidence that, had Gabriel attended in person, he would definitely have been seen by either a registrar or consultant psychiatrist, and consideration would have been given to him recommencing his medication.[92]

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[87] Evidence of Michelle Millen, T 180:8 – T 182:22.
[88] Evidence of Michelle Millen, T 184:23 – T 185:2.
[89] Statement of Michelle Millen, CB 1646 [4.6]; evidence of Michelle Millen, T 196:14-19; T 205:25–T 209:15.
[90] Evidence of Michelle Millen, T 199:22 – T 200:30.
[91] Evidence of Michelle Millen, T 163:4-20; Clinical risk assessment and management in the community form, CB 1650; Assessment form, CB 1652.
[92] Evidence of Dr Lokesh Sekharan, T 268:31 – T 270:22; evidence of Michelle Millen, T 206:25-29.

94. After Ms Millen's call with Gabriel, she also spoke to Fuat Messo on the afternoon of 14 July 2020. Ms Millen gave evidence that the information she received from Fuat did not include anything about threats to harm himself or anyone else, but that Fuat was a concerned parent who was trying to support Gabriel to recommence medication and treatment. Ms Millen relayed that information to the Hume Community Team verbally, that Fuat shared Ms Millen's concerns that Gabriel needed to be seen and to recommence medication.[93]

95. On the evening of 14 July 2020, Mr Aygur visited Gabriel to calm him down. After Mr Aygur left, Gabriel texted him: '*This is written confirmation that the meds are a must. We need a quick fix, too much risk on falling on them for life plus I deserve it. I've been piss farting around too much. Make sure Frank follows up with them tomorrow and hammers their fucking life's*.'[94]

96. Fuat also telephoned NWMH after-hours triage service on two occasions that evening, at 7.22pm and 9.37pm. He was on hold for approximately 23 minutes on each occasion. Fuat's calls went unanswered.[95] NWMH has no record of the calls.[96]

97. In the following days, the Clinic tried to follow up with Gabriel in line with Ms Millen's triage categorisation but were unsuccessful in their attempts to contact him.[97]

<u>Submissions</u>

98. Melbourne Health accepted that, if Gabriel had attended the Clinic in person, he would have received a face-to-face mental state examination. Counsel Assisting highlighted the evidence and submissions before the Court acknowledged, or certainly strongly implied, that visible observations of a patient undergoing a mental state assessment are a critical aspect of that task. Counsel Assisting also submitted that it was open for the Court to find that it is more likely then not that, had Gabriel attend the Clinic, he would have been seen by a psychiatrist.

99. Counsel appearing on behalf of Gabriel's family made submissions that Ms Millen's evidence about offering to see Gabriel face-to-face was implausible because it was not noted in her contemporaneous records nor was it mentioned in her statement to the Court. Gabriel's family also submitted that given Gabriel was outside the Clinic trying to gain entry when the alleged offer was made, his alleged refusal to take up Ms Millen's offer to see him face-to-face at the Clinic is highly improbable.

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[93] Evidence of Michelle Millen, T 178:5-22; statement of Michelle Millen, CB 1645 [2.41].
[94] Statement of Sabri Aygur, CB 198-199.
[95] CCRs, CB 1386a; Statement of Fuat Messo, CB 2105; evidence of Fuat Messo, T 64:9 – T 65:24.
[96] Exhibit 7: Statement of Kirsty Barger, 21 July 2022.
[97] NWMH screening register notes, 14-16 July 2020, Ex 80 of CB 486-488.

100. Gabriel's family also submitted that Ms Millen did not consider adequately or at all whether Gabriel posed a risk to him or others during her triage assessment: she made no note of any such risk assessment and, had she made a proper assessment she would have determined that Gabriel posed a risk to others. Gabriel's family pointed to the evidence of Dr Rudolph that, having regard to the information before Ms Millen,[98] Dr Rudolph agreed that Gabriel posed a risk to others as at 14 July 2020.[99]

101. Counsel Assisting and Melbourne Health both submitted that based on the information Ms Millen knew, her triage categorisation of Gabriel was appropriate. Melbourne Health further submitted that the evidence of Dr Rudolph in relation to the risk posed by Gabriel on 14 July 2020 must be considered in the context of Dr Rudolph's other evidence, namely, his opinion that Ms Millen's risk assessment on that day was appropriate.[100]

Comments

102. Gabriel's telephone call to NWAMHS was the second attempt he made to access treatment on 14 July 2020 and indicated his strong desire to re-engage with mental health treatment. I accept that Ms Millen did not know that Gabriel was in attendance at Broadmeadows Hospital, and I also accept her evidence that had she been aware of this she would have invited Gabriel to attend the Clinic. It is possible that had Gabriel attended in person at the invitation of Ms Millen, that he may have been seen by a psychiatrist and possibly prescribed medication, however this would inevitably have depended on the workloads of other staff on the day.

103. The assessment undertaken by Ms Millen was thorough and comprehensive and at the conclusion of her risk assessment she determined that the appropriate triage category was Category D (follow up within 72 hours). Ms Millen considered Category C (follow up in 8 hours) was more urgent than required and Category E (follow up in 7 days) was not appropriate as Gabriel required a more urgent response. I find that Ms Millen's assessment was reasonable and appropriate.

104. Ms Millen was an experienced and competent practitioner. In her evidence she observed that the IT system supporting staff was sub optimal and did not facilitate accessing a patient's mental health history and relevant documentation with ease. Whilst an experienced practitioner like Ms Millen was able to complete the assessment without all relevant material being available in a single, easily accessible module, steps should be taken by management of NWAMHS to ensure that such resources are collated and readily accessible to all staff. This resource will assist in ensuring that assessments are being completed in a timely manner applying the appropriate criteria.

[98] Gabriel's family listed these factors as including Gabriel's history of deteriorating mental health linked to non-compliance with medication; Gabriel not being on medication; recent display of physical aggression in the family home, Fuat's concerns after the episode of aggression in the family home that Gabriel's mental state would decline further; Gabriel's potential for active psychotic symptoms; Gabriel's risk of psychosis if his mental state were to decline further; lack of sleep the previous night; likelihood his mental state would deteriorate further if lack of sleep continued.

[99] Evidence of Dr Devapriya Rudolph, T 356:25-30.

[100] Evidence of Dr Devapriya Rudolph, T 352 – T 356.

105. I accept that later that evening, following Lilla conveying to Fuat their inability to access mental health services for Gabriel, that Fuat twice contacted the NWMH after hours triage, being on hold for approximately 23 minutes on each occasion, without either call being answered. Further I note that this is the number Fuat was specifically instructed to call upon Gabriel's discharge in January 2020, and during his phone call with NWAMHS on 8 July 2020. The importance of the NWMH after hours triage service cannot be overstated, it is a critical service for individuals and families attempting to navigate mental health crises. Its importance demands adequate resourcing to ensure that calls such as those made by Fuat do not go unanswered.

Incident leading to Gabriel's arrest on 15 July 2020

106. At approximately 4.30am on 15 July 2020, Noura and Nebil Messo, Gabriel's aunt and uncle, were asleep at their residence. Noura was awoken by knocking on the front door of the house that then transferred to knocking on her son's bedroom window. Noura then heard Gabriel calling out one of her son's names repeatedly. Noura immediately rang her nephew, Ilyas Tan, to come to the house and locked the bedroom door.[101] Gabriel then went around to the back door and damaged the security screen door and forced open the wooden door, damaging the door jamb and striker plate in the process.[102]

107. Noura left the bedroom and Gabriel entered the hallway of the house and started to walk towards one of Noura's son's bedroom. Noura told Gabriel that he couldn't go into that room and tried to hold him on his shoulders and push him away from the bedroom, resulting in Gabriel grabbing both her shoulders and throwing Noura to the ground. Noura's husband Nebil then tried to stop Gabriel from entering his son's room and a physical altercation occurred with Gabriel grabbing Nebil by the neck, overpowering him. Whilst Nebil and Gabriel were wrestling on the ground Mr Tan arrived and a physical altercation then occurred between Gabriel and Mr Tan. Mr Tan ended up pinning Gabriel to the ground between the bed and the wall allowing Noura to contact triple zero.[103]

108. Noura called triple zero, handing the phone to a family member who advised: '*he has a weapon. The intruder. He broke into our house and has a weapon… he has a knife. He has a knife. We're trying to hold him down.*'[104]

[101] Statement of Noura Messo, CB 225; statement of Nebil Messo, CB 232; statement of Ilyas Tan, CB 237-238; Recordings of 000 calls, Exhibit 85 of CB; transcript of 000 calls, CB 842-856.
[102] Photographs of damage occasioned, CB 651-657.
[103] Statement of Noura Messo, CB 225-226; statement of Nebil Messo, CB 232.
[104] Recording of 000 call, Exhibit 85; transcript of 000 call, CB 643.

109. Mr Tan managed to restrain Gabriel until police arrived. Noura sustained bruising whilst Nebil sustained bruises, scratches and pain in his neck. He was further described to have sustained a bloody toe, grazing to his knuckles and had a minor neck laceration.[105]

110. Gabriel had developed an obsession with his young cousin in recent times and the incident on 15 July 2020 had followed another incident the day before when Gabriel called Noura at 1am wanting to take his young cousin to the park and attended another family member's house to do so. Mr Tan also attended on that occasion and managed to pacify the situation.[106]

Gabriel's s 351 transfer to Royal Melbourne Hospital on 15 July 2020

111. At approximately 4.46am First Constable (**F/C**) Brandon Lees and F/C Devin Ryan were dispatched by D24 police communications in response to calls of an aggravated burglary whereby an offender had broken into a house in Broadmeadows. Information provided to them enroute to the scene was that the offender had entered the house possibly armed with a knife and was being held down by the occupants of the house. Further information provided was the offender was the nephew of the person who had telephoned police and he was possibly under the influence of drugs.[107]

112. F/C Lees and Ryan were the first Victoria Police members to arrive at Noura and Nebil Messo's residence at approximately 4.50am. Both officers activated their body worn cameras (**BWC**).[108] F/C Lees and Ryan located Mr Tan in one of the bedrooms restraining Gabriel who was face down on the floor. F/C Ryan placed Gabriel in handcuffs.

113. F/C Ryan conducted a pat down search of Gabriel, which did not reveal any weapons, and assisted Gabriel to sit up. F/C Ryan noticed that although Gabriel was calm, he was sweating profusely and there was blood on the floor and on Gabriel's face. Upon seeing the blood, F/C Ryan requested an ambulance to be dispatched and F/C Lees made that request via radio.[109]

114. F/C Ryan placed Gabriel under arrest for aggravated burglary, cautioned him and explained to him his rights. Gabriel answered questions that were asked of him, stating that he did not reside at the house and was not drug or alcohol affected. F/C Ryan believed Gabriel *was* drug and/or alcohol affected given he was so heavily sweating.[110]

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[105] Statement of Noura Messo, CB 226; statement of Nebil Messo, CB 232; statement of First Constable Jessie Coletti, CB 264 [5], [9].
[106] Statement of Ilyas Tan, CB 239-240.
[107] Statement of F/C Devin Ryan, CB 253.
[108] Exhibits 8 and 9.
[109] Statement of F/C Ryan, CB 254; evidence of F/C Ryan, T 387.
[110] Statement of F/C Ryan, CB 254-256; evidence of F/C Ryan, T 387-388.

115. Other police members arrived at the scene, including Detective Senior Constable (**D/S/C**) Georgia Hammond and Senior Constable (**S/C**) Patrick Cotterill. The information provided to them was that a male with a knife was inside the premises and being held down by occupants.[111] Upon arrival, D/S/C Hammond and S/C Cotterill confirmed with police members present that there was no knife located or involved in the incident.[112]

116. D/S/C Hammond and S/C Cotterill entered the bedroom and had a conversation with Gabriel who stated the following:

    116.1. He could not explain what happened;

    116.2. It was his uncle's house and he walked there from Gladstone Park;

    116.3. He had mental health issues and had been diagnosed with chronic bipolar and schizophrenia;

    116.4. He had not been taking medication since August 2009;

    116.5. He had had a scuffle with 'the big boy' [Mr Tan];

    116.6. He came to the house to speak to his little cousin and as soon as his aunty and uncle touched him he got aggressive;

    116.7. He broke the back door to gain entry but could not explain why he did so;

    116.8. His mind was so scattered right now, he was feeling mentally stressed out and did not wish to answer questions.[113]

117. D/S/C Hammond's observations were that Gabriel appeared 'extremely drug affected and delusional.' She observed Gabriel could barely open his eyes and was sweating profusely.[114] S/C Cotterill also observed Gabriel was sweating profusely.[115] F/C Ryan observed Gabriel to be short of breath, tired, disoriented but still well spoken.[116] F/C Ryan continued to believe Gabriel may have been affected by alcohol or drugs because Gabriel could not tell police why he was at the address, what he had gone to do, and it was odd for someone to walk so far from his own residence at 4.50am.[117]

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[111] Statement of S/C Patrick Cotterill, CB 271; statement of D/S/C Georgia Hammond, CB 275.
[112] Statement of S/C Patrick Cotterill, CB 271-272.
[113] Statement of S/C Patrick Cotterill, CB 272; statement of D/S/C Georgia Hammond, CB 275; statement of F/C Devin Ryan, CB 256-257; BWC footage of F/C Ryan, exhibit 9 from 9:40-12:20.
[114] Statement of D/S/C Georgia Hammond, CB 276.
[115] Statement of S/C Patrick Cotterill, CB 272.
[116] Statement of F/C Devin Ryan, CB 257.
[117] Evidence of F/C Ryan, T 388:7-25.

118. S/C Cotterill then spoke with Noura and Nebil Messo who stated Gabriel had a fixation with his cousin.[118] D/S/C Hammond spoke with Noura Messo who stated Gabriel had developed a 'strange obsession' with her son recently and had been attending their house frequently, asking to take the child to the park. Noura stated they had been sending the child to stay with other relatives to avoid any interaction with Gabriel.[119]

119. A paramedic arrived and spoke to Gabriel. Gabriel provided the following additional information in the presence of F/C Ryan:

    119.1. He had not slept well in a month and had not slept at all last night or tonight;

    119.2. He had gone to Broadmeadows mental health the previous day and told them he needed anti-psychotics;

    119.3. He was short of breath and exhausted.[120]

120. The paramedic assessed Gabriel's physical injury. She did not consider he needed to be taken to hospital. S/C Cotterill stated he had concerns about Gabriel's mental health, and the paramedic confirmed Gabriel's lack of sleep and his attempt to seek help the day before. The paramedic asked further questions of Gabriel to which Gabriel stated he tried to get help from Broadmeadows Mental Health the day before due to lack of sleep; he was not planning to hurt himself or others when he arrived at the house; he was not hearing voices or seeing people who weren't there; he has not attempted to self-harm in the past; and he confirmed his diagnosis of bipolar and that he was not taking medication.[121]

121. Following this discussion, F/C Ryan left Gabriel in the bedroom and turned off his BWC. He understood a decision was made to transfer Gabriel to hospital pursuant to s 351 of the Mental Health Act but he could not recall when or how he was made aware of that confirmed decision (beyond the discussion between S/C Cotterill and the paramedic referred to above) and he could not recall any further conversations that he had with S/C Cotterill.[122]

122. Section 351 of the Mental Health Act affords a police officer the power to apprehend a person if the police officer is satisfied that the person appears to have mental illness and because of the persons' apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or another person. As soon as possible after apprehending a person under s 351, a police officer must arrange for the person to be taken to a registered medical or mental health practitioner or hospital to examine the person in accordance with s 30 of the Mental Health Act to determine whether to make an Assessment Order.[123]

[118] Statement of S/C Patrick Cotterill, CB 272.
[119] Statement of D/S/C Hammond, CB 277.
[120] Statement of F/C Devin Ryan, CB 257; BWC footage of F/C Ryan, exhibit 9 from 23:20-34:30.
[121] BWC footage of F/C Ryan, exhibit 9 from 28:40-34:30.
[122] Evidence of F/C Ryan, T 395.5 – T 395.23.
[123] Section 351(5) of the Mental Health Act. An Assessment Order enables a person who is subject to the Assessment Order to be compulsorily examined by an authorised psychiatrist or taken to, and detained in, a designated mental health service and examined there by an authorised psychiatrist: s 28 of the Mental Health Act. Section 30 sets out the requirements of an

123. After S/C Cotterill discussed Gabriel's case with Acting Detective Sergeant Sue Norman, they decided, due to mental health concerns for Gabriel that he would be transferred to hospital under s 351 of the Mental Health Act (**s 351 transfer**).[124]

124. At approximately 5.48am, Constable Jack Goodchap and Leading Senior Constable (**L/S/C**) Paul Van Krieken were tasked to attend the scene to assist with Gabriel's s 351 transfer to hospital. They arrived as Gabriel was being loaded into the ambulance.[125]

125. Constable Goodchap and L/S/C Van Krieken were briefed by F/C Ryan and F/C Lees. There are no notes of this briefing, and it is not captured on BWC. F/C Ryan had no memory of the information he provided but his understanding of the reasons for the s 351 transfer included the fact that Gabriel was diagnosed with chronic bipolar and schizophrenia, he was unmedicated, had not slept in a few days, and he could not tell police why the incident had occurred or why he had walked so far. F/C Ryan did not believe he had any conversations with family members while he was at the scene and did not believe he received information about Gabriel's recent obsession with his cousin and had been coming to the house frequently asking to take the cousin to the park.[126]

126. Constable Goodchap gave evidence that he and L/S/C Van Krieken were provided with the following information either from F/C Ryan or the electronic patrol duty return notes:

    126.1. Gabriel had broken into the property, a family member's house;

    126.2. He had smashed the front door down and had a knife;

    126.3. Gabriel was erratic; and

    126.4. the s 351 transfer was due to Gabriel's uncertain mental state and clearly being a danger to himself and others.[127]

Assessment Order assessment, which includes consideration of the criteria are set out in s 29, namely whether the person appears to need immediate treatment to prevent serious deterioration in the person's mental or physical health or serious harm to the person or another.

[124] Statement of S/C Cotterill, CB 272.

[125] Statement of Constable Goodchap, CB 280.

[126] Evidence of F/C Ryan, T 396:1 – T 397:12; T 399:6 – T 400:28.

[127] Statement of Constable Goodchap, CB 280; evidence of Constable Goodchap, T 419:10 - T 421:25; ePDR for Constable Goodchap and L/S/C Van Krieken, 15 July 2020, CB 2051-2052.

127. L/S/C Van Krieken gave evidence that he and Constable Goodchap were provided with the following information either from F/C Ryan, F/C Lees or the electronic patrol duty return notes:

  127.1. Gabriel was under arrest but needed to be transported for a mental health assessment;

  127.2. Gabriel had broken into the property, a family member's house, and a person had been assaulted;

  127.3. He had smashed the front door down and had a knife;

  127.4. Gabriel's behaviour had raised concerns with family members which led to the decision for the s 351 transfer.[128]

128. Constable Goodchap and L/S/C Van Krieken gave evidence that they did not recall being provided with the following information:

  128.1. Gabriel had become aggressive when touched by his aunt and uncle;

  128.2. Gabriel could not explain why he was at his aunt and uncle's house;

  128.3. Gabriel had walked from his residence to his aunt and uncle's house that morning, a distance of approximately 5km;[129]

  128.4. Gabriel had attended Broadmeadows Mental Health the day before and told them he needed anti-psychotics;

  128.5. Gabriel had not slept at all for two nights, and had not slept well for a month.[130]

129. Constable Goodchap and L/S/C Van Krieken did not speak with any other police officers at the scene, including S/C Cotterill, about the reasons for Gabriel's s 351 transfer. The only information they received was from F/C Ryan and F/C Lees.[131] Constable Goodchap and L/S/C Van Krieken did not know who made the s 351 transfer decision.[132]

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[128] Statement of L/S/C Van Krieken, CB 1353; evidence of L/S/C Van Krieken, T 508:29 – T 509:11; T 512:14-28.
[129] L/S/C Van Krieken gave evidence that he may have been told this information at some point but was unsure when: T 513: 4-8.
[130] Evidence of Constable Goodchap, T 430:1 – T 431:24; T 462:2-9; evidence of L/S/C Van Krieken, T 512:29 – T 513:19.
[131] Evidence of Constable Goodchap, T 419:8-12; evidence of L/S/C Van Krieken, T 508:16 – T 510:21.
[132] Evidence of Constable Goodchap, T 450:17-19; evidence of L/S/C Van Krieken, T 509:29 – T 510:2, T 534:29-30; T 535:25-28.

130. Constable Goodchap's understanding of why Gabriel had been transferred to hospital was that he had broken into his cousin's house, he was a danger to others and attacked a person inside that house, he was erratic and suspected of having a mental health condition.[133] L/S/C Van Krieken's understanding of the reasons for Gabriel's s 351 transfer were that Gabriel's behaviour had raised concerns with family members which led to the decision for the s 351 transfer.[134]

131. Gabriel was transported by ambulance to Royal Melbourne Hospital. Constable Goodchap travelled with Gabriel in the ambulance while L/S/C Van Krieken followed in the police divisional van. In the ambulance, Gabriel told Constable Goodchap that he had bipolar and he had not been taking his mediation.[135] The ambulance arrived at RMH at 6.18am, Gabriel was triaged at 6.30am and off stretcher at 6.36am.[136]

132. Constable Goodchap completed a Victoria Police mental disorder transfer form while he was travelling in the ambulance and waiting in the Emergency Department (**ED**). In the section of the form headed 'reason for police involvement', Constable Goodchap checked the box 'psychiatric crisis'. In the section of the form which was headed 'Circumstances', Constable Goodchap wrote:

> *At approx. 0443 Gabriel has broken into the [above address] and attempted to attack a resident who was a family member. As Gabriel appeared erratic confused and this behaviour is out of place he has been deemed a danger to himself and others.*[137]

133. Constable Goodchap gave evidence that he did not provide this form to anyone at the hospital until it was signed by a doctor upon Gabriel's release back into police custody. Constable Goodchap stated that he understood the purpose of the form was for Victoria Police records not for the hospital.

134. Hospital policy at the time, which has not changed, contemplate police duties to include identification of the patient upon arrival and the reason for presentation, the situation including patient cooperation and any perceived risks.[138] The DHHS-Victoria Police protocol for mental health provides that '*police should provide clear and comprehensive verbal information to the accepting clinical staff*' which includes details of the incident, safety and risk factors, drug and alcohol history, intervention orders, family court proceedings and family circumstances.[139]

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[133] Evidence of Constable Goodchap, T 426:9-19.
[134] Evidence of L/S/C Van Krieken, T 508:29 – T 509:11.
[135] Evidence of Constable Goodchap, T 425:25-29.
[136] VACIS electronic patient care record, CB 863.
[137] Mental Disorder Transfer Form, CB 2107.
[138] Management of Patients Arriving with Police at RMH, CB 1881.
[139] DHHS-Victoria Police protocol for mental health, CB 1415.

135. The Victoria Police Manual, by contrast, states only that:

> *Members may be required to provide information (e.g. observations about a person's behaviour, demeanour etc) to the registered medical/mental health practitioner to assist in determining whether Assessment Order criteria applies to the person.*[140]

It is only in the context of arranging for a mental health examination within a community setting (as opposed to a hospital setting, as was the case for Gabriel) that the Victoria Police Manual recommends that police members should document sufficient information on the circumstances of the person's apprehension in the Mental Disorder Transfer form '*to assist the mental health practitioner in conducting an examination.*'[141]

136. L/S/C Van Krieken gave evidence that upon arrival in the ED, he understood Ambulance Victoria officers performed a handover with hospital staff. He was not present for the handover and did not recall providing a briefing to medical staff himself. L/S/C Van Krieken's evidence was that he was not questioned substantively by hospital staff as to the reasons for Gabriel's s 351 transfer.[142] L/S/C Van Krieken did recall an older Caucasian male in scrubs approach him and question him about why Gabriel had been presented for a s 351 assessment when it was the role of the Forensic Medical Officer to advise if a person was fit for interview or not. L/S/C Van Krieken described this discussion as being 'the first time I've been cross-examined by a member of the medical staff at a hospital about our powers'. L/S/C Van Krieken advised that person it was because of the concerns held by police at the scene given Gabriel's demeanour, but did not provide any information about police reasoning for Gabriel's s 351 transfer or information about his demeanour or the alleged offending because the person (who has not been identified) was questioning the process rather than Gabriel's mental state.[143]

137. L/S/C Van Krieken did not have a discussion with any hospital staff about the information he had in relation to the incident that had occurred at Gabriel's aunt and uncle's house or Gabriel's mental state. He believed that information was handed over by Constable Goodchap, but was not present for such a handover. He noted that, at times Constable Goodchap interacted with medical staff but he did not recall observing Constable Goodchap speaking to a female doctor.[144]

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[140] Victoria Police Manual Guidelines – Mental Health Act apprehensions, CB 1399.
[141] Victoria Police Manual Guidelines – Mental Health Act apprehensions, CB 1399.
[142] Evidence of L/S/C Van Krieken, T 536:26 – T 538:3.
[143] Statement of L/S/C Van Krieken, CB 1390-1391; evidence of L/S/C Van Krieken, T 523:9 – T 525:18; T 537:16-25.
[144] Evidence of L/S/C Van Krieken, T 523:5-8; T 525:15-20; T 527:3-5; T 534:15-23.

138. Constable Goodchap gave evidence that he provided verbal information to a hospital staff member that he described as a Caucasian male with a solid build wearing either black scrubs or a black shirt, and this occurred when Gabriel had been triaged and placed in an ED cubicle.[145] In response to questioning about whether he provided any information during that conversation about the reasons for Gabriel's s 351 transfer, Constable Goodchap stated:

> *I believe I provided some details and then L/S/C Van Krieken would've provided some but often we provide a very brief outline because it's not our job to – like so we give them the rough information on why they're here and what information we've roughly got but we have no bearing on whether someone is kept, why they would or wouldn't be kept because that's up to the medical professionals to talk to Gabriel and figure out what's actually going on and if he's supported enough or requires to stay.*[146]

139. Constable Goodchap believed he also told this person that Gabriel had mentioned his bipolar diagnosis and that he was off his medication.[147] The hospital staff member who Constable Goodchap believes he spoke to was unable to be identified in the course of the coronial investigation.

140. There are no hospital records of a police member providing a handover to hospital staff. The registered nurse who triaged Gabriel, Maria Hatton, and the ED nurse, Melvin Khor, both gave evidence that they did not receive any information from Victoria Police.[148] Ms Hatton and Mr Khor both received handovers from Ambulance Victoria.[149] The ED registrar who assessed Gabriel, Dr Amelia Scharkie, gave evidence that she could not recall police members being present.[150]

141. The information recorded by triage nurse, Ms Hatton, at 6.29am was as follows:

> *Attendance reasons updated: psychiatric (unable to sleep over past couple nights, tonight broke into cousins house and altercation police called and placed under section PMH [past medical history] bipolar, schizophrenia, drug induced psychosis) Section 351.*[151]

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[145] Statement of Constable Goodchap, CB 1287; evidence of Constable Goodchap, T 427:3 – T 428:5; T 432:12 – T 433:29; T 435:22 – T 436:25.
[146] Evidence of Constable Goodchap, T 434:3-13.
[147] Evidence of Constable Goodchap, T 427:3 – T 428:5; T 432:12 – T 433:29.
[148] Statement of Maria Hatton, CB 625 [2.2(c)]; evidence of Melvin Khor, T 574:12-17.
[149] Statement of Maria Hatton, CB 1625 [2.2(c)]; evidence of Maria Hatton, T 553:12-23; statement of Melvin Khor, CB 1628 [2.2(a)]; evidence of Melvin Khor, T 574:13-17; RMH ED patient timeline, CB 886-889.
[150] Evidence of Dr Amelia Scharkie, T 664:30–T 665:2; T 667:17-19; statement of Dr Amelia Scharkie, CB 1635.
[151] RMH ED Patient Timeline, CB 886.

142. Ms Hatton also answered 'yes' to the question: Is the patient an aggression risk?[152]

143. The information recorded by ED nurse, Mr Khor, at 6.33am included the following:

> *Patient story – bipolar, schizophrenia, drug induced psychosis, 2/7 unable to sleep, feels as though going through manic episodes, attempted to seek help at broady health but unable. This AM broke into cousin's house, altercation occurred – punched to face, nil LOC, nosebleed currently. Denies suicidal ideation / harm towards others. Actively wanting to seek help for mental health. Denies hallucinations… denies drug/alcohol use. Lethargy, fatigue.*[153]

144. After a short time, Constable Goodchap gave evidence that the same male hospital staff member signed the mental disorder transfer form and informed Constable Goodchap that Gabriel no longer exhibited signs of mental health crisis and police could take him back into custody. Although Constable Goodchap believed this person was a male and the same person he had spoken to earlier, he accepted that the person who signed the form may have been a female and someone he had not spoken to at all.[154] Evidence before the Court is that the person who signed the form was a female, namely Dr Scharkie. Constable Goodchap gave evidence that he only spoke to one staff member while he attended RMH with Gabriel on 15 July 2020 and did not recall speaking to a female hospital staff member.[155]

145. L/S/C Van Krieken did recall speaking to a female he believed to be a doctor, but described her as a middle-aged female with a dark complexion and short dark hair (this description did not match that of Dr Scharkie) who advised him Gabriel was not presenting in a manner that required an involuntary treatment order but he was free to stay for a voluntary assessment. L/S/C Van Krieken advised the doctor that Gabriel was under arrest so he would be returning to police custody and could obtain assistance in relation to his mental health upon release.[156]

146. Constable Goodchap and L/S/C Van Krieken took Gabriel back into police custody at approximately 7.05am.[157]

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[152] RMH ED Patient Timeline, CB 886.
[153] RMH ED Patient Timeline, CB 887.
[154] Evidence of Constable Goodchap, T 436:29 – T 437:16; T 439:12 – T 440:8.
[155] Evidence of Constable Goodchap, T 439:12 – T 440:8; T 442:8-9; T 460:3-14.
[156] Statement of L/S/C Van Krieken, CB 1391.
[157] ePDR for Constable Goodchap and L/S/C Van Krieken, 15 July 2020, CB 2052; statements of Constable Goodchap, CB 281 and 1388; statements of L/S/C Van Krieken, CB 1354 and 1392.

Submissions

147. Counsel Assisting submitted that it was open to the Court to find that details of the incident at Noura and Nebil Messo's residence on 15 July 2020, and the reasons for Gabriel's s 351 transfer, were not adequately conveyed to Constable Goodchap and L/S/C Van Krieken who were responsible for that transfer. Similarly, details of the incident and reasons for Gabriel's s 351 transfer were not adequately conveyed to hospital staff.

148. Counsel Assisting submitted it was open to the Court to find that L/S/C Van Krieken provided no handover to hospital staff, and to the extent that Constable Goodchap provided information to a hospital staff member, the evidence did not reveal who the male was or the content of the information to any great degree of specificity. Constable Goodchap was not only vague in his recollection, there were no notes (hospital or police notes) and his evidence was also the same male signed the mental health form which is demonstrably wrong.

149. Gabriel's family adopted the submission that there was no proper handover from Victoria Police to RMH staff on 15 July 2020 and, in order to appreciate the failing in this process they referred to the information in the possession of Victoria Police that was not passed on to RMH staff or requested by RMH staff. They noted that the incident at Noura and Nebil Messo's residence was a far from routine instance of possible aggravated burglary and the information police members had demonstrated profoundly bizarre criminal offending. Absent an adequate handover, there is a heightened risk of the true basis for the s 351 transfer being lost. Gabriel's family submitted that this was the case on 15 July 2020.

150. Gabriel's family further submitted that, had there been a proper handover from Victoria Police to RMH staff on 15 July 2020, proper consultation of the CMI would likely have occurred and/or engagement with a mental health practitioner. This is further explored in the section below.

151. Counsel for the CCP and police members questioned what more information should have been conveyed by police members who made the s 351 transfer decision, and police members transferring Gabriel to hospital. They queried the utility of police information in circumstances where they are not trained medical practitioners, paramedics provided sufficient information, and the purpose of a s 351 transfer is for a medical or mental health practitioner to conduct an assessment. They did accept that to reduce the risk of relevant information being missed, the decision maker should, where possible, directly brief the transporting officers as to the reason/s for a s 351 transfer.

152. Counsel Assisting submitted that there was scope for improved understanding by Victoria Police members that, although they do not have medical knowledge or experience, the information they have is important and relevant to hospital staff. The CCP and police members accepted that in their submissions. However, in the context of police officers not being trained medical practitioners, Counsel for the CCP and police members submitted that police will remain reliant on medical practitioners to ask specific questions to ensure that all relevant information is conveyed.

153. Counsel for the CCP and police members also submitted that the evidence suggested Constable Goodchap did conduct a handover with Dr Scharkie.

154. Counsel Assisting submitted it was not open to make a positive finding that Constable Goodchap conducted a handover with Dr Scharkie and that the inference that must be drawn from the evidence is that he did not.

<u>Comments</u>

155. The decision to take Gabriel into custody under s351 of the Mental Health Act was made by S/C Cotterill following a discussion with Acting Detective Sergeant Sue Norman. The transfer to RMH for assessment was undertaken by Constable Goodchap and L/S/C Van Krieken. They were briefed about the circumstances leading to the decision to take Gabriel into custody by F/C Ryan and F/C Lees. This briefing was not detailed and failed to include some relevant information. In particular the information in paragraph 128 above appears not to have been conveyed to Constable Goodchap and L/S/C Van Krieken.

156. It is clearly desirable that as much information as to the circumstances, background and history of the person apprehended be conveyed to the medical officer conducting the assessment, or hospital staff. The medical officer making the assessment will clearly benefit from having access to relevant information, particularly the circumstances leading to arrest, and events immediately before the incident. It is relevant that: Gabriel could not explain why he was at his aunt and uncle's house and became aggressive; that he had walked approximately five kilometres to get to the house where he forced entry; that he had been in contact with mental health services the day prior; that he had not slept at all for two nights and not slept well for a month and that he had an apparent obsession with his cousin. This information was not provided to Constable Goodchap or L/S/C Van Krieken and they could not convey this to hospital staff.

157. Where the arresting officer is not the transporting officer, it is critical that all information is provided to the transporting officer so that it can be provided to medical staff. This should include information about the events leading up to apprehension, any medical history that may be known, and relevant personal circumstances. Police officers do not need medical training to gather this information given it is not medical in nature.

158. I accept that shift work and rostering arrangements makes it very difficult to have the arresting officers or senior officer making the section 351 apprehension decision undertake the transfer, however this highlights the need to ensure that complete and comprehensive hand over information is provided to the members on the next shift.

159. It is wholly inadequate to rely on ambulance officers to convey this information, given they will generally be passing on information that is conveyed to them, whereas Police officers can provide firsthand information gathered contemporaneously. Further, notes of relevant information are highly desirable to ensure that the information conveyed can be checked. The full package of information may also prompt further questioning by the medical officer to obtain relevant mental health or medical records.

160. I note Victoria Police do complete a Mental Health Disorder Transfer form, but this does not contain detailed information that reflects the full picture of past history and circumstances. In any event it is considered by Victoria Police to be an internal document which does not carry a primary purpose of briefing medical staff. From evidence given this form is signed off by medical staff at the completion of the assessment and retained by Victoria Police for their records.

161. In summary I find that information about the incident at the home of Noura and Nebil Messo, and the circumstances of the s 351 arrest, were not adequately conveyed to Constable Goodchap and L/S/C Van Krieken by the officer making the s 351 decision. Further upon arrival at RMH neither Constable Goodchap or L/S/C Van Krieken provided a handover to hospital staff, rather it was left to Ambulance Victoria officers to provide this to the triage nurse and ED nurse.

162. Victoria Police should undertake further training of members regarding the critical importance of a thorough handover being provided by Police members to hospital staff on a s351 transfer. The training should include a focus on ensuring that police understand that the information in their possession, regarding a person's history and circumstances proximate to their apprehension, is important and relevant to hospital staff in completing their assessment and must be comprehensively relayed on all occasions.

Gabriel's assessment and treatment at Royal Melbourne Hospital on 15 July 2020

163. As soon as practicable after apprehending a person under s 351 of the Mental Health Act, police must arrange for the person to be taken to a registered medical or mental health practitioner or hospital to examine the person to determine whether to make an Assessment Order.[158] An Assessment Order allows a person to be compulsorily examined by an authorised psychiatrist (Community Assessment Order) or detained in a designated mental health service to be examined (Inpatient Assessment Order).[159]

164. The criteria for a person to be made subject to an Assessment Order are:

 164.1. The person appears to have a mental illness; and

 164.2. Because the person appears to have a mental illness, the person appears to need immediate treatment to prevent –

  (a) Serious deterioration in the person's mental or physical health; or

  (b) Serious harm to the person or to another person; and

 164.3. If the person is made subject to an Assessment Order, the person can be assessed; and

 164.4. There is no less restrictive means reasonably available to enable the person to be assessed.[160]

165. As noted at paragraphs 140 to 142 above, Gabriel was initially triaged by Ms Hatton. He was moved into an assigned room with the emergency department and then seen by ED nurse, Mr Khor at 6.33am.

166. RMH has an emergency mental health (**EMH**) team embedded within the ED to provide advice and secondary consultation to ED staff; psychiatric assessment; treatment where appropriate; care planning and linkage to other services for follow-up; facilitation of transfer to mental health inpatient units (where required); and undertake risk assessments of patients with psychiatric issues.[161] Not all patients brought to RMH ED under s 351 require a mental health assessment by the EMH team but if an ED clinician would like the EMH team to conduct a mental health assessment, they could make a referral via the electronic medical record, telephone or face to face.[162]

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[158] Section 351(5) *Mental Health Act*.
[159] Section 28 *Mental Health Act*.
[160] Section 29 *Mental Health Act*.
[161] NWMH Assessment in Emergency Departments, CB 1876-1877.
[162] Statement of Lewis McKenzie, CB 1632; evidence of Lewis McKenzie, T 613:21 – T 614.

167. EMH referrals may include, but are not limited to people who:

167.1. Are current clients of NWMH or other public mental health services;

167.2. Exhibit disturbed behaviour;

167.3. Have complex psychosocial problems;

167.4. Have behavioural disturbance associated with misuse of alcohol or other drugs; or

167.5. Experienced a personal or situational crisis.[163]

168. The EMH team had direct access to a psychiatrist at all times, whether it was between business hours, when a registrar and consultant psychiatrist was on-site, or after hours, when a registrar and a consultant would be on-call.[164]

169. Registered nurse Lewis McKenzie was the EMH clinician within the mental health team when Gabriel presented to the ED. Although he was due to finish his shift and was preparing handover to EMH clinicians who would arrive at 7am, Mr McKenzie was monitoring the ED electronic tracking board which displayed all patients in the ED and their reasons for presentation. Several minutes after Gabriel's arrival at RMH, Mr McKenzie noted his name on the tracking board and the reason for his attendance being 'psychiatric' under s 351 transfer. Mr McKenzie understood this meant Gabriel had been detained under the Mental Health Act.[165]

170. Mr McKenzie's evidence was that he would routinely search patients that presented with 'psychiatric' or 'section 351' reasons on the statewide mental health database known as the Client Management Interface (**CMI**). The CMI records contacts with the public mental health system and any admissions to hospital. Mr McKenzie knew the ED doctors and nurses **did not** have access to the CMI (indeed, they still do not have such access) so Mr McKenzie would search it to ascertain whether a person may have had previous contacts with public mental health services in Victoria.

171. If there was mental health history on the CMI, Mr McKenzie's practice was to search the NWMH database for any recent discharge or transfer summaries or reports which generally provide a patient's history, diagnosis, treatment, medications or risk concerns. If Mr McKenzie found such summaries or reports, he would copy and paste that information into a 'consult note' and upload it into the electronic medical record so it was accessible to the ED staff undertaking any subsequent assessment.[166]

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[163] Statement of Lewis McKenzie, CB 1632; evidence of Lewis McKenzie, T 613:21 – T 614.
[164] Evidence of Lewis McKenzie, T 604.
[165] Statement of Lewis McKenzie, CB 1631; evidence of Lewis McKenzie, T 612.
[166] Statement of Lewis McKenzie, CB 1631; evidence of Lewis McKenzie, T 620 – T 621.

172. Mr McKenzie was unaware of any relevant policies or procedures in relation to emergency mental health clinicians providing clinical mental health information to ED clinicians. This was a practice Mr McKenzie conducted on his own initiative and to support his ED colleagues, but unless there was a referral made or discussion with the ED clinician, there was no way for Mr McKenzie to know whether or not the information he uploaded was accessed by ED staff.[167]

173. Mr McKenzie conducted a CMI search in relation to Gabriel on 15 July 2020 and noted a discharge summary from his episode of case management, dated 9 January 2020. At 6.39am, Mr McKenzie copied that discharge summary and uploaded it as a consult note to Gabriel's RMH electronic medical record.[168] The discharge summary uploaded as a consult note included the following information:

    173.1. Gabriel's principal diagnosis of bipolar affective disorder;

    173.2. History of voluntary and involuntary treatment since 2014;

    173.3. History of poor engagement with mental health services, impulsive and risk taking behaviour when unwell, aggression, and intimidatory behaviour towards his parents;

    173.4. History of drug use;

    173.5. Triggers for relapse including lack of sleep and irritability;

    173.6. Family reports that Gabriel was expressing spiritual ideas about the devil, impulsive, irritable and sexually disinhibited in August 2015; and

    173.7. Previous incidents of violence in January-February 2018 which were listed under dynamic and static risk to others: Gabriel believed he was on a mission from God and sent to cull people and that a waitress in a friend's restaurant was a witch and he had made a threat to kill her (31 January – 3 February 2018); Gabriel was aggressive to a friend over the waitress whom he accused of being a witch (1 February 2018); Gabriel breaking a door because a friend had been late picking him up (3 February 2018); and Gabriel breaking a back window at night for reasons unknown (7 February 2018).[169]

[167] Statement of Lewis McKenzie, CB 1631; evidence of Lewis McKenzie, T 622:4 – T 624:3.
[168] RMH ED Patient Timeline, CB 888; Consult Notes, CB 866-873; statement of Lewis McKenzie, CB 1632.
[169] Consult Notes (Discharge Summary dated 9 January 2020), CB 866-873.

174. Mr McKenzie gave evidence that this was valuable information when it came to conducting a mental health assessment and that was one of the reasons why Mr McKenzie uploaded it so the ED had access to it. Mr McKenzie agreed that the history contained in the discharge summary was particularly significant with regard to assessing Gabriel's potential threat to others.[170]

175. Mr McKenzie did not read or consider any of the more recent contact notes from NWMH between 2-14 July 2020 referred to above. Although he did have access to those notes, his evidence was that he believed the discharge summary to be the most recent information available and was the first thing he found. Had he known about the outstanding referral following Gabriel's phone call with Ms Millen referred to above, Mr McKenzie would have uploaded the file note of that contact onto the electronic medical record alongside the discharge summary so that the treating ED clinician could access it. When shown the more recent contact notes from NWMH between 2-14 July 2020, Mr McKenzie agreed that information was just as important as the discharge summary to any RMH ED assessment of Gabriel on 15 July 2020.[171]

176. It is relevant to note at this juncture that, had Gabriel been treated in the past by mental health providers that were not under the auspices of Melbourne Health (as NWMH and RMH were), Mr McKenzie would not have been able to access the detail of the records from those providers. In that circumstance, Mr McKenzie would note the mental health record on the CMI, and then would contact the relevant area mental health in order to obtain the detail of that record. Similarly, if Gabriel had presented at a hospital outside of Melbourne Health, that hospital would not have had immediate access to the detail of Fuat's and Gabriel's most recent contact from 2 July 2020 and the discharge summary from 9 January 2020 as Mr McKenzie did.[172]

177. A record of Mr McKenzie's consult note was immediately visible to the ED staff responsible for Gabriel's care. However, the electronic entry stated only: '*6.39 Consult note signed; consult filed by Lewis McKenzie, Registered Nurse.*' The electronic entry had to be clicked on and opened in order to see the content of the consult note and discharge summary. Unless it was clicked on, there was no indication what the contents of the consult note were. If Mr McKenzie did want to provide a brief summary of the material, he would have been required to submit the consult note and then make a separate note. Similarly, the electronic entry identified Mr McKenzie as a registered nurse and did not specify that he was an EMH clinician.[173]

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[170] Evidence of Lewis McKenzie, T 627:14 – T 629:17; T 643:3-16.
[171] Evidence of Lewis McKenzie, T 634:9 – T 640:29.
[172] Evidence of Lewis McKenzie, T 621:14-26; T 634:9 – T 635:9.
[173] RMH ED Patient Timeline, CB 888; evidence of Lewis McKenzie, T 631:9 – T 632:15; evidence of Dr Amelia Scharkie, T 702:7 – T 703:12.

178. At some point between 6.40am and 6.59am, Gabriel was seen by ED Registrar Dr Amelia Scharkie. Dr Scharkie gave evidence that her role in respect of Gabriel was to:

178.1. stabilise any acute issues, de-escalate any heightened behaviours, and determine a safe disposition for him; and

178.2. conduct a high level mental health and risk assessment in order to determine whether he was an immediate risk to himself or the community and consider whether referral to either outpatient or inpatient psychology services was required.[174]

179. As an emergency doctor, Dr Scharkie gave evidence that by conducting a 'high level mental health and risk assessment' she would determine, at an immediate acute period, whether the patient was unsafe in terms of homicide or suicide or self-harm, acute mania or relapse.[175]

180. In assessing risk to themselves or others, Dr Scharkie would ordinarily ask outright whether the patient had any homicidal or suicidal thoughts, consider their general appearance, how they are interacting with her, how they are answering questions, whether she feels comfortable in the room with them alone, and whether what the patient is saying is congruent with what she is seeing.[176] Dr Scharkie agreed that more information is better than less when conducting such an assessment, including reliable and truthful information, and some understanding of a patient's history of mental health presentations was both relevant and beneficial.[177]

181. At 6.58am, Dr Scharkie uploaded her notes to the electronic medical record which included the following information about her consultation with Gabriel:

> *30 year old man [brought in by ambulance] and police after allegedly threatening cousin with a knife and sustaining punch to nose. No LOC, no vomiting, no nausea. Patient reports 2 months of poor sleep with 48 hours of minimal sleep. Unsure why.*

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[174] Statement of Dr Amelia Scharkie, CB 1634 [2.1].
[175] Evidence of Dr Amelia Scharkie, T 669:25 – T 670:1.
[176] Evidence of Dr Amelia Scharkie, T 670:18 – T 671:22.
[177] Evidence of Dr Amelia Scharkie, T 679: 10-21, T 683: 2-3, T 683:20 – T 686:6; statement of Assoc Prof Mark Putland, CB 1636 [2.2], 1637 [2.8].

Reports longstanding problems with family. Denies any suicidal or homicidal thoughts. Denies any self harm. No delusions or hallucinations.

Reports currently seeing psychologist – seen her 3X, unsure if helping. Reports previous diagnosis of bipolar.

Previous inpatient admission for bipolar in 2012, ***nil since then****.*

Has not been on anti psychotics for 1 year.

History: bipolar, drug induced psychosis.

Denies recent drug use.

…

Physical exam:

…

No obvious delusions or hallucinations. Calm appearing patient.

…

Impression: Not [sic] acute psychiatric issues. No acute medical issues.

Workup: Offered patient EDMH, patient feels not necessary.

Plan: patient safe for discharge. Police wanting to arrest patient.[178]

[178] ED Clinician Note, 15 July 2020, CB 874-875 (emphasis added).

182. Dr Scharkie's assessment of Gabriel was based on her talking to Gabriel and her review of the notes of Ms Hatton and Mr Khor. Dr Scharkie did not recall whether she read or accessed Mr McKenzie's consult note.[179] There is no record in her notes of her doing so.

183. When Dr Scharkie's notes are compared to the discharge summary uploaded by Mr McKenzie, it is evident that Gabriel provided inaccurate information to Dr Scharkie, in particular that he had not had an inpatient admission for bipolar since 2012.

184. Dr Scharkie's memory of Gabriel was limited, which is unsurprising given her role as an ED Registrar. However, Dr Scharkie did recall Gabriel did not appear acutely manic, and indeed appeared very stable, which is incongruent with someone having an acute deterioration with their bipolar disorder.[180]

185. In her statement, Dr Scharkie gave evidence that if she had any concerns about a patient and did not believe that they could wait for a psychologist, she would make a referral to the EMH team and/or consider placing them under an Assessment Order if there was an immediate threat to life. Dr Scharkie did not consider Gabriel met the criteria for a referral to the EMH team. Dr Scharkie offered a voluntary assessment by the EMH team but Gabriel declined. Gabriel was not referred to the EMH team. There was no consultation between Dr Scharkie and Mr McKenzie.[181]

186. Associate Professor Mark Putland, Director of RMH ED, gave evidence that following Gabriel's death, he and Dr Scharkie conducted a review of Gabriel's patient file. Their review determined that the treatment provided to Gabriel was clinically appropriate because he did not satisfy the criteria for an involuntary treatment order following assessment, and an offer was made for him to be seen by the EMH clinician which he declined.[182]

187. Constable Goodchap and L/S/C Van Krieken took Gabriel back into police custody at approximately 7.05am and transferred him to Broadmeadows Police Station for processing arriving at approximately 7.30am.[183]

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[179] Evidence of Dr Amelia Scharkie, T 670:2 – T 670:17, T 676:25-29, T 677:7 – T 679:9.
[180] Statement of Dr Amelia Scharkie, CB 1635 [2.2(h), (j)].
[181] Statement of Dr Amelia Scharkie, CB 1635 [2.2(l)-(n)]. In any event, as Gabriel remained in police custody, it would not have been possible for him to remain at the hospital on a voluntary basis: see evidence of L/S/C Van Krieken, T 538:9 – T 539:3.
[182] Statement of Assoc Prof Mark Putland, CB 1636 [2.3].
[183] ePDR for Constable Goodchap and L/S/C Van Krieken, 15 July 2020, CB 2052; statements of Constable Goodchap, CB 281 and 1388; statements of L/S/C Van Krieken, CB 1354 and 1392.

Interaction between the ED and EMH team

188. Associate Professor Putland gave evidence that the RMH receives a large volume of patients which attend the ED under s 351 and only about 6% are referred to EMH clinicians.[184]

189. Dr Scharkie was questioned about the criteria for an Assessment Order and stated her understanding of the criteria involved an assessment of whether there was an immediate threat to life. In addition, she noted an Assessment Order required her to consider whether there was a less restrictive means, and accepted it also involved consideration of whether it is required to prevent serious deterioration in the person's mental or physical health.[185]

190. Mr McKenzie gave evidence that, if required, he was ready to consult with an ED registrar in respect of Gabriel. However, there was no contact between the ED (nurses or doctors) and the EMH team on the morning of 15 July 2020 in relation to Gabriel. There was no referral made to the EMH team.[186]

191. Although they are both authorised to conduct mental health assessments under the Act, Mr McKenzie and Dr Scharkie had vastly different levels of knowledge and experience in respect of mental health assessments. An ED registrar in Dr Scharkie's position has many competing priorities which is not singularly focused on mental health. Her mental health training involved a rotation with a psychiatrist as an intern, although this is optional rather than mandatory for an ED physician. Her only exposure to psychiatry post-internship was as an ED doctor, and there was no formal training program relating to the Mental Health Act conducted by the Australian College of Emergency Medicine. Dr Scharkie did have weekly training sessions on various topics related to emergency care, some of which related to the Mental Health Act.[187]

192. By contrast, Mr McKenzie's role, training and experience was fundamentally different from an ED registrar.[188] Mr McKenzie had 18 months of tertiary training in mental health nursing and had worked exclusively as a mental health nurse since 2003. That experience included seven years working as a psychiatric nurse at St Vincent's Hospital and three years at the Austin Hospital which involved many mental health assessments.[189]

[184] Statement of Assoc Prof Mark Putland, CB 1637 [2.6].
[185] Evidence of Dr Amelia Scharkie, T 661:5 – T 662:22, T 673:16 – T 674:23.
[186] Statement of Lewis McKenzie, CB 1631; evidence of Lewis McKenzie, T 612:24 – T 615:27; NWMH Team based review, CB 1870-1871.
[187] Evidence of Dr Amelia Scharkie, T 673: 3-15, T 699:27 – T 697:23.
[188] See also evidence of Assoc Prof Mark Putland, T 478:10 – T 479:13.
[189] Evidence of Lewis McKenzie, T 602; statement of Lewis McKenzie, CB 1630.

193. Mr McKenzie's evidence demonstrated a thorough understanding of the requirements of a mental health assessment and how he would conduct one, which included making inquiries of family members, clinical documentation from previous assessments, consideration of issues that have presented over the past couple of days and what has brought the patient to the situation they are now in, and asking about mental health history and treatments. Mr McKenzie's evidence was that such a mental health assessment would take at least at hour, sometimes more.[190]

Relevant changes to processes

194. While ED staff are still unable to access the CMI, the RMH has changed its Electronic Medical Record so that it will alert clinicians if a patient has a CMI record. It will allow triage staff to electronically request a review of that database by the EMH team, who will then search for any previous mental health dealings and provide a snippet of any diagnosis and recent interactions with mental health services. The Electronic Medical Record has also been adapted so that any entry made by an EMH clinician with regard to a CMI check is more easily visible by the ED clinicians.[191]

195. This change came about as a result of Associate Professor Putland's and Dr Scharkie's review of Gabriel's patient file and was implemented in March 2022.

196. A further change that is currently being explored by RMH ED is to ensure EMH clinicians are involved early in cases where they are required and it is clinically appropriate through the addition of a mental health navigator role.[192]

Submissions

197. Counsel Assisting submitted, with Melbourne Health and Gabriel's family agreeing, that it was open to the find that Dr Scharkie was able to, but did not, access Gabriel's discharge summary from January 2020, uploaded by Mr McKenzie. It contained relevant clinical information about Gabriel's mental health history. Also relevant to Gabriel's mental state on 15 July 2020 were the CMI records of Fuat's contact with NWMH between 2-9 July 2020 and the referral made by Ms Millen on 14 July 2020. Although this information was available to Mr McKenzie via CMI, he was not cognisant of it, nor did he upload it.

[190] Evidence of Lewis McKenzie, T 607:9 – T 610:3.
[191] Statement of Assoc Prof Mark Putland, CB 1637 [2.7]-[2.12]; evidence of Assoc Prof Mark Putland, T 480:22 – T 481:3.
[192] Oral submissions from Melbourne Health, T 1036:22-28; supplementary statement of Assoc Prof Mark Putland, dated 18 October 2022.

198. Counsel Assisting also submitted, with Gabriel's family agreeing, that it was open to find Dr Scharkie's mental state assessment of Gabriel was brief and superficial, based primarily on the information she received from, and her observations of, him. Passing regard to the discharge summary would have revealed that Gabriel provided inaccurate information to Dr Scharkie about his mental health history. Counsel Assisting submitted that, had it been appreciated by Dr Scharkie that Gabriel provided inaccurate information, it should have prompted further examination of the available material and/or inquiries of the mental health clinician.

199. Gabriel's family submitted that Dr Scharkie's assessment of Gabriel was cursory, and that Gabriel should have been assessed by the EMH team who had access to the extensive and very recent CMI history. Further, there was a clear failure to identify Gabriel as a person under active referral to the crisis team. In those circumstances, Gabriel's family relied on the evidence of Associate Professor Putland to submit that, had Gabriel been assessed by a mental health practitioner there was a 'definite real probability' that he would not have been discharged from RMH on the morning of 15 July 2020.[193]

200. Counsel Assisting submitted that, although Dr Scharkie's mental health assessment could not be described as thorough, it was likely the result of her position, her inexperience in relation to mental health assessments, and the competing priorities for which she had to cater as an ED registrar. Counsel Assisting submitted that Dr Scharkie's descriptions of her training for, and experience in, mental health assessments highlighted the inadequacies: she was unable to properly articulate the applicable statutory test and did not seek out the information which was available to her – either from the police present or from the uploaded discharge summary.

201. Melbourne Health submitted that Dr Scharkie's examination of Gabriel was not cursory and that she assessed and considered a number of factors, including: the mode of arrival at hospital, the presenting problem, history of sleep disturbance and reasons for it, longstanding family issues, suicidal and homicidal ideation, substance abuse, social and employment issues, testing for delusional thoughts and hallucinations, Gabriel's current treatment with a psychologist, and Gabriel's psychiatric diagnosis and medication adherence. There was no evidence to suggest the mental state examination performed by Dr Scharkie's was other than reasonable given her training, experience and role. Further, there was no evidence that, had Dr Scharkie had greater training and experience she (or indeed another medical practitioner or mental health practitioner, including Mr McKenzie) would have come to a different conclusion. Counsel Assisting agreed the evidence did not support such a finding.

[193] Evidence of Assoc Prof Mark Putland, T 499:19 – T 500:12.

202. Melbourne Health further submitted that even if Dr Scharkie did form a view that Gabriel required immediate treatment to prevent serious deterioration in his mental health or serious harm to himself or others, the additional criteria under the Mental Health Act that there is 'no less restrictive option' could not have been satisfied in the context of Gabriel being treated by, and would be seen by NWMH within 72 hours, voluntarily. That was a less restrictive option that enabled Gabriel to be assessed, preventing Dr Scharkie or any other practitioner from making an assessment order.

Comments

203. Dr Scharkie's mental health assessment of Gabriel was brief and could not be described in any way as comprehensive. This is not surprising given her relative inexperience, her minimal training in conducting mental health assessments and the fact she did not access, nor have access to, Gabriel's entire mental health history. Dr Scharkie relied almost entirely on a review of the notes taken by Ms Hatton and Mr Khor, the history provided by Gabriel and her own observations.

204. Gabriel's statements to Dr Scharkie were, in a number of key aspects, patently incorrect. Despite it being uploaded by Mr McKenzie, Dr Scharkie did not access Gabriel's mental health discharge summary from 20 January 2020 which contained highly relevant information. Further Mr McKenize was not aware of the CMI records of Fuat's contact on 2-9 July 2020 and Gabriel's referral made by Ms Millen the previous day, and therefore did not upload it (albeit Dr Scharkie did not access the discharge summary of 20 January 2020 and therefore it is improbable she would also have accessed these records).

205. There are clearly shortcomings in what transpired that morning within the RMH ED. Despite these observations I am unable to find that had Dr Scharkie been more experienced, or more comprehensively informed, that she would have reached a different conclusion.

206. Nevertheless, it warrants noting the significant difference in the experience and information available to Dr Scharkie (ED registrar) and Mr McKenzie (EMH clinician). It may have been preferable to have had the mental health assessment conducted by Mr McKenzie, or another available EMH clinician dependent upon shift changeover times. He is authorised by the Mental Health Act to conduct s 30 assessments and had access to and obtained relevant medical and mental health history that would have assisted. Further he could complete a more thorough and comprehensive assessment, simply by virtue of his position and competing demands. The EMH clinician is not subject to the constant demands of a busy Emergency Department. There appears to be opportunity for some of these s 30 assessments being completed by the EMH clinician.

207. In Gabriel's case, Mr McKenzie was ready and willing to assist, and it would have been a very simple process for the triage nurse or Dr Scharkie to request his assistance. It appears unlikely that the EMH clinician would be available to assist in all cases, however it is a significant resource that could be used to relieve some pressure in the ED, to provide a level of specialist expertise that would be of great assistance in cases such as Gabriel's. Hospital management should consider opportunities to change current processes to enable the EMH clinician to be utilised more regularly in s 351 transfers, in particular where a patient has a recent mental health history.

208. I note that RMH have made changes to their systems that will alert ED staff if a patient has a CMI record. This is a significant enhancement and will assist in ensuring that information is available when s351 transfers occur. This is a beneficial initiative, and the hospital is to be commended.

209. Mental health assessment in EDs will continue to be a significant part of the ongoing workload. This investigation highlights the need to have relevant information easily available to staff making the assessments, and also identifying the most appropriate staff to conduct assessments, whether that be the ED medical staff or EMH clinicians when available, or some combination. This is a significant challenge for hospital administrators. In this context I note that recent funding has been provided for the establishment of a Mental Health, Alcohol and other drugs Hub at RMH which is a six-bed facility. Perhaps this type of facility may go some way to providing additional resources to assist in management of s351 transfers.

Gabriel's fitness for interview assessment by the Forensic Medical Officer on 15 July 2020

210. Gabriel arrived at Broadmeadows Police Station at approximately 7.27am and was placed in an interview room.[194] F/C Lucy Verplak and F/C Shannon Egan assumed carriage of the investigation involving the trespass and assault at Gabriel's aunt and uncle's house.

211. Prior to Gabriel's arrival, F/C Verplak received a verbal briefing from D/S/C Georgia Hammond in relation to Gabriel and what had occurred at his aunt and uncle's house. Once Gabriel arrived, Constable Goodchap informed F/C Verplak that Gabriel had been cleared from the s 351 by a doctor.[195]

212. F/C Verplak and F/C Egan also received a briefing note which summarised the incident. However, the information F/C Verplak and F/C Egan received did not include the reasons why Gabriel was transferred to hospital under s 351 or his diagnosis of schizophrenia and bipolar. Similarly, it did not include some aspects of Gabriel's alleged offending, such as Gabriel walking to his aunt and uncle's house, his inability to explain why, and that the family had recently removed a child from the home due to fear.[196]

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[194] Exhibit 6: Still images extracted from exhibits 93 and 94 with timestamps of CCTV.

[195] Evidence of Constable Goodchap, T 445:30 – T 446:16; evidence of L/S/C Van Krieken, T 529:1-13; statement of F/C Verplak, CB 284 [6].

[196] Statement of F/C Egan, CB 298 [5]; evidence of F/C Egan, T 719:29 – T 722:26; statement of F/C Verplak, CB 288-289 [6]; Briefing note by D/S/C Georgia Hammond, CB 1255-1257.

213. During her initial interactions with Gabriel, F/C Egan observed him to be dishevelled, talking to himself, sweating, and not able to stand still. She observed Gabriel's eyes darting around and considered that he appeared to be paranoid. As a result of her observations, F/C Egan had concerns about Gabriel's mental health and his fitness to be interviewed by police about the trespass and assault. F/C Egan considered Gabriel should be assessed by a forensic medical officer (**FMO**).[197] F/C Verplak did not hold the same concerns based on her own interactions with Gabriel. Although Gabriel advised her he had not slept and was tired and because of that he was not fit to be interviewed, F/C Verplak observed Gabriel to have no problem holding a conversation and to be generally courteous and polite.[198]

214. F/C Egan contacted her sergeant who agreed Gabriel should be assessed by the FMO as to whether he was fit to be interviewed by police.

215. A fitness for interview assessment can involve consideration of physical injuries, mental health concerns, substance use or intoxication or withdrawal, intellectual impairment, or any other concerns that relate to a person's wellbeing and capacity to engage with police in a formal record of interview relating to criminal charge/s and appropriately protect themselves and their interests in an interview.[199]

216. F/C Egan contacted the FMO, Dr Romey Giles, at approximately 8.30am to arrange a fitness for interview assessment. F/C Egan advised Dr Giles why Gabriel was in custody and that he had been transferred to hospital under s 351 that morning. F/C Egan also described her own observations of Gabriel and information she had obtained from the police database LEAP, pertaining to Gabriel's history with police.[200]

217. Prior to conducting her assessment of Gabriel, Dr Giles made enquiries in relation to Gabriel's mental health history. This necessitated a number of phone calls including to Austin Hospital mental health service, Western psychiatric triage, and RMH because she did not have access to the CMI. In making those enquiries, Dr Giles wanted to establish what had happened with the s 351 transfer and obtain details of any collateral information that could enhance her assessment of Gabriel. Dr Giles did in fact obtain information about Gabriel's mental health history from RMH including: his diagnoses of bipolar affective disorder and schizophrenia; admissions for psychiatric issues; history of poor engagement, violence to others, impulsive and risk taking behaviour and religious delusions; his discharge from case management in January 2020; and that he was not currently medicated.[201]

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[197] Statement of F/C Egan, CB 298 [6]-[8]; evidence of F/C Egan, T 715:2-22.
[198] Statement of F/C Verplak, CB 289-290 [9]-[13]; statement of F/C Egan, CB 298 [9]; evidence of F/C Egan, T 715:23 – T 716:14, T 719:15-22.
[199] Evidence of Dr Romey Giles, T 754:27 – 756:5 ; T 779:20-30.
[200] Statement of F/C Egan, CB 299 [11]-[12]; evidence of F/C Egan, T 721:20 – T 722:26; Dr Romey Giles notes, CB 680.
[201] Evidence of Dr Romey Giles, T 768:24 – T 770: ; T 773:22 – T 774:29; Notes of Dr Romey Giles, CB 678-679.

218. At 9.45am, Dr Giles spoke to Gabriel over the telephone and conducted a fitness for interview assessment with Gabriel.[202] That assessment took approximately 1 hour and involved the consideration of Gabriel's alleged offences, his behaviour since apprehension, psychiatric history, sleep pattern, drug use, medication, social and occupational history, demeanour, and a 'mini' mental state examination.[203]

219. Upon completion of her assessment, Dr Giles' opinion was that Gabriel was fit to be interviewed. Dr Giles provided that advice to F/C Egan immediately following the assessment and recommended Gabriel have follow up psychiatric assessment and evaluation that was already arranged via NWMH.[204] Dr Giles also advised F/C Egan that Gabriel presented well and was orientated but there was a chance of an underlying mental health disorder. Dr Giles instructed F/C Egan to stop the interview if Gabriel became agitated or distressed, and requested a call back after the completion of the interview and once Gabriel's remand/bail disposition was established so she could arrange ongoing mental health follow ups.[205]

220. Dr Giles gave evidence that she did not receive the following information:

220.1. The incident for which Gabriel had been arrested involved an alleged assault against two family members, and Gabriel had reportedly been aggressive towards his aunt and uncle when they touched him;

220.2. Gabriel had walked to his aunt and uncle's house in the early hours but could not explain why;

220.3. Gabriel's family were concerned about his deteriorating mental health; or

220.4. The reasons why police decided to apprehend Gabriel under s 351 of the Mental Health Act.

221. Dr Giles' evidence was that, had she received this information, it would have been useful and relevant to her assessment and it may had led to further discussions with police about how to manage Gabriel, but it would not have changed her opinion he was fit to be interviewed. Dr Giles noted that there was nothing during her conversation with Gabriel which made her concerned about anyone's ongoing safety, he was polite, responded appropriately to every question, had good insight into his mental health symptoms and, overwhelmingly, he came across as a person who needed help and was keen to receive help.[206]

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[202] Ordinarily the assessment would have been conducted in person but COVID-19 restrictions in force at the time necessitated changes to the usual processes: Fitness for interview report of Dr Romey Giles, CB 305.
[203] VIFM Forensic Medical Examination Record, Fitness for Interview, completed by Dr Romey Giles on 15 July 2020, CB 661-677.
[204] Fitness for interview report of Dr Romey Giles, CB 305.
[205] Statement of F/C Egan, CB 300 [16].
[206] Evidence of Dr Romey Giles, T 763:12 – T 765:29, T 798:27 – T 799:25, T 809:9-19, T 816:25 – T 817:9.

222. Following the assessment, F/C Egan noted a definite change in Gabriel's behaviour and that he appeared very calm.[207] Gabriel was interviewed by police between 10.43am and 10.57am and responded with 'no comment' to most of the questions asked. He appeared to be calm throughout and to understand the questions and his rights (opting to call his mother prior to the commencement of the interview). Gabriel was then charged with criminal damage, recklessly causing injury, unlawful assault, and trespass. In response to the charges Gabriel said 'I don't think I'm in a very good mental state to say anything.'[208]

223. Throughout the morning of 15 July 2020 while Gabriel was in custody, F/C Verplak had the following conversations with Gabriel's family members.

223.1. Prior to Gabriel's police interview, Fuat called the police station and spoke with F/C Verplak. He advised her of Gabriel's mental health history and that he had not hurt anyone before, and Fuat did not think he was capable of hurting anyone. Fuat said Gabriel had unsuccessfully sought help from a doctor the day before and was not taking medication. F/C Verplak advised Fuat she would keep him updated with their progress as police interviewed Gabriel.[209]

223.2. Following Gabriel's interview at approximately 11.15am, Gabriel's cousin Banibal Messo, and Gabriel's uncle, Norman Messo, attended Broadmeadows Police Station, concerned about Gabriel's welfare. They spoke to F/C Verplak for approximately 15 minutes[210] during which time they told her Gabriel had not been taking his medication and they believed he needed help mentally, they did not want him released but wanted him held for mental health treatment. F/C Verplak explained Police were unable to hold him for those reasons unless they had concerns for his safety or the safety of others.[211] Banibal gave evidence that he asked three times to be put in touch with the FMO because he believed Gabriel would say anything the assessor needed to hear in order to get out. When F/C Verplak refused, Banibal asked at least for his contact details to be provided to the FMO and F/C Verplak took down his, and Norman's, details. According to Banibal, F/C Verplak advised she would pass their contact details on to the FMO. Banibal also requested F/C Verplak contact him once the decision was made about Gabriel because his aunt and uncle were still frightened at home and would leave the house if Gabriel was to be released.[212]

[207] Statement of F/C Egan, CB 300 [16].
[208] Gabriel's record of interview, 15 July 2020, CB Exhibit 12; Charge sheet and summons, CB 633.
[209] Statement of F/C Verplak, CB 290-291 [17]-[18]; notes of F/C Verplak, CB 2115.
[210] Exhibit 6: Still images extracted from exhibits 93 and 94 with timestamps of CCTV.
[211] Statement of F/C Verplak, CB 292-293 [29]-[30]; notes of F/C Verplak, CB 2115.
[212] Statement of Banibal Messo, CB 152-153.

224. F/C Egan gave evidence that she was not advised about these conversations.[213]

225. Police decided to grant Gabriel bail. In coming to that decision they considered Gabriel's disposition, his absence of prior convictions, the fact the incident had been downgraded to criminal damage and assault (rather than the more serious charge of aggravated burglary) and Gabriel's expressed desire to seek help upon release in relation to his mental health. In Acting Sergeant Prestia's view, the risks of granting bail to Gabriel were mitigated by bail conditions and the family violence safety notices that were put in place to protect Gabriel's aunt, uncle and their family.[214]

226. At approximately 12.31pm, F/C Egan telephoned Dr Giles again to inform her the interview was concluded and Gabriel would be bailed. Dr Giles then contacted NWMH and confirmed that Gabriel had been placed on a triage list for follow-up psychiatric assessment and evaluation and that he would be contacted by NWMH in the next 24-48 hours. Dr Giles passed this information on to F/C Egan by telephone at 12.50pm. F/C Egan told Gabriel about those arrangements and he seemed to be very positive about it.[215]

227. Dr Giles gave evidence that she was not advised that Gabriel's family members had contacted police while Gabriel was in custody and held specific concerns about the danger Gabriel posed to himself and others, and that Gabriel was good at presenting to health practitioners. However, her evidence was that, if she had received that information, it would not have impacted her ultimate opinion as to Gabriel's fitness for interview.[216] Had she been made aware Gabriel's loved ones wished to speak to her, she would have obtained consent from Gabriel prior to contacting them.[217]

228. F/C Egan telephoned Nebil Messo to advise him Gabriel would be released on bail. Although Nebil wished to pick Gabriel up from the station, F/C Egan advised him that could not occur due to the family violence notices that were to be issued, prohibiting contact between Gabriel and the victims of his alleged offences, which included Nebil. Nebil advised Gabriel's cousin was in the area and would pick him up.[218]

229. At approximately 1.25pm Gabriel was bailed to appear in the Magistrates' Court on 20 July 2020.[219] He left Broadmeadows Police Station alone, but Mr Aygur was waiting for him out the front.

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213 Evidence of F/C Egan, T 732:23 – T 733:23.
214 Statement of A/Sergeant Prestia, CB 311-312.
215 Statement of F/C Egan, CB 301 [21]-[23]; evidence of Dr Romey Giles, T 790:26 – T 794:7, T 796:24 – T 797:14; notes of Dr Romey Giles, CB 681.
216 Evidence of Dr Romey Giles, T 776:19 – T 780:11.
217 Evidence of Dr Romey Giles, T 780:12-29.
218 Statement of F/C Egan, CB 301-302 [23]-[24].
219 Charge sheet and summons, CB 633; Exhibit 6: Still images extracted from exhibits 93 and 94 with timestamps of CCTV.

230. Just after 1.30pm, Banibal Messo returned to Broadmeadows Police Station with Ilyas Tan. They spoke to F/C Verplak once again.[220] Banibal was upset that he had not been contacted prior to Gabriel's release from custody. Banibal and Ilyas both told F/C Verplak they believed Gabriel was dangerous and showed her a photo Gabriel had posted on Facebook with his younger cousin saying it was his own son. They asked F/C Egan what they could do and what avenues they could look at in order to assist Gabriel. F/C Egan advised they should attend the upcoming court date with Gabriel and express their concerns to a Magistrate. By doing so, Gabriel could receive court-ordered assistance regarding his mental health. F/C Egan also advised them that the FMO had arranged an appointment for Gabriel with mental health services.[221] At this point, Banibal Messo felt like his cries for help were falling on deaf ears.[222]

Submissions

231. Counsel Assisting submitted that it was open to make the following findings:

231.1. Even though F/C Egan was provided little background information, her decision to have the FMO assess Gabriel's fitness to be interviewed was sound and appropriate.

231.2. Although Dr Giles was not advised that Gabriel's family members were wishing to speak to her, nor specifically as to the circumstances leading to Gabriel's arrest:

(a) Dr Giles' assessment as to Gabriel's fitness to be interviewed was thorough and considered; and

(b) this information, whilst relevant, would not likely have impacted her ultimate assessment of Gabriel's fitness for interview.

231.3. Dr Giles did not have access to the CMI, but this did not stop her from making inquiries in order to ascertain Gabriel's relevant mental health history.

232. Counsel for the CCP and police members submitted that F/C Verplak and F/C Egan were not provided information about the original basis for the police decision to apprehend Gabriel pursuant to s 351 because he had already been cleared from RMH at that stage and such information would not have served any purpose. They rejected criticism that the information provided to F/C Egan was inadequate because she was the investigating police officer with a primary task of investigating the alleged offending and being aware of the allegations so as to be in a position to conduct an interview with Gabriel. She received a briefing note and had access to the police databases detailing the allegations as well as contact details of witnesses.

[220] Statement of F/C Verplak, CB 293-294 [35]-[38]; statement of Banibal Messo, CB 153-154; Exhibit 6: Still images extracted from exhibits 93 and 94 with timestamps of CCTV.
[221] Statement of F/C Verplak, CB 293-294 [35]-[38]; statement of Banibal Messo, CB 153-154.
[222] Statement of Banibal Messo, CB 154.

Comments

233. F/C Verplak considered Gabriel fit for interview whilst F/C Egan had formed a different view based on her observations of Gabriel in the time he had been at the Broadmeadows Police Station. Quite properly F/C Egan spoke to her sergeant who agreed that he should be assessed by an FMO as to whether he was fit for interview and arrangements were made for Gabriel to be assessed by Dr Giles.

234. Dr Giles was diligent and thorough in her assessment of Gabriel. She had taken steps to gather background information as to Gabriel's mental health background and history and conducted a thorough and comprehensive assessment. She also took additional steps to ensure that arrangements were in place for Gabriel to be placed on the triage list for follow up psychiatric assessment and evaluation and for him to be contacted within 24-48 hours by NWAMHS.

235. The gathering of background and history on Gabriel required Dr Giles to make a number of phone calls. Direct access to CMI information by FMO's would have enabled much more timely access to this information. It is unclear why this information is not made available to FMO's as a matter of course given the nature of the assessments that they are required to undertake.

236. I am satisfied that the processing of Gabriel at the Broadmeadows Police Station, including the engagement of Dr Giles to assess Gabriel's fitness for interview, and the subsequent assessment undertaken, was both reasonable and appropriate.

Follow up calls from NWAMHS on 15 and 16 July 2020

237. On 15 July 2020 at 10.28am and 3.55pm, and at 1.10pm on 16 July 2020, Gabriel received calls from NWAMHS following up Gabriel's attempt to access the Clinic on 14 July 2020. The calls went unanswered and through to his voicemail.[223]

238. Throughout 15 July 2020, Fuat telephoned NWAMHS on a number of occasions to advise them that Gabriel was in police custody due to an altercation with his uncle. He subsequently called again to advise Gabriel had been released on bail and that he (Fuat) believed Gabriel needed medication and may be a risk to others due to his mental state. Fuat expressed frustration that Gabriel had been seen at RMH but they did not admit him.

239. At approximately midday on 16 July 2020, Fuat attended the Clinic and spoke with Richard Buck, registered nurse, by telephone from the carpark. Fuat pleaded to speak to someone in person and Mr Buck came outside the hospital doors to speak with him. Fuat again explained what had happened the day before and said they needed to get Gabriel in. Mr Buck advised Fuat there was a meeting between 2pm and 4pm and he would put the case forward on behalf of Gabriel.[224]

240. On 16 July 2020 at a meeting commencing at 2pm, the NWMH clinical Brief Intervention Team discussed Gabriel's self-referral of 14 July 2020 and a plan was made to have Gabriel assessed face to face by a clinician within 24 hours.[225]

[223] Voicemail recordings, Exhibits 125, 126 and 127 of the Inquest Brief.
[224] CCRs, CB 1386b; statement of Fuat Messo, CB 127; statement of Richard Buck, CB 1727-1728 [1.10]-[1.16].
[225] Statement of Dr Lokesh Sekharan, CB 1725 [25(e)]; statement of Dr Devapriya Rudolph, CB 1738; NWMH screening register notes, CB 1807.

The events of 16 July 2020 prior to Victoria Police attendance at John Coutts Reserve

241. Between 7.55am and 9.58am an extensive number of text messages were exchanged between Gabriel and Ms Cleur, in total Gabriel sent eighty-six messages and Ms Cleur replied on sixteen occasions. It is difficult to ascertain Gabriel's intentions within these messages, some of them reading '*But I'm spiritually near death*', '*I just want what I want*' and '*I'm not asking. I am demanding. I deem it more than fair .. After the 30 years I've existed*'. Fuat messaged Gabriel a number of times that morning however did not receive a response.

242. Ms Cleur later that morning also rang Gabriel as she had become aware of his attendance at the Clinic and RMH. Ms Cleur within her statement gave evidence that during that conversation

> *Gab finally started talking about a girl he had in Thailand called Cartoon and he wanted me to take him to see her or bring her here … … I told Gab during this conversation that he was a white mouse running in a wheel. I told him he was running but getting nowhere. Gab agreed with this and said that was how he felt.*[226]

243. Gabriel also rang Mr Aygur and asked him to come over as he was '*losing it and needed help*'.[227] Mr Aygur whilst enroute spoke with Ms Borromeo and requested she contact the Clinic and ascertain if they were able to assess Gabriel urgently that day due to the episodes he was experiencing. Ms Borromeo contacted the Clinic and spoke with mental health clinician Richard Buck who advised Ms Borromeo that he had been attempting to contact Gabriel over the last few days, however there had been no response to his telephone calls and voicemails.

244. Upon arriving at Gabriel's premises, Mr Aygur found Gabriel sitting on a park bench opposite his house. Whilst there he received a telephone call from Ms Cleur who asked Mr Aygur:

> '*to speak with a particular person at Community Mental Health which I did. He was very professional, very helpful and very humble over the phone. He told me he would be attending a meeting and the meeting would be from 2pm and 4pm. He said he would try his absolute best to get the Doctors to admit Gabriel for treatment. He promised me he would get to me straight after 4pm*'.[228]

Upon Mr Aygur leaving Gabriel indicated that he was going to stay at the park writing in his book. He indicated to Gabriel that he would try to return by 4pm at the latest so that he could take Gabriel straight from his house and get him admitted.

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[226] Statement of Corina Cleur, CB 216-217.
[227] Statement of Christina Borromeo, CB 207.
[228] Statement of Sabri Aygur, CB 200.

245. At 1.10pm the following voicemail was left on Gabriel's mobile from Mr Buck, '*Gabriel, this is Richard, I'm one of the nurses over at Broadmeadows Community Mental Health. We wanted to get in touch with you to see how you are going after the recent troubles. Give us a ring on 8345 5611. Bye*'.[229]

246. At 1.27pm Ms Cleur received a call from the NDIS confirming that Gabriel's application and plan was approved. She immediately sent a text message to Gabriel confirming this.

247. At 2.34pm Gabriel sent the following text message to Lilla, '*Come see me. I am at the house. Be here in 1 hour please Im so sad I need to see you*'. Fuat then received a telephone call from Lilla who said that Gabriel had called her and that he wanted or needed to see her. Fuat indicated it was up to Lilla however Mr Aygur advised not to go, there was no need as he had just seen Gabriel and would be returning by 4pm. Sometime later Lilla again telephoned Fuat saying Gabriel had contacted her again and that Gabriel really needed to see her.[230] Lilla responded to Gabriel's text message at 2.50pm saying '*Okay Gabby I will see you [kiss emojis]'.*

248. At 3.02pm Gabriel walked into John Coutts Reserve from Katrina Drive and sent a text message to Lilla telling her where to meet him. Lilla arrived and walked into John Coutts Reserve at 3.24pm.

249. Just under two minutes later, CCTV captured Lilla meeting Gabriel, who immediately pushed his mother to the ground and commenced what can only be described as a sustained and violent assault that continued for seventeen (17) minutes prior to the arrival of police divisional unit Broadmeadows 303. Initially Gabriel was unarmed when the assault commenced and he was using clenched fists to attack Lilla, however at both 3.33pm and 3.35pm Gabriel is seen to grab objects off the ground (believed to be sticks or similar), immediately returning to assault Lilla. At no stage was Lilla observed to be defending herself, it is believed she had become unconscious at a very early stage of the assault.

250. A number of eyewitnesses who were either walking or riding through the John Coutts Reserve observed what was occurring. Numerous calls were made to triple zero at 3.36pm, 3.37pm, 3.41pm and 3.43pm reporting the assault. Various eyewitnesses reported that Gabriel was on top of Lilla punching her without stopping and that later during the assault was alternating between punching and stabbing motions. One eyewitness approached Gabriel saying '*Stop*' with Gabriel responding '*Go away, you don't know anything*'. The eyewitness then replied '*Please don't hurt them*' with Gabriel again responding '*You don't know anything, she's taken my babies, she's taken everything from me. Go away or I'll hurt you too*'. Due to the ferocity of the assault and Gabriel's aggression, none of the eyewitnesses intervened.

[229] Voicemail audio recording, Exhibit #127 of the Inquest Brief.
[230] Statement of Sabri Aygur, CB 201.

D24 Police Radio Broadcasts in response to multiple triple zero calls

251. At 3.38.41pm in response to the first triple zero call received, D24 Police Radio broadcast '*Broadmeadows 302 or 303 for a priority one assault with injuries. John Coutts Reserve in Gladstone Park*'. Broadmeadows 303 acknowledged with Police Radio further updating '*I've had a couple of calls on this, it's come through as an assault with injuries at the John Coutts Reserve, one male hitting another person, complainant can see blood. I've also had a call come through as it being a stabbing, they possibly think they've used a knife or a stick and they've got blood all over their hand. Complainant's watching from a distance. VKC to Broadmeadows 302 are you able to head that way?*'. Both Broadmeadows 302 and White 714 callsigns acknowledged the broadcast and Craigieburn 251, the Patrol Supervisor, broadcast that '*I'll monitor at this stage, if they can give me a sitrep when they get there whether it's a stabbing or what it actually is*'.

252. At 3.40.24pm Police Radio broadcast a further update '*Broadmeadows 302 and 303 it looks like we've got another call coming through now from the Ambulance saying that they've got a 35 year old male stabbed in the face with a stick, I've got no further from them right at the moment … … it looks like it might actually be a female that's been stabbed there with the stick, I've got a male offender in a grey t-shirt, blue stripe on the shirt, female victim, still getting further*'. Broadmeadows 302 broadcast that due to where they were expediting from '*303 might beat us to it*' and then questioned '*has anyone got eyes on the offender at the moment*?'. Police Radio replied indicating '*I've got one complainant whose standing off from a distance away, doesn't feel safe hanging up just yet, the female is still lying on the ground and the males on top of her repeatedly stabbing at the female*'.

253. At 3.42pm the Patrol Supervisor, Craigieburn 251 confirmed that they would also be responding to the incident with the Divisional Patrol Supervisor, Fawkner 265 then confirming that he was monitoring the transmissions and then questioned '*whose the 251 in relation to safety briefing and Forward Commander for this*'. Craigieburn 251 confirmed their role as Forward Commander and then directed over Police Radio '*I'll get the first unit to attend there given the nature of the offences let's just get there and deal with what they have in front of them, make sure she doesn't get any further injuries*'.

Sources of Evidence | Conduct of Constable Andrew and F/C Churcher

254. At inquest Constable Andrew, through his Counsel, objected to giving evidence and claimed privilege in respect of self-incrimination pursuant to s 57 Coroners Act. In a ruling delivered on the final day of the inquest, I granted Constable Andrew's application and found that the interests of justice did *not* require that he give evidence. He was therefore subsequently excused, and I rely therefore upon Constable Andrew's three written statements provided to investigators that are contained within the Inquest Brief. I draw no adverse inference or conclusion from Constable Andrew having made this application.

255. Neither F/C Churcher nor Constable Andrew activated their BWCs either enroute to, or upon arriving at John Coutts Reserve. Whilst both members uploaded footage post-incident, it only captured the circumstances *after* Constable Andrew had discharged his police issued firearm three times. In determining the factual circumstances of these discharges, I rely therefore upon the written statements of the two members, civilian eyewitness statements, the viva voce evidence given by F/C Churcher at inquest, and the footage recorded on CCTV and the mobile phones of a number of eyewitnesses who were standing some distance from where the incident was occurring. I will return to this issue of the non-activation of their BWCs later within this Finding.

Conduct of Constable Andrew and F/C Churcher at John Coutts Reserve

256. At 3.44.04pm Constable Andrew transmitted they were '*Code 5*', that is Broadmeadows 303 had arrived at John Coutts Reserve. F/C Churcher was driving the Broadmeadows 303 divisional van whilst Constable Andrew was the observer. They were the first emergency responders to arrive on scene. Apart from acknowledging the initial broadcast at 3.38.41pm, there had been no transmissions from Broadmeadows 303 as they expedited to the location. Constable Andrew in his statement stated that '*we received a job from D24 over the radio in relation to an assault in a Reserve. The assault was a Priority One job. I didn't really hear what the dispatcher said over the radio but knew it was in a reserve*'.[231]

257. As the Broadmeadows 303 divisional van drove to the end of Linacre Crescent and was in the process of turning left into Katrina Drive, directly opposite John Coutts Reserve, CCTV footage captures Constable Andrew had already opened the front passenger door of the vehicle well before the divisional van came to a stop. He alighted from the divisional van and immediately ran into John Coutts Reserve, leaving the front passenger door of his vehicle wide open. F/C Churcher alighted from the driver's side of the vehicle, ran around and closed the front passenger door then locked the vehicle prior to running into John Coutts Reserve, approximately nine seconds behind Constable Andrew.

[231] Statement of Constable Andrew, CB 443.

258. Constable Andrew indicates within his statement that '*when I got out of the Police vehicle I asked the people who were standing on the footpath several times where the assault was taking place. I was unaware who was involved in the assault other than we were attending an assault. The people indicated in the direction where the assault was taking place. I then looked in that direction and could see a male person and he had something I think in his right hand. The hand was going up and down*'.[232]

259. Constable Andrew ran towards where Gabriel was continuing to violently assault Lilla. Within his written statement Constable Andrew states '*I was running towards where the male was and as I got closer I could see he had a stick in his hand. The stick was maybe thirty centimetres long, I am not sure … … The male was stabbing the female with the stick around the face region when I was running towards them. The female was on her back and the male was on top of her stabbing her in the face*'.[233]

260. Constable Andrew repeatedly yelled out to Gabriel directing him to stop however Gabriel did not respond and refused all verbal directions given by Constable Andrew to cease. Constable Andrew then came to a halt approximately 2-3 metres from where Gabriel was. Whilst Constable Andrew in his statement gave evidence that he was, at that time, between 7-10 metres from Gabriel, [234] I find from viewing the mobile phone footage that he was much closer than that. I also note that F/C Churcher within her statement gave evidence that Constable Andrew stopped 2-3 metres before Gabriel. [235] At that time Lilla was motionless on the ground, Gabriel was on his knees leaning over Lilla continuing to violently assault her.

261. Constable Andrew again commanded Gabriel '*Police, drop it, drop it*' and then pointed his firearm directly at Gabriel. Gabriel looked up at Constable Andrew briefly saying '*you're not going to shoot*' and then returned to attacking Lilla. Constable Andrew immediately discharged his firearm once, the bullet impacting Gabriel causing him to flinch forward momentarily however the assault did not cease.[236] F/C Churcher, who had been running, then came to a stop on the right-hand side and approximately a metre behind Constable Andrew. When Gabriel continued to assault Lilla, Constable Andrew discharged his firearm a second time, this second bullet also impacting Gabriel.[237]

262. Gabriel then threw the stick that he was holding away whilst he was still kneeling and rose to his feet, clutching his mid-chest and abdominal region and causing F/C Churcher to draw her firearm. Gabriel took two steps and then stopped, after which Constable Andrew discharged his firearm a third time. Gabriel reacted to the impact of the third bullet, flinching and bending over, and approximately five seconds later collapsed to the ground. Constable Andrew remained in approximately the same location at the time of all three discharges of his firearm.

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[232] Statement of Constable Andrew, CB 444.
[233] Statement of Constable Andrew, CB 444-445.
[234] Statement of Constable Andrew, CB 445.
[235] Statement of F/C Churcher, CB 453.
[236] Statement of Constable Andrew, CB 446.
[237] Exhibit 22 Mobile Phone Footage.

263. At 3.45.37pm Broadmeadows 303 broadcast over Police Radio '*Shots fired, shots fired, shots fired*'. Constable Andrew handcuffed Gabriel and then commenced CPR whilst F/C Churcher commenced emergency first aid upon Lilla. They were relieved soon after by First Constable Saydar, Constable McKenna, and First Constable Lim Joon. Ambulance Victoria Paramedics arrived soon after commencing treatment assisted by the Victoria Police Officers on scene.

264. Gabriel was declared deceased at the scene at 4.05pm.

265. Ambulance Victoria Paramedic Davis examined Lilla Messo and found her to be unconscious, not breathing and without a palpable pulse.[238],[239] MICA Paramedic Humar assisted and determined she was suffering gross facial injuries, facial lacerations and puncture wounds, a punctured left eye and neck injuries. At 4.22pm Lilla was urgently transported by ambulance to the Royal Melbourne Hospital being treated by MICA 14 enroute. Upon arrival her condition was assessed as critical and not stable.[240]

Critical Incident and Crime Scene Investigation

266. A critical incident was immediately declared, crime scene established, and investigation of the incident taken carriage by the Victoria Police Homicide Squad overseen by the Professional Standards Command.

267. Both Constable Andrew and F/C Churcher were subject to mandatory drug and alcohol testing with negative result. They were transported back to Broadmeadows Police Station where statements were taken.

268. During the subsequent forensic crime scene examination, in the south-east corner of John Coutts Reserve was a park bench on which were located pair of white 'Everlast' size 12 runners, pair of white socks, 'Classic Notebook' with a navy cover and 10 pages of hand-written notes[241] and 600ml 'Mount Franklin' water bottle. Located near Gabriel's body were two mobile phones (one containing cards in the name of Lilla Messo), car key, various items of clothing that had been cut off by Paramedics and a blood-stained branch measuring approximately 400mm.[242] Approximately six and a half metres north from the feet of Gabriel's body, three fired cartridge cases were located.[243]

[238] Statement of Ambulance Paramedic Samantha Davis, CB 515.
[239] Statement of MICA Paramedic Matthew Humar, CB 521.
[240] Statement of Detective Senior Constable Rossiani, CB 550.
[241] Handwritten notebook of Gabrielle Messo, CB 694-699.
[242] Statement of Leading Senior Constable Huf, CB 563-564.
[243] Statement of Leading Senior Constable Griffiths, CB 565.

269. Within the ten pages of hand-written notes was contained the following words '*Lilla Messo anhilate ... mother declares forgiveness I can grant but not to any woman that betrays her own children 100 ... Or father ... This Act can NOT FORGIVE*'. [244]

270. An examination of Gabriel's phone indicated that he had saved within his contacts Lilla's number under the name '*Mum 100 Anhilation Or You Burn In Underworld… Divine Mothers Condems Her To Anhilation*' whilst Fuat's number under the name '*Frank To Be Seen Needs Anhilation Lol 100*'.

271. At a later date an examination of Constable Andrew's semi-automatic pistol by the Ballistics Unit confirmed that a total of three (3) cartridges had been discharged.

272. Enquiries undertaken at a later date confirmed that Constable Andrew was OSTT qualified, having first qualified on 27 June 2019 during his VPA Recruit Training and requalifying on 8 July 2020 at Craigieburn OSTT Unit.[245]

Injuries to Lilla Messo

273. Upon arrival at RMH, Lilla Messo was unconscious and in cardiac arrest. Lilla suffered three subsequent cardiac arrests in the emergency department, that all responded to resuscitative measures and defibrillation. Lilla was reviewed by multiple specialities, including trauma surgery, eye surgery, ENT and plastic surgery. Following a Trauma CT scan she was taken to the operating theatre for surgery, then admitted to ICU, where she remained until 27 July 2020. Lilla's final diagnosis included:[246]

    273.1. Facial lacerations, requiring repair; and

    273.2. Ruptured globe of left eye requiring exenteration (removal of eye); and

    273.3. Laceration of neck requiring exploration and ligation of vessels in theatre; and

    273.4. Subdural haematoma of brain, conservatively managed; and

    273.5. Acquired Brain Injury, combination traumatic and result of cardiac arrest; and

    273.6. Nasal bone fracture, conservatively managed; and

    273.7. Haemopneumothoraces (collapsed lungs) bilateral, treated with intercostal drains; and

    273.8. Multiple cardiac arrests, possibly due to trauma initially, but less certain origin of subsequent arrests; and

    273.9. Ventilator Associated Penumonia.

[244] Handwritten notebook of Gabrielle Messo, CB 699.
[245] Recorded OST Training History of Constable Andrew, CB 700.
[246] Statement of Dr David Read, Director of Trauma Surgery, CB 592.

274. In the opinion of Dr David Read, Director of Trauma Surgery, RMH '*the injuries are consistent with the effects of multiple areas of penetrating trauma about the head, neck and chest. The injuries have resulted in permanent loss of vision in one eye, facial scarring and a brain injury. The injuries resulted in four cardiac arrests which responded to emergency measures. The injuries were significant enough to be a threat to life. This report does not take into account any resulting psychological harm*'.[247] Whilst Lilla continues to make significant steps in her rehabilitation, it must be recognised that the events of 16 July 2020 have resulted in permanent and life-long injuries.

Assessment of the conduct of Victoria Police at John Coutts Reserve

Assessment of conduct of Constable Andrew and FC Churcher prior to the firearm discharges

275. Foundational to Police members' training are the Operational Response Principles (ORP) and the Operational Safety Tool, SAFE TACTICS. In support of these Principles and to contextualise them, Police members are provided with the Operational Safety Tool, SAFE TACTICS, that provides a number of relevant prompts:

    275.1. '*Slow Down, Step Back, Consider your response, Don't rush in*' – '*Always consider the safety of yourself and others. Take control of your emotional response and adrenalin. Control the urge to rush in; your response is likely to be ineffective if it is not safe. Consider whether what you are doing, or intending to do, is safe, necessary and sanctioned by legislation or policy*'.

    275.2. '*Formulate a Plan, Identify objectives and how they'll be achieved*' – '*Make every effort to prepare a planned response to an unplanned incident. Consider the information you have at hand, your personal capability and experience along with that of other attending resources. Having assessed the risks, develop a plan that mitigates those risks and achieves your objectives*'.

276. Constable Andrew within his first statement made no reference to there being any discussion with F/C Churcher enroute to John Coutts Reserve. In respect of the Police Radio transmissions, he stated that '*we received a job from D24 over the radio in relation to an assault in a Reserve. The assault is a Priority One job. I didn't really hear what the dispatcher over the radio but knew it was in a reserve. I didn't hear the exact location … … when we were travelling to the Reserve we were getting updates from D24. The updates we were getting were that the assault was still ongoing*'.[248] It is unclear on the basis of Constable Andrew's evidence precisely how much of either the initial broadcast, or subsequent updates, he heard, understood and processed in respect of the events unfolding within John Coutts Reserve.

[247] Statement of Dr David Read, Director of Trauma Surgery, CB 593.
[248] Statement of Constable Andrew, CB 443.

277. The only reference F/C Churcher makes to any conversation enroute was in respect of the members activating their BWCs, stating '*I remember as was I driving there, I started to make a mental plan because I continued to hear the further calls coming over the radio. I remember thinking that we had to make an assessment and stop the assaults*'.[249]

278. At inquest F/C Churcher was unable to articulate any conversation that occurred between herself and Constable Andrew.[250] F/C Churcher was unable to recall firstly whether anything was said to Constable Andrew, and secondly *if* there was a conversation, what the contents of that conversation were. Rather F/C Churcher gave evidence that '*the aim was just to get there and stop the assaults. We don't – we didn't have enough information to make a solid plan for it*'.

279. Constable Andrew's conduct as he arrived at John Coutts Reserve also indicates an absence of any planning or coordination with his partner. As the divisional van turned the corner from Linacre Crescent into Katrina Drive, he had already opened the front passenger door ready to alight. As the vehicle was slowing to a stop Constable Andrew alighted, ran across into the reserve leaving his front passenger door open. Constable Andrew's conduct was unexpected to F/C Churcher, at inquest she conceded that it had surprised her.[251]

280. F/C Churcher further conceded in her evidence at inquest that a divisional van conducting uniform duties contains a minimum of two Police members, allowing those members to work together as a team, providing a greater range of tactical options to deal with situations and allowing for contingencies as a situation develops.[252] Specifically F/C Churcher acknowledged that members working as part of a team allows for them to interact with a person, assessing the situation individually each time, considering the full range of tactical options, and allowing for one member to attempt to resolve a situation with one tactical option whilst the second member provides backup and cover with a second, different, tactical option.[253]

281. F/C Churcher did not agree with Counsel Assisting that Constable Andrew's conduct, running off as described, affected their ability to work as a team and that they were unable to accommodate contingencies previously described.[254]

[249] Statement of F/C Churcher, CB 453; evidence of F/C Churcher, T 869:24 – T 871:1.
[250] Evidence of F/C Churcher, T 869:24 – T 871:1.
[251] Evidence of F/C Churcher, T 875:9-10, T 877:5-18.
[252] Evidence of F/C Churcher, T 871:2-27.
[253] Evidence of F/C Churcher, T 871:28 – T 873:5.
[254] Evidence of F/C Churcher, T879:14-20.

Submissions

282. Counsel Assisting submitted that it was open to find that there was no articulated or understood plan between Constable Andrew and F/C Churcher whilst they were in their divisional van enroute to the incident. It was further submitted that F/C Churcher's entry into John Coutts Reserve was delayed due to being required to close the front passenger door of the divisional van, left open by Constable Andrew as he alighted from the vehicle and sprinted away.

283. Counsel for the Chief Commissioner submitted that contrary to the submissions made by Counsel Assisting, it is not open to infer from the evidence of F/C Churcher, or all the other available evidence, that the officers did not in fact make a verbal plan. Regardless, Counsel for the Chief Commissioner further submitted that '*the significance of any lack of verbal planning in the vehicle is disputed … … the significance of Constable Andrew running into the park first is also disputed. There is no evidence that Constable Andrew deliberately left his door open, or that he failed to tell F/C Churcher of any plan he had in this regard. Further it took mere seconds for F/C Churcher to close the door*'.

284. Counsel Assisting submitted that the absence of apparent planning and coordination between Constable Andrew and F/C Churcher resulted in a number of outcomes, including Constable Andrew working autonomously, without regard for the advantages in working as part of a team and the loss of any opportunity to plan once they had information at the scene. Counsel for the Chief Commissioner submitted that whilst the general statements made by Counsel Assisting as to the tactical advantages of working as a team were accepted, Counsel Assisting '*failed to recognise that that is exactly what Constable Andrew and F/C Churcher were doing on the day*'. Further Counsel for the Chief Commissioner submitted that as this was a time critical incident, Constable Andrew's conduct resulted in him being able to reach Gabriel's location more quickly than had he waited to travel in tandem.

Comments

285. The evidence before me does not support a finding that there was any substantive communication, planning or coordination between F/C Churcher and Constable Andrew prior to their arrival at John Coutts Reserve in respect of a plan for managing the situation or coordinating together to cease the assault.

286. I find Constable Andrew's conduct unnecessarily delayed F/C Churcher's entry into John Coutts Reserve as she was forced to run from the driver's side of the vehicle across to the passenger side to close the door, and then retrace her steps prior to entering John Coutts Reserve.

287. Further, I find on the basis of the available footage, that Constable Andrew discharged his firearm for the first time whilst F/C Churcher was still running towards his location, and for a second time either as she was still running or had only just stopped and was in no position to provide any direction or support. I do not agree with Counsel for the Chief Commissioner's submission that F/C Churcher had reached Constable Andrew just prior to the first shot being fired, such a submission is not supported by the objective evidence.

288. Contrary to the submission made by Counsel for the Chief Commissioner, there is minimal evidence available to me that Constable Andrew and F/C Churcher were working together as a team as they approached the incident within John Coutts Reserve. It is evident that Constable Andrew's conduct effectively excluded F/C Churcher from any of the critical tactical decisions that occurred. It must also be remembered that F/C Churcher was the senior member of the divisional van that shift, and Constable Andrew's conduct provided no opportunity for F/C Churcher's experience to contribute to resolving the incident.

289. Constable Andrew's conduct also demonstrated no regard for foundational aspects of his training, particularly in respect of the Operational Safety Tool, SAFE TACTICS. There is no evidence that Constable Andrew slowed down, stepped back, considered his response and didn't rush in. Further there is no evidence that Constable Andrew formulated a plan, identified the objectives and how they were to be achieved. I reject the submission made by Counsel for the Chief Commissioner that it was important that Constable Andrew reached Gabriel's location as soon as possible, as to have waited to travel in tandem with F/C Churcher would have sacrificed precious time. What was sacrificed was any regard for the advantages in working as part of a team and the consequences, previously identified, that flowed from that.

Assessment of Constable Andrew's evaluation of the tactical options available

290. At the commencement of his shift on 16 July 2020, Constable Andrew was equipped with the following operational safety and tactical equipment:[255]

(a) Semi-automatic pistol, holstered on his right leg attached to his equipment belt; and

(b) Oleoresin capsicum (OC) spray in the OC pouch left-hand side equipment belt; and

(c) Handcuffs in handcuff pouch on left hip; and

(d) ASP expandable baton in scabbard on front of ballistic vest; and

(e) MK9 large Oleoresin capsicum (OC) foam on left leg.

[255] Statement of Constable Andrew, CB 1346.

291. Neither Constable Andrew nor F/C Churcher were equipped with a conducted energy device (CED) (taser).

292. Senior Sergeant Sarvas gave evidence about police training, referring to the Victoria Police Manual Operational Safety and the Use of Force:[256]

> '*Members are trained in a range of techniques and a variety of operational safety equipment to enable them to have options when responding to an incident. The level of force required to bring an incident under control may need to increase or decrease depending on the situation, and is determined by a range of factors including:*
>
> - *legislative provisions including 322K & 462A of the Crimes Act 1958*
> - *the type of incident*
> - *the capability of the responding members*
> - *the responding members assessment of the risk'.*

293. Senior Sergeant Sarvas further stated that

> '*Victoria Police utilises a situational Tactical Options Model (TOM) as opposed to a use of force continuum, which is a linear application of tactical options. The TOM is driven by the totality of information and intelligence and is subjected to a continuous assess and reassess cycle. If force is unavoidable, the random arrangement of tactical options encourages police members to escalate and deescalate the choice of equipment or tactics in accordance with the direction the incident is taking and the information available to them.*
>
> *The TOM does not dictate how an incident is to be managed but supports and assists the decision-making process and can be used to assist incident resolution … … the over-riding consideration in the model is that a member's response must be reasonable and proportionate. The model is displayed as a circle as there is no hierarchy of tactical options. Consider all tactical options and make informed decisions on the escalation and de-escalation of force in a dynamic environment*'.[257]

[256] Statement of Senior Sergeant Sarvas, CB 1337.
[257] Statement of Senior Sergeant Sarvas, CB 1338.

294. A review of the Police Radio broadcasts clearly indicates that whilst the initial broadcast was for '*a stabbing, they possibly think they've used a knife or a stick*' that three subsequent broadcasts clarified the situation as involving '*stabbed in the face with a stick*', '*female that's been stabbed there with the stick*' and '*male still sitting on top of the female stabbing at her with a stick*'. Further Constable Andrew clearly identified, that as he ran towards Gabriel, that '*as I got closer I could see he had a stick in his hand. The stick was maybe thirty centimetres long, I am not sure … … the male was stabbing the female with the stick around the face region*'.[258]

295. The evidence is unsettled as to when Constable Andrew drew his firearm from its holster. In his initial written statement Constable Andrew indicates running towards Gabriel yelling at him to stop repeatedly, coming to a stop after which '*the male kept stabbing the female and I drew my firearm*'.[259] As previously indicated Constable Andrew claimed privilege in respect of self-incrimination pursuant to s 57 Coroners Act and was unable to be examined further on this issue. I make no adverse inference from this application.

296. F/C Churcher in her written statement indicates '*I can't remember if I saw Emmanuel with his firearm drawn as I arrived or weather [sic], he got it out as I was standing next to him, but I remember that he was pointing the firearm at the guy as he was yelling at him to stop stabbing the person*'.[260] At inquest F/C Churcher gave evidence that she was unable to recall when Constable Andrew first drew his firearm.[261]

297. F/C Churcher at inquest gave evidence that in her opinion, there were no other options that were appropriate in this instance.[262] However she was then unable to articulate in respect of OC aerosols whether she had turned her mind to their application and ruled them out, or whether she had not even thought about deploying them.[263] Whilst Counsel Assisting's question was prematurely terminated by her answer, the effect of her answer appears to be she never turned her mind to deploying an extendable baton.[264] During questioning by her own Counsel, F/C Churcher gave evidence that OC spray/foam was subject to the elements[265] and a baton would not have been appropriate '*because he had a sharp weapon that he was using to stab someone. I'd have to get close enough for him to be able to stab me to use a baton.*'[266]

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[258] Statement of Constable Andrew, CB 444.
[259] Statement of Constable Andrew, CB 445-446.
[260] Statement of F/C Churcher, CB 454.
[261] Evidence of F/C Churcher, T879:21-24, T888:31 - T889:1.
[262] Evidence of F/C Churcher, T 895:26 – T 896:16.
[263] Evidence of F/C Churcher, T 896:23-27.
[264] Evidence of F/C Churcher, T 896.28.
[265] Evidence of F/C Churcher, T 905:4-8.
[266] Evidence of F/C Churcher, T 904:26-31.

298. F/C Churcher conceded that there had been no discussion with Constable Andrew in respect of approaching the assault together, enabling one member to deploy a less than lethal option covered by their partner, with a lethal option in support.[267] During questioning by her own Counsel, F/C Churcher indicated that such an approach would not have been appropriate in the circumstances although had difficulty articulating the reasons why, numerous times responding to questioning with '*I just don't think it would've been appropriate*'.[268]

Submissions

299. Counsel Assisting submitted that one of the consequences of the absence of apparent planning and coordination between Constable Andrew and F/C Churcher limited the tactical options available to the Police members. Counsel for the Chief Commissioner submitted that this should be rejected and that in fact, Constable Andrew's conduct meant that the tactical option of negotiation was able to commence, and ultimately be dismissed, due to non-compliance by Gabriel at an earlier stage.

300. Counsel Assisting further submitted that Constable Andrew at the very least reached for, if not drew, his firearm as he entered John Coutts Reserve.[269] Counsel for the Chief Commissioner, in oral submissions appeared to accept that proposition, submitting '*Yes, it is true that Constable Andrew had his firearm out, or drawn I think was the expression used, prior to getting to the scene. In our submission that is not inappropriate given the information that he had been provided in the car on the way there*'.[270]

Comments

301. I accept Counsel Assisting's submission that the assessment of the reasonableness of police conduct should be approached in a realistic manner, judged by reference to the reality that decisions have to be made quickly, often under pressure in emergency situations, not by reference to hindsight.[271]

302. The initial written statement of Constable Andrew fails to articulate in any meaningful way the significant information that had been broadcast by Police Radio as they were enroute to John Coutts Reserve in respect of the incident they were responding to. At most Constable Andrew articulates '*the assault is a priority one job. I didn't really hear what the dispatcher over the radio but knew it was in a reserve … … the updates we were getting were that the assault was still ongoing*'.[272] Immediately upon arrival Constable Andrew further states '*when I got out of the Police vehicle, I asked the people who were standing on the footpath several times where the assault was taking place. I was unaware who was involved in the assault other than we were attending an assault*'.

[267] Evidence of F/C Churcher, T 896:6-10.
[268] Evidence of F/C Churcher, T 905:12-25.
[269] Exhibit 97 CCTV at 41'23"
[270] Submissions on behalf of the Chief Commissioner of Police, T 1046:1-5.
[271] *Walker v Hamm* [2008] VSC 596, [55] (Smith J); *Woodleigh v Boyd* [2001] NSWCA 35, [37] (Heydon JA).
[272] Statement of Constable Andrew, CB 444.

303. I find that on the basis of Constable Andrew's evidence, it is difficult to ascertain precisely what he had heard, understood and processed in respect of the D24 Police Radio broadcasts whilst they were enroute to John Coutts Reserve or immediately after his arrival. I note F/C Churcher's evidence at inquest that both, whilst they were in their vehicle, and immediately upon alighting from the vehicle whilst they were on the street, the assault incident was not visible to her.[273] On the basis of Constable Andrew's statement it would appear he likewise had no immediate view of the assault.

304. I find that on the basis of the D24 Police Radio broadcasts that whilst initially the weapon was initially broadcast as a knife, three subsequent and separate broadcasts clarified that Gabriel was assaulting Lilla with a stick. Further I find that Constable Andrew as he ran towards Gabriel clearly recognised and identified the weapon as a stick, and did not identify Gabriel of being in possession of any other weapons.

305. It is clear on Constable Andrew's evidence, and from the mobile phone footage capturing the incident[274], that Constable Andrew moved from verbal negotiation directly to his police issued firearm. The only evidence given by Constable Andrew on this point was that '*I fired my pistol at the male to stop him because I thought the male was going to kill the female*'. Whilst Constable Andrew was equipped with an ASP extendable baton, OC spray and OC Foam canister there is no evidence available in respect of what, if any, evaluations Constable Andrew made in respect of these tactical options prior to deploying lethal force with his police issued firearm.

306. I find that at the very least, Constable Andrew reached for his holster and firearm as he initially ran into John Coutts Reserve. The CCTV and mobile phone recordings available do not allow me to find, to the requisite standard, that he withdrew his firearm at this time. The absence of BWC footage from both members has resulted in the coronial investigation not having the benefit of the best evidence available in this respect. The fact that Constable Andrew reached for his holster and firearm at this stage is telling, it indicates that Constable Andrew was already considering escalating his tactical option to lethal force, despite not having available to him much of the pertinent information in respect of the circumstances of the assault, or what precisely was occurring.

[273] Evidence of F/C Churcher, T 873:15-27.
[274] Exhibit 22 Mobile Phone Footage.

307. I find that Constable Andrew's conduct failed to be in accordance with elements of his training. The Operational Safety Tool, SAFE TACTICS, required Constable Andrew in respect of tactical options to '*select the most appropriate, but be prepared to adjust ... ... you have a variety of tactical options, including operational safety equipment, available to assist you in effectively and safely responding to policing tasks ... ... the choice of tactical option should always consider the nature of the task and the proportionality of the police response*'. Further as Senior Sergeant Sarvas articulates, '*the Tactical Options Model (TOM) is driven by the totality of information and intelligence and is subjected to a continuous assess and reassess cycle*'. There is no evidence before me upon which I can find Constable Andrew engaged in any of these processes.

308. It is difficult to understand why Constable Andrew did not turn his mind to alternative tactical options. In his initial written statement he clearly states that he recognised the weapon as a stick that was '*maybe thirty centimetres long*'.[275] It is indisputable that both Gabriel's fists, and this tree branch (later determined to be 400mm in length) had caused life-threatening injuries to Lilla, the medical evidence is unequivocal in this respect. However the duration of the assault also needs to be recognised, Gabriel had been violently assaulting Lilla for a seventeen-minute period prior to the arrival of Victoria Police. Further upon Constable Andrew stopping within 2-3 metres of Gabriel, it is clear Gabriel was in a tactically inferior position on his knees, armed with a tree branch.

309. Ultimately F/C Churcher gave evidence that, even with the benefit of hindsight, there were no opportunities to approach the incident differently.[276] Notwithstanding F/C Churcher's evidence, and the ferocity of the assault that Gabriel was inflicting upon Lilla, it concerns me greatly that there is no evidence before me that either Constable Andrew or F/C Churcher turned their mind to, and subsequently ruled out, utilising less than lethal tactical options, such as an extendable baton, OC spray or OC foam.

310. This incident escalated from verbal negotiation directly to lethal force and the repeated discharge of a police firearm. The threat that faced the Officers was a male on his knees armed with a tree branch stabbing an unconscious female. It is difficult to understand why less than lethal tactical options were not attempted, even with the backup of a lethal option provided by the second Officer. In the circumstances attempts could have been made to disarm Gabriel with either an extendable baton, or OC spray/foam, or both. Had they been ineffective then Officers may have been required to escalate to a lethal tactical option, however not before these less than lethal tactical options had at least been attempted.

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[275] Statement of Constable Andrew, CB 444.
[276] Evidence of F/C Churcher, T 898:19-22.

Assessment of the use of force by Constable Andrew

311. In finding the factual circumstances in respect of the three separate discharges of Constable Andrew's firearm I make the following preliminary comments.

312. Firstly, as submitted by Counsel Assisting, the assessment of the reasonableness of police conduct should be approached in a realistic manner, judged by reference to the reality that decisions have to be made quickly, often under pressure in emergency situations, not by reference to hindsight.[277]

313. Secondly, the absence of BWC footage from either Constable Andrew or F/C Churcher has resulted in the coronial investigation not having the benefit of the best available evidence.

314. Thirdly, in the absence of relevant BWC footage, the objective evidence of greatest assistance available is mobile phone footage recorded at distance from a number of civilian eyewitnesses who were, however, standing some distance from the discharges.

315. Fourthly it is evident that having reviewed all of the multimedia available, both CCTV and recorded mobile phone footage, that Constable Andrew, F/C Churcher and numerous members of the public have not accurately recalled in certain aspects the factual circumstances surrounding the three discharges in respect of Constable Andrew's firearm. I make no adverse inference from this, it simply reflects the fallibility of human memory in an emotionally charged and high pressure incident. I note F/C Churcher's response to questioning at inquest as to how she was feeling at the time, '*I don't know. It was just a lot of adrenaline and high stress*'.[278]

316. I will briefly summarise Constable Andrew's and F/C Churcher's evidence below and then make findings in respect of what the various recordings capture. I do not seek to dissect each and every witness statement made by civilian eyewitnesses within this Finding, instead I give the greatest weight to the objective recordings that have captured the incident.

[277] *Walker v Hamm* [2008] VSC 596, [55] (Smith J); *Woodleigh v Boyd* [2001] NSWCA 35, [37] (Heydon JA).
[278] Evidence of F/C Churcher, T 903:24-25.

317. Constable Andrew within his initial statement gives evidence that after repeatedly directing Gabriel to cease that he pointed his firearm at Gabriel who

> '*looked up at me for a split second and said, "You are not going to shoot" … … as soon as the male stopped looking at me and looked back at the female I fired one shot … … I don't remember what he did after that but at some point, he got up to his feet … … at some point he has gotten up and I fired two more shots. The male said something to me when he stood up and at this point, I fired two more shots to stop him. I don't know if he still had the stick in his hand when he stood up … … when the male stood up he was very close to the female still standing over the top of her. The female was in the middle between the male and myself. I was still in the same spot, I hadn't moved any closer to them I fired when I fired second and third shot because I was really worried he was going to go back stabbing the female and kill her. I fired my pistol at the male to stop him because I thought the male was going to kill the female*'.[279]

A number of aspects of Constable Andrew's evidence are not supported by the mobile phone recordings including Gabriel's position when he fired the *second* discharge and Gabriel's proximity to Lilla when he fired the *third* discharge.

318. On 11 September 2020 Constable Andrew provided a second statement to the Coroner's Investigator. Within that statement Constable Andrew gives evidence that after firing the first discharge, his thought process was that

> '*he was still close to her and still close to me. He started to come at me or go back to her. It almost seemed as though the first shot didn't do anything and he was still able to get up and move freely*'.[280]

Constable Andrew was unable to recall if Gabriel still had the stick in his possession when he got up nor the exact sequence of the discharges.

[279] Statement of Constable Andrew, CB 446-447.
[280] Statement of F/C Churcher, CB 449.

319. F/C Churcher in her initial statement gave evidence that as she approached the incident, she was able to hear Constable Andrew yelling at Gabriel to stop and drop the weapon without effect. She then stated

> '*at this stage I was now standing about a metre behind Emmanuel and to the right of him and I could clearly see that the male was stabbing the person to the face and I couldn't make out if it was a male or female on the ground because of all the blood … … I let him take the lead and give the directions for the male to stop … … I remember that he was pointing the firearm at the guy as he was yelling at him to stop stabbing the person. I think it was at this stage that I got my firearm out of the holster because the incident was so serious in the way the male was stabbing the person … … I remember it would've been seconds later that Emmanuel shot the guy once and it was like he didn't event flinch and then he went back to stabbing the person. I think it was seconds later that Emmanuel shot him again and the male threw the stick away and he stood up and he stared at us. I remember that we were both give him directions now to get onto the ground and then he started to advance on us and we were yelling at him to stop and then Emmanuel shot him a third time*'.

320. A number of aspects of F/C Churcher's evidence are not supported by the mobile phone recordings including her position at the time of the *first* discharge, when she withdrew her firearm from its holster as well as Gabriel's conduct after standing up after the *second* discharge. Counsel Assisting sought to clarify these matters with the witness at inquest however F/C Churcher was unable to resolve these matters.[281]

Submissions

321. Counsel Assisting submitted that: the *first* and *second* discharge occurred whilst Gabriel was attacking Lilla; that attack placed Lilla's life at risk; and further Constable Andrew was alone dealing with Gabriel as F/C Churcher was still moving towards the scene. Further Counsel Assisting submitted that Constable Andrew's use of lethal force during the *first* and *second* discharges was reasonable, the level of force was not disproportionate to Constable Andrew's objective to prevent the assault from continuing and to protect Lilla from really serious injury or death.

[281] Evidence of F/C Churcher, T 880:16 – T 890:16.

322. Counsel Assisting submitted however there were major points of distinction between the circumstances in which the first two shots were fired, and those that applied at the time of the *third* discharge. At the time of the *third* discharge it was submitted that Gabriel:

322.1. Had stopped assaulting Lilla;

322.2. Had thrown away the stick he had been using to assault Lilla;

322.3. Stood up;

322.4. Clutched his upper abdomen with both hands in front of his body; and

322.5. Increased the distance between himself, his mother and police.

323. Counsel for the Chief Commissioner submitted that Counsel Assisting's analysis '*relies heavily on artificially confining the conduct of the first responders by reference to the incident with the benefit of hindsight and does not grapple with the reality of the life threatening and dynamic scene which confronted the police officers*'.

324. Counsel for the Chief Commissioner submitted that a review of the available footage shows the following sequence of events:

324.1. F/C Churcher had reached Constable Andrew just prior to the first shot being fired;

324.2. Despite already having been shot twice in the chest, Gabriel stood up suddenly and aggressively after the second shot;

324.3. The footage does not show Gabriel throwing away the stick (and it is noted that, whilst F/C Churcher believes she saw Gabriel throwing away the stick, Constable Andrew did not see Gabriel throwing away the stick – and that according to another eyewitness, Gabriel was still holding the stick when the third shot was fired);

324.4. Gabriel was facing away from the officers when he clutched his upper abdomen, and thus this motion would not have been apparent to the officers;

324.5. The suggestion that Gabriel increased the distance between himself, his mother and police is misleading:

(a) At most, he did so by a matter of centimetres over the course of one second;

(b) Immediately before the third shot, Gabriel turned back towards the officers

324.6. All of this took place within mere seconds. Indeed, the third shot was fired just 2-3 seconds after Gabriel had stood up suddenly and aggressively following the second shot.

325. Ultimately Counsel for the Chief Commissioner submitted that all three discharges were lawfully justified and in accordance with Constable Andrew's training.

Comments

326. Firstly I disagree with Counsel for the Chief Commissioner's summary of the footage of the three discharges of Constable Andrew's firearm outlined within their submissions and reproduced at paragraphs 324.1-324.6 above. It does not reflect my own observations of the relevant footage. Further I reject the further submission that Counsel Assisting has sought to '*summarise events millisecond by millisecond ultimately providing a false impression of what took place*'. Counsel Assisting has sought to engage in no such micro-analysis and has assisted by referring to the relevant case law on how matters such as these should be approached.

327. Specifically in respect of the circumstances of the *first* and *second* discharges of Constable Andrew's police firearm I make the following findings:

    327.1. Prior to the *first* discharge Constable Andrew has issued repeated verbal commands to Gabriel to stop and cease his assault upon Lilla, all of these verbal directions were ignored by Gabriel;

    327.2. Prior to the *first* discharge Constable Andrew clearly identified and recognised the weapon that Gabriel was holding was a stick;

    327.3. At the time of the *first* discharge Gabriel was on the ground on his knees over Lilla continuing the assault with a stick held in his right hand, Constable Andrew was standing a distance 2-3 metres from Gabriel. F/C Churcher was still running towards their location and did not have her firearm drawn;

    327.4. After the *first* discharge Gabriel reacted, flinched forward and towards the ground, presumably from the impact of the first bullet;

    327.5. At the time of the *second* discharge Gabriel remained on his knees over Lilla and had his right arm raised about to strike at Lilla. F/C Churcher had only just arrived at the location and come to a stop standing approximately a metre behind and to the right hand side of Constable Andrew, her firearm holstered.

    327.6. The *first* and *second* discharges occurred within a time period less than two seconds.

328. The reasonableness of the use of force by Constable Andrew needs to be assessed against s 462A *Crimes Act 1958* Use of force to prevent the commission of an indictable offence that provides:

> *'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'.*

329. The use of force by Constable Andrew also needs to be assessed against s 322K *Crimes Act 1958* Self-defence (including defence of another) that provides:

> '*a person is not guilty of an offence if the person carries out the conduct constituting the offence in self-defence. A person carries out conduct in self-defence if (a) the person believes that the conduct is necessary in self-defence; and (b) the conduct is a reasonable response in the circumstances as the person perceives them'*.[282]

330. On the evidence available, in respect of the *first* and *second* discharges I am satisfied that Constable Andrew believed that his conduct was necessary in the defence of Lilla and that that conduct was a reasonable response in the circumstances as he perceived them. The level of force used was not disproportionate to Constable Andrew's objective to prevent the assault from continuing and to protect Lilla from really serious injury. Lilla's medical evidence is self-evident.

331. Specifically in respect of the circumstances of the *third* discharge of Constable Andrew's police firearm I make the following findings:

    331.1. After the *second* discharge Gabriel ceased assaulting Lilla and discarded the stick;

    331.2. Gabriel then rose to his feet, there were no weapon visible in either hand. As Gabriel was rising to his feet F/C Churcher withdrew her firearm from its holster and pointed it at Gabriel;

    331.3. Gabriel then clutched his abdomen/torso region with both hands whilst directly facing towards the Officers;

    331.4. Gabriel then moved two steps to his left (to the Officers' right as they were facing him), that is Gabriel moved away from Lilla and also moved away from Constable Andrew and F/C Churcher. He was, at that time, increasing the distance between himself and Lilla and moving away from the Officers.

    331.5. The *third* discharge occurred approximately five (5) seconds after the *second* discharge.

[282] The circumstances in which a person may carry out conduct in self-defence include the defence of the person or another person.

332. I am gravely concerned in respect of Constable Andrew's *third* discharge. I accept Counsel Assisting's submission that there are major points of distinction between the circumstances in which the first two shots were fired, and those that applied at the time of the *third* discharge. For the reasons stated in respect of the *third* discharge I *am not* satisfied that Constable Andrew's use of force was not disproportionate to the objective as he believed on reasonable grounds to be necessary to prevent the continuance of an indictable offence.

Section 49(1) Coroners Act | Referral to the Director of Public Prosecutions

333. Section 49(1) Coroners Act requires that the Principal Registrar notify the Director of Public Prosecutions if I believe that an indictable offence may have been committed in connection with Gabriel's death.

334. Counsel Assisting has simply submitted that '*the Court will be cognisant of s 49 of the Coroners Act 2008 and the circumstances in which it applies. It will also be mindful of the proscriptions in s 69 of the Act*'. Counsel for the Chief Commissioner has submitted that it is not open to me to form the state of mind contemplated by the legislation.

335. The concept of belief has been variously expressed, it is however settled that it requires something more than suspicion, and is an inclination of the mind towards assenting to, rather than rejecting, a proposition, based on facts that are sufficient to create that inclination of the mind in a reasonable person.[283]

336. The requisite threshold that I must attain has been expressed by the legislature as a '*belief that an indictable offence may have been committed*'. This is not a belief, as submitted by Counsel Assisting, '*that it was committed, nor that a jury would find a person guilty of that offence or even that it would be open to a jury to find a person guilty of a particular offence*'. I accept Counsel Assisting's submission that '*may have been committed'* is a concept substantially lower than the ultimate criminal burden of proof beyond reasonable doubt.

337. Further the decision I make is substantially different to the one required to be made by the Director of Public Prosecutions. The Director is guided by an extensive and comprehensive policy that requires a prosecution may only proceed if there is *both* a reasonable prospect of a conviction and the prosecution is in the public interest. In determining whether there is a reasonable prospect of conviction the policy identifies ten separate factors that the Director is required to have regard to. Those are considerations for the Director of Public Prosecutions. They are *not* considerations for myself as the State Coroner presiding over the inquest into the passing of Gabriel Messo.

[283] *George v Rockett* (1990) 170 CLR 104.

338. As previously stated within this Finding:

  338.1. I accept Counsel Assisting's submission that there are major points of distinction between the circumstances in which the first two shots were fired, and those that applied at the time of the *third* discharge. At the time of the *third* discharge, approximately five seconds after the second discharge, Gabriel had ceased his assault upon Lilla, he was no longer armed with the stick or any other weapon, and he was increasing his distance and moving away from both Lilla and the Officers; and

  338.2. For the reasons stated in respect of the *third* discharge I *am not* satisfied that Constable Andrew's use of force was not disproportionate to the objective as he believed on reasonable grounds to be necessary to prevent the continuance of an indictable offence.

339. In these circumstances I have formed a belief to the requisite standard that an indictable offence *may* have been committed by Constable Andrew in connection with Gabriel's death. The indictable offences I have formed a belief to the requisite standard include but are not limited to the following pursuant to the *Crimes Act 1958*, those of homicide, causing serious injury intentionally, conduct endangering life or assault.

340. Accordingly I direct the Principal Registrar to notify the Director of Public Prosecutions and for this matter to be referred through to the Director for their consideration.

The non-activation of Body Worn Cameras by Constable Andrew and FC Churcher

341. At the time of Gabriel's passing, the lead policy document in respect of BWCs was the Chief Commissioner's Instructions CCI 06/19 Body worn camera deployment. The Chief Commissioner's Instruction contained the following:[284]

    341.1. Beneath the heading 'Kit Up' is contained the relevant excerpt '6. When receiving a BWC, members must ensure the BWC is … … switched on and placed into standby mode'.

    341.2. Beneath the heading 'When to start a BWC recording – 'BWC Activation Framework' is contained the relevant excerpt '10. Members **should** start a BWC recording when exercising a legislated or common law power and the recording would assist in collecting evidence'.

342. The Chief Commissioner's Instruction was superseded on 10 December 2020 by the Victoria Police Manual Body worn cameras. That policy now states 'A member wearing a BWC **must** start a recording when exercising a legislated or common law powers … … or to capture an incident occurring, likely to occur or which has occurred'.[285] The removal of any discretion on the part of Police members expressed within the Chief Commissioner's Instruction is welcome.

343. Neither F/C Churcher or Constable Andrew activated their BWCs until *after* Constable Andrew had discharged his police issue firearm and the footage therefore only captures the immediate aftermath post-shooting.

344. The only reference to BWC that Constable Andrew makes in his initial written statement is within the final paragraph where he states '*I discussed with Rebecca at some point that I didn't have my body worn camera on and she told me that she didn't have hers on either. At some point when I realised that I didn't have my body worn camera on that I then turned it on*'.[286]

345. F/C Churcher within her statement states that '*when we first got in the car and started to drive to the incident, I remember I said to Emmanuel that we needed our Body Worn Cameras because this was a serious sounding incident, I turned my camera into the on position and I think he did as well*'.[287] F/C Churcher then states she double tapped her BWC as she ran towards Constable Andrew and Gabriel within John Coutts Reserve.[288] Post-discharge whilst first aid was being rendered F/C Churcher then states '*I remember Emmanuel going shit I didn't have my camera on, and I remember saying don't worry I have mine on and when I looked down mine was on green but not active so I hit the button again*'.[289]

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[284] Chief Commissioner's Instruction CCI 06/19 – Body worn camera deployment, CB 1512.
[285] Victoria Police Manual Body worn cameras, CB 1592-1603.
[286] Statement of Constable Andrew, CB 447.
[287] Statement of F/C Churcher, CB 452.
[288] Statement of F/C Churcher, CB 453.
[289] Statement of F/C Churcher, CB 455.

346. In evidence at inquest F/C Churcher was clearly aware of the provisions of the Chief Commissioner's Instruction except the requirement that the camera be placed in standby at the kit-up stage.[290],[291] F/C Churcher further clarified that in her statement when she had stated she had turned her camera into the on position, she meant the standby position and that the BWC system had acknowledged with a beep that it was now in standby.[292] The only plausible explanation for the failure of F/C Churcher's BWC to activate is that whilst she believed she had 'double tapped' it as she ran into John Coutts Reserve, she had not. The BWC system was clearly working and in standby mode as evidenced by the later recording post-shooting.

Submissions

347. Counsel Assisting submitted that pursuant to the Chief Commissioner's Instruction, members were required to have their BWC's in standby mode from the time they 'kit up' at the start of their shift, and that neither member did this. Further it was submitted that whilst it was not mandated nor prohibited that they activate the recording at any particular time, neither member started their BWC prior to getting out of the vehicle, nor prior to their interaction with Gabriel.

348. Counsel for the Chief Commissioner submitted that it has not been suggested, nor could it be, that the members deliberately failed to activate their BWC's, rather the omission was clearly an oversight, likely due to the newness of the equipment and the urgency of the situation. Counsel for the Chief Commissioner further submitted that '*fortunately, despite the BWCs of the first responders not being activated at the time of the shooting, various members of the public filmed the incident on their mobile phones, such that there is good evidence of what took place*'.

Comments

349. F/C Churcher's and Constable Andrew's failure to activate their BWCs, has resulted in the coronial investigation not having the benefit of the best available evidence in respect of their conduct immediately preceding, and at the time Constable Andrew discharged his police firearm. The exact reasons for that remain somewhat unclear.

350. The absence of that evidence is significant. I reject the Chief Commissioner's submission that despite this, eyewitness recorded mobile phone footage has resulted in there being '*good evidence of what took place*'. The mobile phone footage is semi-adequate, it is less than ideal, and does not provide me with what could have been the best evidence available to allow me to discharge my statutory functions under the Act. It does not for example enable me to make a Finding in respect of precisely when Constable Andrew withdrew his firearm from his holster, nor does it capture the precise verbal interaction that occurred between Gabriel and Constable Andrew.

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[290] Evidence of F/C Churcher, T 863:4 – T 865:11.
[291] Evidence of F/C Churcher, T 866:7 – T 867:3.
[292] Evidence of F/C Churcher, T 865:12-30.

351. The advantages of BWC being utilised by Police members cannot be overstated, they facilitate evidence being captured objectively, they significantly increase transparency in relation to the conduct of Victoria Police members and interactions with members of the public, and they ultimately assist in capturing and recording from an evidential perspective precisely the occurrence of events. They are and will continue to remain of great assistance to both coronial and criminal jurisdictions, and they are of great significance, especially in circumstances such as the current where the conduct of a Victoria Police member results in discharges of a police issued firearm, resulting in the loss of life.

352. This is not the first time that the issue of non-activation of BWCs has come before this Court and this jurisdiction. There is much attractiveness to the submission made by Counsel Assisting that '*as demonstrated by this case, even the use of directive language is only of value when the user operates the device correctly, and in accordance with that policy … … whilst it is acknowledged that there may be diverse views, this case provides another example of the virtues of automatic camera activation (cameras start recording on an event such as on the removal of a firearm from a holster) thus removing the "human error" element*'.

353. It is recognised that anytime a Police member draws their firearm it should be in response to a situation they perceive could result in really serious injury or death, and therefore how to manage and resolve that situation is, and should be, at the forefront of the Officer's mind, activation of their BWC may not. I note the statement of A/Inspector Stewart, Information Systems and Security Command – Frontline Technologies Division that appears on the Inquest Brief[293]. It details technology such as the Axon Signal – Sidearm that is '*a small device with its own internal power source that is attached to the exterior of all Police holsters. Once a firearm is drawn, the magnetic link is broken and the Signal Sidearm sends the Bluetooth signal to all BWC within range to start recording*'. Further I note A/Inspector Stewart's evidence that whilst Victoria Police have yet to consider the Axon Signal – Sidearm technology, other Australian jurisdictions including Tasmania and Western Australia Police agencies are or have deployed their BWC with the added capability of this technology.

354. The statutory functions I am required to discharge pursuant to s 67 Coroners Act, that is to determine the circumstances in which Gabriel's death occurred through the multiple discharges of Constable Andrew's police issued firearm, demands I have the best evidence available. I do not, and I should.

[293] Statement of A/Inspector Stewart, CB 1975-1978.

355. Section 72 Coroners Act empowers me to make recommendations on any matter connected with a death, including recommendations relating to the administration of justice. In these circumstances, and given the issue continues to arise within this jurisdiction, I make the following recommendation to the Chief Commissioner of Police.

Recommendation

356. I recommend that the Chief Commissioner of Police reviews the feasibility of acquiring technology facilitating the automatic activation of members' Body Worn Camera upon a police issued firearm being withdrawn from its holster (for example the Axon Signal – Sidearm technology).

Comments in relation to the training, polices, procedures and practices for NDIS registered organisations

357. Ms Cleur founded ABC Aged and Disability Services in early 2020 and her role in respect of Gabriel was assisting him to apply for funding through the NDIS.

358. Ms Cleur had regular contact with Gabriel via phone and text message.[294] She also attended a psychologist session with him on one occasion. Gabriel trusted Ms Cleur and referred to her at times in text messages as 'mother'. Ms Cleur accepted that Gabriel was a vulnerable individual and throughout her interactions with him she was concerned he might pose a risk to himself or family members.[295]

359. Ms Cleur gave evidence that, on 16 July 2020 she received a text message from Gabriel that led her to believe that Gabriel was 'obviously in some form of psychosis' but his message to her was not overly unusual, so she was not concerned.[296] Other messages Gabriel sent to Ms Cleur throughout June and July 2020 similarly indicated Gabriel was either experiencing an episode of psychosis or considering self-harm and, at the very least, raised matters of concern in relation to his mental health. Despite this, Ms Cleur did not act on those messages and agreed in evidence that, due to her own personal circumstances and training, she was not in a position to be able to navigate or assist him in these times.[297]

[294] Messages between Gabriel and Corina Cleur, Exhibit 114 of the Court Book; evidence of Corina Cleur, T 115:21 – T 116:14.
[295] Evidence of Corina Cleur, T 103:15-30, T 107:19 – T 109:15.
[296] Statement of Corina Cleur, CB 217 [12]; Messages between Gabriel and Corina Cleur, Exhibit 114 of the Court Book, 8 and 16 July 2020.
[297] Statement of Corina Cleur, CB 215; evidence of Corina Cleur, T 112:28 – T 115:9, T 118:29 – T 126:15, T 129:27 – T 131:12.

360. Ms Cleur did not have any particular training other than lived experience in dealing with people in Gabriel's situation. Further, Gabriel was not in fact a client of ABC Aged and Disability Services as he had not yet been accepted for NDIS funding, and therefore, there were no applicable policies or guidelines because it was considered 'pre-engagement'. Ms Cleur also gave evidence that:

360.1. The NDIA did not give any guidance as to how one might go about a pre-engagement procedure; and

360.2. The NDIA did not require any specific training to people fulfilling that role.[298]

361. Organisations providing NDIS-related services inevitably deal with vulnerable individuals. From time to time, these individuals may demonstrate behaviours suggestive of a risk of causing harm to themselves or others. Support from the NDIA may have equipped Ms Cleur to recognise and deal with Gabriel's behaviours better. She was dealing with a very troubled and vulnerable person in Gabriel who she was doing her best to help. However, she was not assisted by any relevant training or support to manage him, or to even appreciate his more concerning behaviour.

362. Gabriel was, because of his mental health, a vulnerable person. At times he displayed behaviours of concern; behaviours which indicated that he posed a risk of harm to himself or others. This concerning behaviour is observed in some of the messages he sent to Ms Cleur. It appears Ms Cleur did not appreciate, nor report, the concerns which should have been apparent. Nor did she realise at the time that she was ill-equipped to deal with them.

363. Counsel assisting submitted that the evidence supports a finding that, for organisations registered under the NDIS:

363.1. there are no specific reporting obligations for; and

363.2. there is no relevant training or support in relation to resources, options and appropriate responses to,

behaviour of clients (or potential clients) which could reasonably indicate concerns of significant risk of harm. This area is ripe for improvement.

[298] Evidence of Corina Cleur, T 101:3 – T 102:15.

364. I agree with Counsel assisting that Registered NDIS service providers do not have reporting obligations and there is no relevant training or support to guide service providers in responding to behaviour of clients and potential clients where they encounter threats, risk of self-harm or harm to others. This appears to be a gap in the NDIS outsourcing of care arrangements which should be addressed. The NDIA should ensure that a component of approval to be a registered NDIS service provider is that the organisation can demonstrate that it has policies and guidelines in place, and appropriate training of staff, to ensure that these risks, when identified, are appropriately escalated and managed.

Recommendation

365. The NDIS Quality and Safeguards Commission should conduct a review of the outsourcing arrangements to ensure that outsource providers of NDIS services have appropriate policies guidelines and training for staff to manage clients suffering mental health conditions who make threats of self-harm or harm to others. The policies and guidelines and training should include identifying a client's deteriorating mental health, and concerning behaviours, and guidelines on the management, escalation and/or referral to appropriate services including escalation to police in appropriate cases

CONCLUSION

366. Pursuant to s 67(1) of the Coroners Act I make the following findings:

 a) the identity of the deceased was Gabriel Messo, born 27 October 1989;

 b) the death occurred on 16 July 2020 at John Coutts Reserve, Gladstone Park, Victoria, from GUNSHOT WOUNDS TO THE CHEST;

 c) in the circumstances described above.

367. I convey my sincerest sympathy to the family and friends of Gabriel Messo.

368. I order that this finding be published on the internet in accordance with s 73(1) Coroners Act and the Rules.

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

The Family of Gabriel Messo;

Mr Shane Patton APM, Chief Commissioner of Police;

Professor Christine Kilpatrick AO, Chief Executive, Melbourne Health;

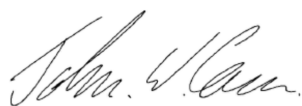
Mr Siva Sivarajah, Chief Executive, Northern Health;

Ms Tracy Mackey, NDIS Quality and Safeguards Commissioner;

Professional Standards Command, Victoria Police;

Detective Sergeant David Woolfe, Homicide Squad, Coroner's Investigator.

Signature:



JUDGE JOHN CAIN
STATE CORONER
Date: 1 December 2022