IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 2226

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF GLENN ROBERT THOMAS

Findings of:	Coroner Simon McGregor
Delivered On:	17 September 2026
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	17 September 2026
Assisting the Coroner:	Nicholas Ngai, Senior Solicitor
Catchwords	Death during police attempt to apprehend or arrest; suicide in presence of police; unregistered firearm; Aboriginal

Aboriginal and Torres Strait Islander readers are advised that this content refers to a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

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SUMMARY

1. Glenn Robert Thomas was 55 years old when he died on 29 April 2023 at the Royal Melbourne Hospital in Parkville of a gunshot wound to the head.

2. On the afternoon of 27 April 2023, Mr Thomas called Triple Zero from Chinaman's Weir in Nathalia threatening to end his life using a firearm. His call prompted a Victoria Police operation to locate and apprehend pursuant to section 351 of the *Mental Health Act 2014* to prevent serious and imminent harm to him or others.

3. As police members approached him at 5.30pm on 27 April 2023, Mr Thomas sustained a self-inflicted gunshot wound.

THE CORONIAL JURISDICTION

4. Mr Thomas' death constituted a *'reportable death'* pursuant to section 4 of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and was unexpected, unnatural and violent.

5. Coroners independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[1] The *cause* of death refers to the *medical* cause or mechanism of death, for coronial purposes, the *circumstances* in which death occurred refers to the surrounding circumstances but limited to events that are sufficiently proximate and causally relevant to the death.[2]

6. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety and the administration of justice by their

[1] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[2] This is the effect of the authorities – see for example Harmsworth v The State Coroner [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

findings and by making comments[3] and recommendations[4] about any matter connected to the death they are investigating.[5]

7. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[6]

Mandatory inquest

8. As Mr Thomas' death occurred while police were actively seeking to apprehend or arrest him, I regard Mr Thomas as a *person placed in custody or care* at the time of his death.[7] In these circumstances, an inquest was mandatory under section 52(2)(b) of the Act.

9. At the conclusion of my investigation, I was satisfied I was able to make findings about the deceased's identity, the cause of death and the circumstances in which death occurred, this case was listed for inquest in accordance with the Act. The Inquest was a Summary Inquest – one conducted without oral testimony – as there were no evidentiary conflicts or discrepancies that would justify calling witnesses.

Sources of Evidence

10. This Finding draws on the totality of the material the product of the coronial investigation into Mr Thomas' death. That is, the court records maintained during the coronial investigation, the Coronial Brief prepared by Detective Sergeant (**D/Sgt**) Megan Adams of the Homicide Squad and further material sought and obtained by the Court, the evidence adduced during the Inquest and any submissions provided by Interested Parties.

11. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

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[3] Section 67(3) of the Act.

[4] Section 72(2) of the Act.

[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[6] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

[7] As this phrase is defined in section 3 of the Act.

BACKGROUND

Personal History

12. Mr Thomas was 55 years old at the time of his death. He was the sixth of Barry and Barbara Thomas' eight children and was raised in northern Victoria.

13. As an adult, Mr Thomas worked as a pearl diver in the Northern Territory, as an arborist in Nathalia, Victoria, and for more than a year before his death, drove a semitrailer 50-60 hours per week delivering stock feed in the Goulburn Valley and Gippsland.[8] He was considered a good and reliable worker.[9]

14. Mr Thomas' medical history included rheumatoid arthritis,[10] thrombocytosis,[11] diverticulitis,[12] musculoskeletal disorders,[13] depression and smoking.[14]

15. Mr Thomas was first diagnosed with depression in 2001 in the setting of relationship breakdown, loss of employment, financial stressors and excessive alcohol consumption which was ameliorated by prescription of an antidepressant and alcohol counselling.[15] Re-occurrence of depression following the death of a sibling was managed in 2004-2005 with psychiatric review, antidepressants, and social worker support.[16] In 2016-2017, Mr Thomas reported suicidal ideation and attempted suicide[17] during a depressive episode

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[8] CB 96-7 and 101.

[9] CB 101.

[10] Rheumatoid arthritis is a chronic autoimmune disorder involving inflammation of joints (swelling, stiffness, damage), particularly affecting small joints of the hands and feet.

[11] Thrombocytosis is a condition characterized by an abnormally high platelet count, often triggered by an underlying inflammatory or infective condition such as rheumatoid arthritis. Symptoms of thrombocytosis include clotting or bleeding disorders, headaches/dizziness, weakness, altered sensation (numbness, burning), or shortness of breath.

[12] Diverticulitis is the inflammation or infection of small, pre-existing pouches (diverticula) in the colon wall characterized by intense abdominal pain, fever, nausea and bowel changes.

[13] Among Mr Thomas' musculoskeletal disorders were osteoarthritis of the left knee, right subacromial bursitis, tight tendinopathy, and degenerative and bulging discs of the lumbar spine.

[14] Mr Thomas' Nathalia Medical Clinic Records, pages 1 and 2 of 300.

[15] Mr Thomas' Nathalia Medical Clinic Records, pages 231, 266 and 277 of 300.

[16] Mr Thomas' Nathalia Medical Clinic Records, page 220 of 300.

[17] Mr Thomas' Nathalia Medical Clinic Records, page 201 of 300. On 11/10/2016 Mr Thomas called Triple Zero to report his intention to suicide and requesting a 'cleanup crew.' He was found by police near a creek (in possession of a length of rope) and apprehended under the *Mental Health Act* 2014 and transferred to hospital for mental health assessment.

following his survival of a motor vehicle collision in which a friend died.[18] Thereafter, depressive episodes in 2018[19] and 2021[20] involved suicidality, the latter with planning[21] and occurred in the context of unemployment and chronic pain. In 2021, Mr Thomas' antidepressant was changed[22] from sertraline[23] to duloxetine.[24]

16. In February 2023, Mr Thomas was admitted to Goulburn Valley Health[25] for conservative management of contained perforation of diverticulitis.[26] Although when he was reviewed as an outpatient on 21 March 2023, the surgeon hoped emergency bowel resection might be avoided, subsequent medical notes suggest a partial bowel resection was likely and planning had commenced.[27] Based on his communications with family members about medical decision-making and financial and testamentary arrangements around that time, Mr Thomas anticipated undergoing surgery.[28]

17. Mr Thomas' regular medications included methotrexate,[29] duloxetine and paracetamol/codeine.[30]

18. Mid-shift on 19 April 2023, Mr Thomas called his employer to say he was 'quitting on the spot.'[31] He provided no further explanation – though his employer assumed the cause

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[18] Mr Thomas' Nathalia Medical Clinic Records, pages 27-28 and 201 of 300.

[19] Mr Thomas' Nathalia Medical Clinic Records, page 23 of 300.

[20] Mr Thomas' Nathalia Medical Clinic Records, page 9 of 300.

[21] Reference was made to 'his rifle.'

[22] Mr Thomas' Nathalia Medical Clinic Records, page 8 of 300.

[23] Sertraline is a selective serotonin reuptake inhibitor (SSRI) used to treat depression, anxiety, post-traumatic stress disorder and obsessive-compulsive disorder.

[24] Duloxetine is a serotonin-norepinephrine reuptake inhibitor (SNRI) which functions as an antidepressant and pain-reliving agent used to treat major depressive disorder and musculoskeletal and nerve pain.

[25] Mr Thomas' Goulburn Valley Health Records, page 64-158 of 195.

[26] Contained perforation in diverticulitis occurs when a ruptured diverticulum (pouch) in the colon is sealed off by surrounding tissue or organs, often creating a localised abscess rather than free perforation into the abdomen. While a serious complication of acute diverticulitis causing pain, fever, and leukocytosis, it is often treated with antibiotics or draining, avoiding immediate emergency surgery.

[27] Mr Thomas' Goulburn Valley Health Records, page 62 of 195.

[28] CB 98 and 99.

[29] Methotrexate is a disease-modifying antirheumatic drug and antimetabolite used to treat severe autoimmune conditions, including rheumatoid arthritis.

[30] Paracetamol and codeine (an opiate) are used in combination for the short-term relief of mild to moderate pain when other analgesics fail.

[31] CB 101.

was health-related – and left the truck, with his possessions inside, at the feed mill and went home by taxi.[32]

19. On 21 April 2023, Mr Thomas contacted his former partner, with whom he had two children, an adult daughter from whom he was estranged and a minor son whom he spoke to and saw regularly.[33] Mr Thomas alerted his former partner that there may be a 'ripple' in his financial support of their youngest child (which was already in arrears) but that 'tax will offset.'[34]

CIRCUMSTANCES OF DEATH

20. On Thursday 27 April 2023, around mid-morning, Mr Thomas's niece, Colleen Thomas stopped at her grandparents' place in Nathalia and not finding them at home stayed to have a coffee and chat with her uncle, Mr Thomas, who lived with them.[35]

21. Mr Thomas and his niece had a close relationship and used to talk often and 'about everything.'[36] Ms Thomas was aware of her uncle's financial strain and health issues and, though his report that day that he'd stopped working due to being too sore to drive all day was unexpected, their conversation and his demeanour was just like 'every other day.'[37]

22. Before leaving Mr Thomas at home around lunchtime, Ms Thomas had given him a lift to and from the supermarket where he bought a 10-pack of Wild Turkey bourbon and some cigarettes.[38]

23. At 3.47pm, Mr Thomas called Triple Zero and told the Operator that he was near Broken Creek at Chinaman's Weir in Nathalia and intended to take his own life using a firearm.[39]

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[32] CB 102.

[33] CB 93 and 97.

[34] CB 108.

[35] CB 93.

[36] CB 93.

[37] CB 94.

[38] CB 94.

[39] CB 110-111.

He could not be more specific about his location and refused to provide his name.[40] Mr Thomas ended the call when the Operator asked him to stay on the line so that he could be connected to a police sergeant (**Sgt**).[41]

24. At 3.50pm, Police Communications (**D24**) broadcast over police radio a 'priority 1 threat of suicide' job to Nathalia 259.[42] Among the details provided were that the caller 'sounded possibly intoxicated,' that the call originated in the area claimed and the phone on which the call was made was registered to Glenn Thomas.[43]

25. Sgt Rigoni (Nathalia 259) broadcast that he knew Mr Thomas and to request that Numurkah 253 attend to assist.[44] Sgt Gleeson (Numurkah 253) acknowledged the request via D24.[45] Leading Senior Constable (**LSC**) Westrope (Katamatite 209) had heard the job and volunteered to assist, and was authorised to do so by the Patrol Supervisor, Wangaratta 251.[46] The Wangaratta 251, Sgt Iskov, requested information about Mr Thomas be broadcast.

26. Among the information broadcast by D24 about Mr Thomas was a person warning flag dating to 2017 for 'use of force' and that he was not recorded as holding a firearm license.[47] The Wangaratta 251 then broadcast on air directions[48] for the three units: that they nominate a rendezvous point; wear ballistic vests when attending and activate their body worn cameras (**BWC**) to capture any briefings.[49] Sgt Iskov further directed a member with knowledge of Mr Thomas to try to contact him by phone.[50]

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[40] Mr Thomas asked if the Emergency Services could 'track his phone' and he was told that they could not: CB 111.

[41] CB 113.

[42] CB 114.

[43] CB 114.

[44] CB 114.

[45] CB 114.

[46] CB 114-115.

[47] CB 115.

[48] CB 86.

[49] CB 116.

[50] CB 116.

27. At about 3.56pm, Sgt Rigoni called Mr Thomas from the Nathalia police station, having activated his BWC which captured his side of their conversation.[51] They spoke for about 19 minutes, during which time Mr Thomas re-stated his intention to end his life using a firearm and identified his main reason as financial stress.[52] Sgt Rigoni tried to elicit details of Mr Thomas' location and the firearm, suggest practical options to address Mr Thomas' financial concerns and dissuade him from taking his own life.[53] Mr Thomas ended the call around 4.15pm.[54]

28. Sgt Rigoni telephoned Sgt Iskov to update her.[55] He confirmed that he had spoken to Mr Thomas, who had sounded 'intoxicated' and made further threats to suicide, and had ended the call.[56] The Wangaratta 251 broadcast that the members would try to re-engage Mr Thomas and 'sort out a peaceful resolution strategy with him.'[57]

29. By around 4.20pm, both Sgt Gleeson and LSC Westrope had arrived at Nathalia. Sgt Gleeson conducted a LEAP check of Mr Thomas; Sgt Rigoni was sceptical that Mr Thomas had a firearm, or access to one, based on their conversation and the fact that no firearm was registered to him.[58] Nonetheless, the police members discussed safety given the possibility of a firearm and nominated a rendezvous point on Weir Track, approximately 300 metres from Chinaman's Weir.[59] From that location they would attempt to find Mr Thomas using LSC Westrope's drone given the size of the area, its topography and vegetation.[60]

30. By 4.35pm, Sgts Rigoni and Gleeson and LSC Westrope had arrived at the agreed meeting point on Weir Track, the sergeants travelling together in one of two marked

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[51] Exhibit 13 (Sgt Rigoni's BWC footage, file 1) and CB 59-60. Sgt Rigoni could not activate the 'speaker' function on the phone so that Mr Thomas' side of their conversation could be captured.

[52] CB 60.

[53] Exhibit 13.

[54] Exhibit 13.

[55] CB 60 and 77. While Sgt Rigoni was on the phone with Mr Thomas, the Wangaratta 251 had requested via radio that Sgt Gleeson provide a situation report once he'd rendezvoused with Sgt Rigoni: CB 125.

[56] CB 87 and 60.

[57] CB 132.

[58] CB 67 and Exhibit 13. LSC Westrope appears to have shared Sgt Rigoni's skepticism: CB 77.

[59] Map of the Incident location, with scale, produced by Coroner's Investigator (Map).

[60] CB 77 and 60 and Map.

police vehicles. Sgt Rigoni asked Sgt Gleeson to call Mr Thomas.[61] Both members activated their BWCs.[62]

31. At 4.37pm, Sgt Rigoni broadcast a situation report for the Wangaratta 251.[63] Sgt Iskov broadcast that members ensure they had 'adequate cover' and to 'come up' on radio 'straight away' if they saw a firearm.[64] Meanwhile, LSC Westrope launched his drone and viewed the footage from its camera through his mobile phone.[65]

32. Sgt Gleeson's conversation with Mr Thomas was broad ranging and canvassed similar themes to those of Sgt Rigoni's earlier conversation. Although he believed he'd developed a good rapport with Mr Thomas, Sgt Gleeson never felt they were 'making any good progress towards him putting the gun down and walking away from it.'[66]

33. At 4.53pm, Sgt Rigoni broadcast that Mr Thomas' vehicle had been located about 200 metres from Chinaman's Weir on the south (Nathalia) side of Broken Creek.[67] A couple of minutes later via radio, he asked the Wangaratta 251 to arrange triangulation of Mr Thomas' phone, confirming that Mr Thomas continued to threaten suicide.[68]

34. There were no further situation reports broadcast until 5.30pm.[69]

35. At 4.58pm, the sergeants gathered around LSC Westrope who had alerted them to drone footage of Mr Thomas, seated at a picnic table and using his mobile phone (speaking to Sgt Gleeson) about 300 metres away on the same side of Broken Creek.[70] Mr Thomas'

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[61] CB 67.

[62] Exhibits 14 (Sgt Rigoni's BWC footage, file 2) and 16 (Sgt Gleeson's BWC footage, file 1).

[63] CB 139 and Exhibit 14 (Sgt Rigoni's BWC footage, file 2). Sgt Rigoni broadcast that the members had arrived and would try to 'get observations' on Mr Thomas: CB 140.

[64] CB 140.

[65] CB 78.

[66] CB 69.

[67] CB 148 and Exhibit 14 (Sgt Rigoni's BWC footage, file 2).

[68] CB 149-150. At 5pm, Sgt Rigoni phoned Sgt Iskov and told her she could cancel the request for triangulation because Mr Thomas had been located: (Sgt Rigoni's BWC footage, file 2). Around the same time, LSC Westrope shows Sgt Rigoni drone footage showing the firearm near Mr Thomas, and this too, is relayed (by phone) to the Wangaratta 251.

[69] CB 171.

[70] Exhibit 14 (Sgt Rigoni's BWC footage, file 2).

dog was lying under the table, and what appeared to be a rifle leant against Mr Thomas' leg.[71]

36. At about 5.17pm,[72] the nearly 47-minute phone call between Sgt Gleeson and Mr Thomas ended 'mid-sentence.'[73] Sgt Gleeson's impression was that the line had dropped out, not that Mr Thomas had hung up.[74]

37. After viewing some of LSC Westrope's drone images, Sgt Gleeson told his colleague, 'I can't tell if he's going to do it or not' but Mr Thomas had said that if 'anyone came within ten feet of him, he'd shoot himself.'[75]

38. Sgt Gleeson called Mr Thomas again at 5.19pm.[76] Mr Thomas answered, saying that he'd lost reception when he retrieved another drink from his car.[77] He then said 'in four seconds' he would shoot his dog and then himself.[78] Sgt Gleeson started to talk about his dog in an effort to engage Mr Thomas considering that 'while he's talking, he's still alive' and might be redirected from suicide.[79]

39. At all material times thereafter, Sgt Gleeson remained on the phone with Mr Thomas.

40. Between 5pm and about 5.25pm there were telephone calls between: Wangaratta 251 and the Divisional Patrol Supervisor, Senior Sgt (**S/Sgt**) Incoll (Bright 365); Sgt Rigoni and Bright 265; LSC Westrope and Sgt Iskov; and finally, Sgt Iskov and Sgt Rigoni.[80] While S/Sgt Incoll's recollection of the outcome of these conversations differs from that of Sgts Iskov and Rigoni,[81] given what followed, it is evident that Sgt Rigoni and the Wangaratta

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[71] Exhibit 19 (footage from LSC Westrope's drone) and CB 78-79.

[72] Exhibit 16 (Sgt Gleeson's BWC footage, file 1).

[73] CB 68. The themes of their conversation were similar to the earlier conversation between Mr Thomas and Sgt Rigoni.

[74] CB 68.

[75] Exhibit 16 (Sgt Gleeson's BWC footage, file 1).

[76] CB 69.

[77] CB 69.

[78] CB 69.

[79] CB 69.

[80] CB 87, 90, 62 and 80, and Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[81] S/Sgt Incoll recalled advising Sgt Rigoni that he would contact the Critical Incident Response Unit (CIRT) for the assistance of a negotiator: CB 90-91. I note that he telephoned D24 'via the supervisor direct number' to obtain CIRT's contact details and was put on hold; he did not request CIRT assistance via police radio.

251 'discussed a plan' for members to approach Mr Thomas, using the police vehicle as cover, and 'continue to engage and negotiate a surrender plan with him'[82] given dusk was approaching and specialist supports had not been requested.[83]

41. Following his conversation with the Wangaratta 251, Sgt Rigoni and LSC Westrope entered the police vehicle and before moving off at 5.27pm, Sgt Rigoni told his colleague that they would 'just go up there, high-beam him, and see how we go.'[84] As he drove past Sgt Gleeson, Sgt Rigoni said, 'we're going to go up there.'[85]

42. As he drove, Sgt Rigoni stated for the benefit of his BWC, 'we'll drive up to him, see what response we get; if he picks the firearm up, we'll just back off, challenge him.'[86]

43. At 5.29pm, the police vehicle had progressed along the dirt track to a levee situated within meters of Mr Thomas' position.[87] Using the police vehicle's public address facility, LSC Westrope gained Mr Thomas' attention by saying his name and then asking him to move away from the firearm.[88] Seconds later, BWC footage captures Sgt Rigoni state, 'he's done it'[89] and then broadcast via radio an urgent request for an ambulance because Mr Thomas had shot himself.[90]

44. Sgt Rigoni manoeuvred the police vehicle closer to the picnic table and so that Mr Thomas' vehicle remained between police and Mr Thomas.[91] The police members alighted from the vehicle, Sgt Rigoni approaching to remove and make safe the firearm before attending to Mr Thomas.[92] By this time, Sgt Gleeson had arrived at the scene.[93]

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[82] CB 87 and 62.

[83] CB 62.

[84] Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[85] Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[86] Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[87] CB 62.

[88] Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[89] Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[90] CB 171.

[91] CB 62.

[92] CB 63.

[93] Sgt Gleeson had been speaking to Mr Thomas on the phone, the latter's last comment being words to the effect that he 'could see a sergeant.' Almost immediately afterwards, he heard Sgt Rigoni's radio request for an

45. The police members provided first aid to Mr Thomas.[94] Paramedics arrived 25 minutes after dispatch,[95] with Advanced Life Support and Mobile Intensive Care Ambulance paramedics providing care until Mr Thomas was extricated from the scene and transferred by Helicopter Emergency Medical Service to Royal Melbourne Hospital (**RMH**).[96]

46. Following his admission to RMH, diagnostic imaging revealed Mr Thomas had sustained an un-survivable brain injury.[97] He was placed in the intensive care unit on life support.[98] When informed of Mr Thomas' grave condition, his family indicated it was Mr Thomas' wish to be an organ donor and they generously consented to donation of organs.[99] Life support was ceased on 29 April 2023 after the organ donation procedure was concluded.[100]

IDENTITY OF DECEASED

47. Glenn Robert Thomas, born 4 November 1967, late of an address in Nathalia, was visually identified by his brother.[101]

48. Identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

49. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and partial autopsy of Mr Thomas' body on 30 April 2023 and provided a written report of her findings dated 11 July 2023.

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ambulance and Sgt Gleeson ran in the direction he'd seen his colleagues take a few minutes earlier: CB 70 and Exhibit 16 (Sgt Gleeson's BWC footage, file 1).

[94] CB 171 and 190.

[95] The closest paramedic unit was 20 kilometres from the scene: CB 177.

[96] CB 191-194.

[97] Medical Deposition completed 28 April 2023.

[98] Medical Deposition completed 28 April 2023.

[99] Medical Deposition completed 28 April 2023.

[100] CB 46.

[101] Statement of Identification dated 28 April 2023.

50. Among Dr Baber's anatomical findings were a gunshot wound to the forehead associated with skull fractures, devastating intracranial injuries and metal fragments.[102]

51. Routine toxicological analysis of ante-mortem blood samples detected[103] alcohol (~0.14g/100ml), duloxetine (~0.1mg/L), midazolam[104] (~0.2mg/L) and ketamine.[105] Midazolam and ketamine were considered likely to have been administered in the therapeutic context.[106]

52. Dr Baber provided an opinion that the medical cause of death was 1(a) gunshot wound to the head.[107]

53. I accept Dr Baber's opinion.

THE CORONIAL INVESTIGATION

54. Following Mr Thomas' self-inflicted injury at Weir Road, Nathalia, a crime scene was established with members of the Victoria Police Homicide Squad[108] commencing a coronial investigation with oversight provided by Professional Standards Command.[109]

55. Forensic examination of the areas in and around where Mr Thomas was located, and of his vehicle,[110] was undertaken by a member of the Wangaratta Crime Scene Services. Among the items seized were a .22 Winchester Magnum Rimfire bolt action repeating rifle (**rifle**), detachable magazine with a five-cartridge (round) capacity, one spent and one live cartridge, and a box of (live and spent) ammunition.[111]

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[102] CB 46-50.

[103] CB 46 and 52.

[104] Midazolam is a fast-acting, short-duration benzodiazepine used for procedural sedation.

[105] Ketamine is a powerful anesthetic used in hospital which generally preserves breathing reflexes and stimulates heart function.

[106] CB 46.

[107] CB 46.

[108] Initial investigative response was provided by Wangaratta Crime Investigation Unit, with oversight by Professional Standards Command: CB 35.

[109] Coronial brief, page 177. PSC oversight is required by pursuant to Victoria Police Manual policies and guidelines when there is a death or serious injury arising from an incidents involving police.

[110] Police located ammunition and the diary allegedly stolen from an address in Endeavour Hills in Mr Newman's vehicle: Coronial brief, 60 and 175.

[111] CB 30-34.

56. The rifle was further examined by a ballistics analyst at Victoria Police Forensic Services Centre.[112] It's dimensions were measured and testing established the rifle was unlikely to discharge other than by applying pressure to the trigger and that the trigger-pull measurement was above normal limits (both suggesting a reduced likelihood of unintentional discharge).[113] The ballistics analyst formed the view, based on comparison examination, that the fired cartridge found at the scene had been discharged by the rifle.[114]

57. Mr Thomas did not have a firearm license, had no firearms registered to him in Victoria and was not authorised to possess or use cartridge ammunition.[115] The rifle was not registered in Victoria[116] and police investigations failed to reveal how (or when) the rifle came into Mr Thomas' possession.[117]

The Victoria Police operation to apprehend Mr Thomas

58. The focus of my investigation into Mr Thomas' death, following service of the brief of evidence compiled by D/Sgt Adams, was on Victoria Police's operational response to Mr Thomas' call to Triple Zero on 27 April 2023.

59. My examination of the police response was informed by the policies and guidance Victoria Police provides through the Victoria Police Manual (**VPM**)[118] to equip its members to meet the challenges of operational policing. Among the applicable policy and guidance to which I have had regard are: VPMP *Operational duties and responsibilities;* VPMG *Resource management and patrol supervision;* VPMG *Patrol responsibilities and communications;* VPMG *Apprehending persons under the* Mental Health Act*;* VPMP *Operational safety and use of force;* VPMP *Emergency management*

[112] CB 40-41.

[113] CB 40-41.

[114] CB 41.

[115] CB 105.

[116] CB 105.

[117] CB 10 and 105. Mr Thomas told Sgt Gleeson that he'd acquired the rifle a decade earlier while working in the Northern Territory: CB 68.

[118] The Victoria Police Manual (VPM) is issued under the authority of the Chief Commissioner in section 60 of the *Victoria Police Act* 2013. Noncompliance with or departure from policy rules (VPMP) may be subject to management or disciplinary action. Procedures and guidelines (VPMG) are not mandatory requirements on their own but must be used to help make decisions in support of the rules.

response; VPMP *Specialist Support;* VPMP *Remotely Piloted Aircraft Systems; and* VPMP *Body worn cameras.*[119]

60. I have also considered the outcomes of Victoria Police's Operational Safety Committee review of Mr Thomas' "suicide in police presence." The terms of reference for the review were decision-making during the operation to apprehend Mr Thomas and the extent of compliance with relevant legislation and Victoria Police policies. I was provided with a copy of the Committee's final report known as the Operational Safety Critical Incident Review (**OSCIR**).[120]

61. I have also considered the challenges inherent in mounting an operational response to Mr Thomas' mental health crisis on 27 April 2023 in regional Victoria where police members are comparatively few and widely dispersed[121] and from which specialist resources – largely based in Melbourne[122] – are remote.

VPM framework

62. All police members are individually responsible for their own actions while on duty.[123] Broadly, BWCs should be activated when a police member is exercising a power, attending an event or task or otherwise when duties result in contact with the public.[124] Once an event is allocated to a member/unit, that member/unit is responsible for resolution of the task.[125] Patrol Supervisors provide supervision and leadership to all

[119] As in force in April 2023.

[120] I note that one of the components of the review was an 'incident debrief' conducted at Wangaratta on 19 July 2023 and involving Nathalia 259, Numurkah 253, Katamatite 209, Wangaratta 251 and Bright 265 (and the Review Officer). Thus, the OSCIR contains, among other information, some that is not explicit in the coronial brief of evidence. A relevant example is the details of an 'Initial Action Plan' which I will refer to in the body of this finding below.

[121] Sgt Rigoni appears to have been working alone at Nathalia, as were Sgt Gleeson at Numurkah and LSC Westrope at Katamatite: CB 75 and 66. When the job involving Mr Thomas was broadcast each member was at their respective police station: Nurmurkah 24 kilometres and Katamatite 50 kilometres from Nathalia. Sgt Iskov was based in Wangaratta, 127 kilometres from Nathalia, and her supervisory responsibilities for the shift extended across the Wangaratta Police Service Area covering Wangaratta, Alpine and Moira shires; CB 86. S/Sgt Incoll was based at Bright (200 kilometres from Nathalia) and had supervisory responsibilities for divisions 3 and 4 of Eastern region of Victoria: CB 90.

[122] Approximately 230 kilometres away from Nathalia.

[123] VPMP *Operational duties and responsibilities*, section 3.3.

[124] VPMP Body worn cameras, section 3.

[125] VPMP *Operational duties and responsibilities*, section 2.3.

patrol units in their area and oversee the allocation and coordination of tasks;[126] 251s are expected to notify the Divisional Patrol Supervisor of significant incidents.[127] The police radio is the primary mode of operational communications; D24 is to be notified of particular activities,[128] including situation reports concerning actions extending over protracted periods, the occurrence of serious incidents and if additional resources are required.[129]

63. When there is a 'serious incident,' one where the safety of responding personnel or others is at risk, Patrol Supervisors are to consider issuing "On Air Directions" via police radio to provide guidance to responding members and/or identify that they are "In Charge."[130]

64. The police response to incidents and emergencies involves a functions-based management system that may be scaled up or down depending on the size and complexity of the event, known as the Incident Command and Control System (**ICCS**).[131] The Police Forward Commander (**PFC**), or Police Commander[132] (where required), is responsible

[126] Although the VPMG lists separately the responsibilities of 'metropolitan' and 'country' Patrol Supervisors, 'country' 251s responsibilities are 'the same as for the metropolitan District Supervisor however may be part of a normal patrol unit. Must ensure that all employees within the District are effectively supervised:' VPMG *Resource management and patrol supervision*, 4. The term "District Supervisor" is used nowhere else in the VPMG and is not defined. Additionally, the metropolitan 251 responsibilities include 'incident management,' a section which states that the Patrol Supervisor does not have to supervise other sergeants 'however [they] …. Have command responsibility at incidents where another Sergeant is attending [and] should arrange for another Sergeant to *take charge* of an incident when [they] cannot meet the needs of the incident [or when they deem appropriate, and] … seek guidance [form the 265] regarding any confusion over incident management: VPMG *Resource management and patrol supervision*, 4.

[127] VPMG *Resource management and patrol supervision*, 4.

[128] Such as the start/end of each shift, when an incident is responded to, whenever an employee leaves/returns to a police vehicle or when a patrol unit leaves its area of patrol: VPMG *Patrol responsibilities and communications*, section 1.

[129] VPMG *Patrol responsibilities and communications*, section 1.

[130] VPMG *Patrol responsibilities and communications*, section 1.

[131] Although 'emergency' is defined in the Emergency Management Act 2013, its definition is broad, encompassing events from the imminent threats to safety or health of any person to a road accident or plague or war-like act. As the VPM requires consistency of police response whether an event is an "incident" or an "emergency," 'all incidents are considered emergencies and the response to these emergencies is referred to as the emergency management response:' VPMP *Emergency Management Response*, context.

[132] The Police Commander has 'overall strategic command of police resources in response to an emergency and is responsible for providing direction, oversight and support to the PFC. Although the duties of a Police Commander and PFC may overlap, the Poloice Commander 'should not assume responsibility for operational or tactical activities.' VPMP *Emergency Management Response*, section 2.

for the functions required to respond to the emergency, will perform a command and/or control function and have operational command of police resources at an emergency. [133]

65. The PFC will ordinarily be the first or most senior police member at the scene and should identify themselves to police communications.[134] Depending on the scale of an emergency, the PFC may assume both operational and strategic leadership roles, supported through the normal Victoria Police chain of command (251, 265, 150).[135] Among other things, the PFC will direct the overall direction of response activities, assess the present and expected impact and nature of the emergency, establish a command structure, perform (or delegate) ICCS functions, prepare an Incident Action Plan and communicate objectives or outcomes to everyone involved, including by on-air briefing prior to any opportunity to document a written plan.[136] When managing the emergency, the PFC will identify and address risks, apply operational safety tools and principles[137] if there is any potential for the use of force, ensure timely flow of information and that required response or support services (including from other agencies)[138] are in attendance or have been notified.[139] The PFC will determine when the emergency is resolved and facilitate any post-emergency activities.[140]

66. Victoria Police have several specialist response,[141] investigation and advisory[142] units that may be required to manage or resolve an incident or emergency. The circumstances in which specialist unit may be requested, how a request must be made, when deployment will be authorised and rules for command interaction during an operation are governed by the VPM.[143] Relevantly, the Critical Incident Response Team (**CIRT**), or its

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[133] Planning, operations, logistics investigation, intelligence, public information: VPMP *Emergency Management Response*, section 2.6.

[134] VPMP *Emergency Management Response*, section 2.

[135] VPMP *Emergency Management Response*, section 2. A '150' is a supervisor of the rank of Inspector.

[136] VPMP *Emergency management response*, sections 2 and 3.

[137] ICENCIR (Isolate, Contain, Evacuate, Negotiate, Conclude, Investigate, Rehabilitate) principles: VPMP *Emergency Management Response*, section 2.

[138] VPMP *Emergency management response*, section 5.

[139] VPMP *Emergency management response*, sections 2 and 3.

[140] VPMP *Emergency management response*, section 3.

[141] For example, the Critical Incident Response Team or the Search and Rescue Squad.

[142] For example, Criminal investigation and forensic services units or the Media Unit.

[143] VPMP *Specialist support*.

Negotiators, respond to incidents that are beyond the scope, experience or skills of general duties members but do not meet the criteria for the Special Operations Group. For instance, CIRT 'must' be requested if it is reasonable suspected that a person is armed with a weapon or to mental health incidents where a person is threatening suicide (where intervention exceeds general duties members' capabilities).[144] The PFC or Police Commander must 'as soon as practicable' request attendance of the CIRT via D24 and notify the Divisional Patrol Supervisor (265) of the request.[145] Police communications will contact the CIRT Operations Supervisor, who will assess the request and provide assistance and advice to the PFC/Police Commander as needed.[146]

Command, control and co-ordination

67. The incident involving Mr Thomas arguably met the definition of an "emergency" at 3.50pm when the job was dispatched. Once Sgt Rigoni had spoken to Mr Thomas and confirmed his intention to end his life and unknown location, a request for triangulation of Mr Thomas' mobile phone could have been made (at 4.15pm). If a request had been made then, assuming the phone remained on, Mr Thomas might have been located sooner.

68. Though the content of the briefing that occurred before Sgts Rigoni and Gleeson and LSC Westrope left the Nathalia police station is not reflected in BWC footage, radio broadcasts or explicitly in their statements, some planning occurred. The OSCIR, informed by an incident debrief between all members involved, suggests the Initial Action Plan included: establish Mr Thomas' location; confirm the presence of a firearm; cordon and isolate the area;[147] keep Mr Thomas on the phone and engaged with police; and prioritise safe resolution of the incident before nightfall (around 6pm).[148]

69. The OSCIR Review Officer considered that 'upon notification of the incident' members developed a command and control structure involving the Bright 265 as Police

[144] VPMP *Specialist support,* section 6.

[145] VPMP *Specialist support,* section 6.

[146] VPMP *Specialist support,* section 6.

[147] To 'cordon and isolate the area' was not a realistic objective given the available personnel.

[148] OSCIR, page 10.

Commander and Sgt Rigoni as PFC.[149] The Review Officer noted that Sgt Iskov's role as 'conduit' between Police Commander and PFC was contrary to the ICCS but likely developed because Sgt Rigoni did not 'initially take the PFC role;' rather, Wangaratta 251 gave directions and Sgt Rigoni 'negotiated' to assume the PFC role after reporting the outcome of his call to Mr Thomas to Sgt Iskov.[150] My own view is that the command and control structure was and remained unclear.

70. That said, by the time the members were on Weir Track at 4.35pm, Sgt Rigoni had assumed the role of PFC though there was no radio transmission to that effect. He assigned tasks to Sgt Gleeson and LSC Westrope. While there is no evidence to suggest specialist input from a CIRT Negotiator was necessary at that juncture, there is also no evidence the PFC considered seeking the assistance or advice of a CIRT Negotiator before asking Sgt Gleeson to contact Mr Thomas (or that he sought CIRT advice himself at any point thereafter, when it was clear Mr Thomas was willing to talk but there was no progress towards resolution). Similarly, it is not clear why CIRT was not informed of the unfolding situation in Nathalia and of the potential need for assistance and/or deployment.

Use of personal drone

71. LSC Westrope was a qualified Victoria Police drone pilot[151] but use of a personal drone for policing activities is prohibited by the VPM.[152] Nonetheless, in circumstances where the closest Victoria Police drone or Airwing asset was two hours from Nathalia, it was imperative to locate Mr Thomas and confirm the presence of a firearm and a drone might achieve this covertly and without any risk to responding members, it was a justifiable operational decision to use a personal drone. The OSCIR contained a similar conclusion

[149] OSCIR, page 10. I note that S/Sgt Incoll does not appear to have been aware of the incident until around 5pm when he was contacted by Sgt Iskov by phone, after Mr Thomas had been located and his possession of a firearm confirmed: CB 87 and 90.

[150] OSCIR, page 10.

[151] Statement of LSC Westrope signed 25 February 2024.

[152] VPMP *Remotely piloted aircraft systems*, section 2.

and noted that local police management had reinforced policy and legislative[153] requirements relating to the use of drones.[154]

72. Mr Thomas was located and confirmed to possess a firearm at 4.58pm but there was no situation report via radio to this effect. Sgt Rigoni telephoned Sgt Iskov (around 5.01pm).[155] He relayed that Mr Thomas had a firearm and that he was still talking to Sgt Gleeson who indicated his view when asked that Mr Thomas would not give up the weapon.[156] The PFC said, 'our next thing would be CIRT, or …' and that they were 'losing the light.'[157]

73. At 5.03pm, the PFC told Sgt Gleeson (still on the phone with Mr Thomas) that the Wangaratta 251 is 'going to see if she can get CIRT or somebody up' and to remain with LSC Westrope.[158]

CIRT assistance

74. As PFC, Sgt Rigoni had the authority to request CIRT assistance and, indeed, was best placed to determine the need for the CIRT and make the request. It is unclear why both Sgt Rigoni and Sgt Iskov appear to have believed that S/Sgt Incoll's prior approval was required, though the OSCIR identified a 'local practice to seek 265 approval that sits outside policy guidelines.'[159]

75. Notwithstanding the "local practice," the PFC did not contact Bright 265 himself. Rather, Sgt Iskov contacted S/Sgt Incoll and they discussed requesting additional resources including Airwing and a CIRT Negotiator based on Mr Thomas' possession of a firearm and ongoing threats to suicide.[160] According to Sgt Iskov, the Bright 265 directed that no

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[153] Use of a private drone for policing activates might constitute an offence against the Civil Aviation Authority Regulations.

[154] OSCIR, page 11. I note that LSC Westrope's RPAS license was suspended as a result of this incident: Statement of LSC Westrope signed 25 February 2024.

[155] The OSCIR characterizes what transpires in this conversation as an "Incident Management Meeting' between Sgts Rigoni and Gleeson and LSC Westrope that 'identified a requirement for CIRT negotiators to be contacted:' OSCIR page 13. I disagree with that characterization based on what is captured by Exhibit 14 (Sgt Rigoni's BWC footage, file 2).

[156] Exhibit 14 (Sgt Rigoni's BWC footage, file 2).

[157] Exhibit 14 (Sgt Rigoni's BWC footage, file 2).

[158] Exhibit 14 (Sgt Rigoni's BWC footage, file 2).

[159] OSCIR, page 14.

[160] CB 87.

request be made for specialist units and that local members continue negotiations to resolve the situation. In contrast, S/Sgt Incoll stated that he told the Wangaratta 251 that he would request a CIRT Negotiator.[161]

76. Though the sequence of telephone calls is unclear, it seems likely that next there was a call between the Bright 265 and Sgt Rigoni. The PFC's account of that conversation was that S/Sgt Incoll had said 'CIRT was not needed' because local members had a good rapport with Mr Thomas, Sgt Gleeson was speaking to him by phone and Mr Thomas had not threatened police or anyone else.[162] Sgt Rigoni's impression was that the Bright 265 'might … [make] some calls to CIRT to see what they could do,' and reflected that '[CIRT] would've been hours away and it was going to be night time shortly.'[163] According to S/Sgt Incoll, Sgt Rigoni was 'comfortable with the situation at present' and that he told the PFC that he would contact the CIRT and 'attempt to gain the services of a negotiator.'[164]

77. The OSCIR records that during the incident debrief, S/Sgt Incoll confirmed that he decided not to immediately engage CIRT because of the rapport between Mr Thomas and local members, the absence of threats of violence toward them, the fading light and the time it would take the CIRT to attend Nathalia.[165]

78. According to S/Sgt Incoll, at about 5.30pm he telephoned the D24 Supervisor to obtain contact details for the CIRT and was put on hold.[166] He remained on hold when he heard Sgt Rigoni's radio transmission that Mr Thomas had shot himself.[167] It is not clear to me whether the Bright 265 called D24 because he misapprehended how a request for the CIRT must be made or because he intended only to inquire about what CIRT "could do" as Sgt Rigoli had understood.[168]

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[161] CB 90.

[162] CB 62.

[163] CB 62.

[164] CB 90-91.

[165] OSCIR, page 13.

[166] CB 91.

[167] CB 91.

[168] I note that the Review Officer considered that the Bright 265 (effectively) changed his decision to not request the CIRT 'belatedly' and the manner of his request for CIRT assistance was therefore non-compliant with the VPM and was 'not clearly known or articulated to the 251 or PFC:' OSCIR, page 15.

79. The OSCIR Review Officer found that given the information he had been provided, Bright 265 'incorrectly elected not to approve a request for attendance or seek advice of specialist resources, including CIRT negotiators.'[169]

80. The Review Officer also found that the decision not to request assistance from the CIRT or a Negotiator while local members were at Weir Track (a period of 96 minutes) was a 'missed opportunity.'[170] In her view, earlier CIRT/Negotiator contact would have potentially provided guidance about engagement strategies and informed key decisions, and if a request for CIRT attendance had been made at the earliest opportunity, sufficient time to deploy them to Nathalia via Airwing was 'achievable and should have been explored.'[171]

81. I acknowledge that general duties policing in Victoria often involves working across large geographic areas, and the centralisation of specialist resources can at times reportedly contribute to a sense of distance or isolation for members on the ground. I note that Victoria Police has committed to providing relevant members with updated, strengthened and expanded training to improve compliance with policies on the engagement of specialist resources.[172]

PFC's absence from Weir Track, without notice or handover

82. The PFC left the scene for 21 minutes, between 5.04 and 5.25pm, to attend to a personal matter.[173] Although the OSCIR Review Officer considered Sgt Gleeson had assumed the role of PFC in Sgt Rigoni's absence, there was no formal handover either when Sgt Rigoni left or returned and no evidence he notified D24, Wangaratta 251 or Bright 265 of the change to PFC.[174] As such, there was no contingency planning (should the incident have escalated while Sgt Rigoni was away), no oversight by the 251, depleted police resources at the scene, and Sgt Gleeson's capacity to exercise command and control of the operation was limited by performance of his role of negotiator. The Review Officer considered Sgt Rigoni's absence from the scene in these circumstances to be contrary to

[169] OSCIR, page 15. I note that the Review Officer

[170] OSCIR, page 15.

[171] OSCIR, page 15.

[172] Correspondence from Victoria Police dated 27 July 2026.

[173] Exhibits 14 and 15 (Sgt Rigoni's BWC footage, files 2 and 3).

[174] OSCIR, pages 12-13.

relevant policy and had the potential to expose his colleagues and Mr Thomas to heightened risk.[175] I agree. The OCSIR noted that 'associated learnings would be addressed at the local level.'[176]

Sub-optimal handover of information (to the PFC)

83. For all but a period of two minutes, when Sgt Rigoni was away from Weir Track, Sgt Gleeson was on the phone with Mr Thomas. Notwithstanding Sgt Rigoni's account that he could 'gauge what was happening because Sgt Gleeson was keeping me up to date,'[177] BWC footage suggests Sgt Gleeson's opportunity to provide updates was limited and largely non-verbal, conveyed instead by gesture.[178] Between 5.17pm and 5.19pm, Sgt Gleeson relayed to LSC Westrope that:

> All [Mr Thomas'd] tell me is he's by the creek at the edge of the weir … He'd be alright to talk to but then he'd … well not crack it, but you know?
>
> [Sgt Rigoni] mentioned something about trying to get CIRT or some sort of …? I'm not keen on going anywhere near him … he's intoxicated but didn't sound pissed-pissed, you know what I mean? … He was talking about going back into town to get some more Turkeys ….
>
> I'll give him a call back, mate: at least while I'm talking to him, he's not doing anything stupid … [and in response to a query from LSC Westrope] Anyone gets within ten feet, he's going to shoot himself.[179]

84. There is no evidence that LSC Westrope relayed anything Sgt Gleeson mentioned to Sgt Rigoni upon his return to the scene at 5.25pm. In my view, the information that Mr Thomas said he would shoot himself if anyone approached was important information for the PFC to have, and to consider.

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[175] OSCIR, page 13.

[176] OSCIR, page 13.

[177] CB 61.

[178] Exhibit 14 (Sgt Rigoni's BWC footage, file 2) and Exhibit 16 (Sgt Gleeson's BWC footage, file 1).

[179] Exhibit 16 (Sgt Gleeson's BWC footage, file 1).

Sub-optimal resolution plan

85. When Sgt Rigoni returned to the meeting point, I infer that LSC Westrope was on the phone to Sgt Iskov.[180] LSC Westrope handed the PFC the phone and Sgt Rigoni's BWC captures his side of the conversation concerning a "resolution plan" in the absence of any specialist support.[181] The plan consisted of police members approaching Mr Thomas, using the police vehicle as cover and engaging with him to 'negotiate a surrender plan.'[182] If Mr Thomas picked up the firearm, members would retreat, though Sgt Rigoni (unlike Sgt Gleeson) did not appear concerned that Mr Thomas might use the firearm to harm him.

86. The PFC apparently also did not consider it likely that Mr Thomas would harm himself with the firearm. He told the Wangaratta 251, 'if he was going to do it, he would have done it by now; we've been on the phone to him for an hour.'[183] The PFC did not know Mr Thomas had threatened to shoot himself if anyone approached and LSC Westrope did not mention the possibility when Sgt Rigoni told him the approach plan.

87. The extent to which Sgt Gleeson was aware of the plan – beyond "we're going to go up there" – is unclear.

88. Although not explicit from on air transmissions or conversations or briefings captured on BWC, Sgt Rigoni[184] (and Sgt Gleeson)[185] anticipated apprehending Mr Thomas pursuant to the police power under the *Mental Health Act* 2014. This outcome would likely require (if compliant with the VPM), Mr Thomas' transfer by ambulance to a mental health service for assessment.

89. Given the presence of a firearm, other possible outcomes of the plan to approach Mr Thomas included gunshot injury to Mr Thomas or to police members (or both, if gunfire was exchanged). Thus, any *resolution* might reasonably be expected to require

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[180] Neither LSC Westrope nor Sgt Iskov mention a phone call. The OSCIR Review Officer made the same inference: OSCIR, page 13.

[181] Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[182] CB 87.

[183] Exhibit 15 (Sgt Rigoni's BWC footage, file 3).

[184] CB 61.

[185] Exhibit 16 (Sgt Gleeson's BWC footage, file 1). Sgt Gleeson suggested to Mr Thomas several times that he put down the firearm and walk out so that professional (mental health) support could be provided.

ambulance involvement, and, in my view, an ambulance should have been requested and on scene before police members approached Mr Thomas.[186] It does not appear that the PFC considered a request for ambulance attendance until after Mr Thomas had self-inflicted his ultimately fatal gunshot wound.

90. The approach plan, its comprehensiveness and the timing of its execution, were influenced by mutually reinforcing factors including: suboptimal information sharing (or briefings) between the members at Weir Track; an unclear command/control structure; the "local practice" of deferring CIRT requests to the 265 and/or a misapprehension that a PFC cannot make the request unilaterally; the Bright 265's refusal to request CIRT assistance; Nathalia's remoteness from Melbourne/specialist supports; and, approaching darkness.

FINDINGS

91. Having investigated the death of Glenn Robert Thomas, and having held an inquest in relation to Mr Thomas' death on 17 September 2026 at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

    (a) that the identity of the deceased was Glenn Robert Thomas, born on 4 November 1967;

    (b) that Mr Thomas died at Royal Melbourne Hospital, Parkville, Victoria on 29 April 2023 from a gunshot wound to the head;

    (c) in the circumstances described above in paragraphs 20-46.

92. I find that given circumstance and the lethality of the means he chose, Mr Thomas intended to take his own life.

93. Although I have identified some deficiencies in the police response to Mr Thomas' call to Triple Zero on 27 April 2023, namely, the unclear command and control structure; the missed opportunity for CIRT assistance; suboptimal information sharing; and the absence of a request for an ambulance before the "approach plan" was executed, I unable

[186] I concede the possibility for further protracted negotiations between Mr Thomas and police face-to-face after an approach and of the operational impost on Ambulance Victoria had a unit been tied up at the Weir Track incident for a lengthy period.

to conclude that these deficiencies singly or in combination caused or contributed to the tragic outcome.

ORDERS

94. Pursuant to section 73(1) of the Coroners Act, I order that this finding be published on the internet.

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

(a) Mr Thomas' family;

(b) Chief Commissioner of Victoria Police;

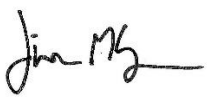
(c) Kate Wright, Minter Ellison;

(d) Madeleine Lovelle, Victoria Police – Civil Litigation Unit

(e) Detective Sergeant Dianne Dale, Victoria Police – Professional Standards Command;

(f) Sergeant Megan Adams, Coronial Investigator.

Signature:



Simon McGregor
Coroner
Date: 17 September 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.