IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4573

FINDING INTO DEATH WITH INQUEST

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

INQUEST INTO THE DEATH OF JOHN DOE*

Findings of:	Coroner Leveasque Peterson
Delivered On:	16 November 2023
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	10 November 2023
Assisting the Coroner:	Sam Brown, In House Legal Services
Representation:	Ben Lloyd, Russell Kennedy for Chief Commissioner of Police
Catchwords	Death during police operation to apprehend; suicide in presence of police; firearm

*Pursuant to section 55(2)(e) of the *Coroners Act* 2008, a pseudonym replaces the name of the Deceased, and his family members and associates have been deidentified.

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SUMMARY

1. John Doe was 33 years old when he died on 10 September 2018 at a rural property on Warneet Road in Blind Bight, Victoria, of a contact range shotgun injury to the head.

2. At the time of his death, a large-scale Victoria Police operation had been underway for several hours to locate and apprehend John Doe pursuant to section 351 of the *Mental Health Act* 2014 to prevent serious and imminent harm to him or others.

THE CORONIAL JURISDICTION

3. John Doe's 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.

4. 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]

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

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

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[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.)

[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.

Mandatory inquest

7. As John Doe's death occurred while police were actively seeking to arrest him, I regard John Doe 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.

8. 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, so 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

9. This Finding draws on the totality of the material the product of the coronial investigation into John Doe's death. That is, the court records maintained during the coronial investigation, the Coronial Brief prepared by Detective Sergeant Glen Weaver 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.

10. 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.

BACKGROUND

Personal History

11. John Doe was the eldest of his parents' three children together.[8] Behavioural issues – outbursts of aggression – were evident from an early age.[9] Although clinicians were

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

[8] Coronial brief, page 99.

consulted, no formal diagnosis or treatment followed.[10] John Doe left school at 15 years of age and was employed intermittently thereafter. At the time of his death, he had very little contact with anyone in his family of origin.[11]

12. John Doe had a ten-year relationship with Partner 1 which produced a child.[12] The couple had married in about 2011 but in 2016 Partner 1 ended the relationship.[13] Partner 1 described John Doe as 'controlling' but not physically violent towards her until after the relationship ended.[14] The separation of John Doe and Partner 1 became particularly acrimonious after she re-partnered with conflict centring on contact with their child.[15]

13. In about April 2017, after Partner 1 reported John Doe's allegedly physically abusive behaviours toward her to police, an interim Family Violence Intervention Order (**IIO**) was granted to protect her and their child.[16] The IIO prohibited John Doe from committing family violence against the Affected Family Members and from having any contact with Partner 1, except to arrange child contact via text message.[17] Although consistently in force, the IIO was not served on John Doe before 16 August 2018.[18]

14. In 2016, John Doe commenced a romantic relationship with Partner 2. Throughout their relationship Partner 2 observed a 'decline' in John Doe's mental health which she attributed to the 'volatile' relationship he had with Partner 1, the 'custody battle' over their child, and later, financial stress after he lost his job in about July 2018.[19]

15. Partner 2 ended her relationship with John Doe on or about 14 August 2018. During a conversation on that day, Partner 2 became concerned about John Doe's mental health and Partner 1 and her partner's welfare when John Doe threatened to kill them because

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[9] Coronial brief, page 102.

[10] Coronial brief, page 102.

[11] Coronial brief, pages 99; 96.

[12] Coronial brief, page 76.

[13] Coronial brief, page 76.

[14] Coronial brief, page 76.

[15] Coronial brief, page 77.

[16] Coronial brief, pages 226-229.

[17] Coronial brief, pages 230-236.

[18] Coronial brief, page 195.

[19] Coronial Brief, page 209.

they had 'ruined [his] whole life.'[20] Partner 2 was also concerned for her own safety given John Doe's apparent irrationality and volatility[21] and reported her concerns to police. An application for an IIO to protect Partner 2 from John Doe was sought by police and granted.[22]

16. On 16 August 2018, John Doe was arrested, charged with making threats to kill and possession of methylamphetamine, and remanded in custody.[23]

17. On 24 August 2018, John Doe pleaded guilty to all the listed charges.[24] He was sentenced to complete a Community Corrections Order.[25] John Doe was released from custody that day.

CIRCUMSTANCES OF DEATH

Events immediately proximate to death

18. Early on 10 September 2018 it is alleged that John Doe broke into a residential address in Endeavour Hills connected with Partner 1.[26] From that address it is alleged John Doe stole a diary thought to contain Partner 1's residential address.[27]

19. At about 6.30am,[28] John Doe sent his father a text message. The father then viewed John Doe's Facebook profile where John Doe had posted a video of himself holding a gun to his own head. Just before 7am, John Doe's father contacted Cranbourne Police Station to report concerns about his son's safety and the safety of John Doe's former parents in law.[29] John Doe had stated he was 'at the in-laws.'[30]

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[20] Coronial brief, page 208; 205.

[21] Coronial Brief, pages 209; 208.

[22] Coronial brief, pages 218-221; 90;

[23] Coronial brief, page 161.

[24] Coronial brief, page 161.

[25] Coronial brief, page 161. Orders were made at the Dandenong Magistrates' Court on 24 August 2018 [J12159190].

[26] Coronial brief, pages 80; 84.

[27] Coronial brief, page 84.

[28] Coronial brief, page 97. The diary also contained the address of the property at which John Doe was located.

[29] Coronial brief, page 97.

[30] Coronial brief, page 97.

20. Senior Constable (**SC**) Haig, who received the call, notified the Patrol Supervisor Acting Sergeant (**A/Sgt**) Justice and Divisional Patrol Officer Senior Sergeant (**S/Sgt**) Huth, and provided the details she received from John Doe's father to the Emergency Services Telecommunication Authority (**ESTA**).[31] Those details were broadcast over Police Communication (**D24**) within minutes.[32]

21. A/Sgt Justice directed SC Haig to request triangulation of John Doe's mobile phone and make other enquiries using the Law Enforcement Assistance Program (**LEAP**) database to ascertain John Doe's whereabouts or likely destination.[33] A/Sgt Justice liaised with S/Sgt Huth and the Critical Incident Response Team (**CIRT**).[34]

22. At about 7.30am, Partner 1 saw that she had received two text messages and missed calls from John Doe. The messages had similar content to those seen by John Doe's father and claimed that Partner 1 had 'ruined [John Doe's] life.'[35] Partner 1 called Triple Zero;[36] among the additional information she relayed included John Doe 'threatening my baby … in this video' half an hour earlier,[37] her assessment that John Doe was affected by drugs and concern that he was looking for her given his recent threats.

23. The additional information provided by Partner 1 was not broadcast.[38]

24. Around the same time, Partner 2 was at Knox Police Station reporting receipt of text messages and emails sent by John Doe in contravention of the IIO.[39] John Doe's messages to Partner 2 had similar content to those he sent to his father and Partner 1,[40]

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[31] Coronial brief, pages 247-253.

[32] Coronial brief, 375-378.

[33] Coronial brief, 115-116 and 120-121.

[34] Coronial brief, 121 and 384.

[35] Coronial brief, pages 77-78. Around the same time Partner 1 received messages from Partner 2 forwarding similar messages relayed to her. Partner 2 separately reported John Doe's messages to Knox Police.

[36] Coronial brief, page 78.

[37] Coronial brief, page 256.

[38] Coronial brief, pages 385-386.

[39] Coronial brief, page 116.

[40] Coronial brief, page 116.

in addition to explicit threats to kill both of his former partners.[41] Knox Police relayed this intelligence to SC Haig by phone.[42]

25. At about 8.18am, triangulation of John Doe's mobile phone was authorised with the first report – that the phone was in the vicinity of Cannons Creek heading towards Tooradin (at 8.22am) – received at about 8.28am. This location information, which appeared to confirm John Doe was heading towards Partner 1's address, was broadcast via D24.[43]

26. Cranbourne Police called Partner 1 to advise her of John Doe's apparent location and told her to remain inside.[44]

27. A/Sgt Justice requested the assistance of local police units and specialist units CIRT and Police Airwing (**Airwing**) to attend the vicinity and locate John Doe.[45] ESTA broadcast that A/Sgt Justice was the 'Incident Controller.'[46]

28. At 8.38am, triangulation of John Doe's phone located it in Blind Bight. Additional police units were deployed to the area.[47]

29. By 8.42am a police unit was in position near Partner 1's address to monitor it and ensure her safety.

30. Sometime later, Narre Warren Police contacted Partner 1 to ask that she and her children attend the police station; they arrived at the police station around 9am.[48]

31. By 9am, A/Sgt Justice had directed police units to the intersection of Baxter-Tooradin and Warneet Roads to monitor vehicles, and CIRT and Airwing were en route to Blind

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[41] Coronial brief, page 117.

[42] Coronial brief, pages 116-117. Partner 2 was advised to leave her home and stay somewhere safe until John Doe was apprehended.

[43] Coronial brief, page 404.

[44] Coronial brief, page 78.

[45] Coronial brief, pages 122 and 401-402.

[46] Coronial brief, page 407.

[47] Coronial brief, page 405.

[48] Coronial brief, page 78.

Bight.[49] Police sought to ascertain whether the vehicle John Doe was thought to be using was in the area.

32. At about 9.05am Special Operations Group (**SOG**) was notified to liaise with S/Sgt Huth about deployment.[50]

33. Repeated attempts by police to contact John Doe via his mobile phone were unsuccessful.[51]

34. By 9.10am, Airwing was in Blind Bight and had commenced a search for John Doe and his vehicle.

35. At 9.15am, the description of the vehicle John Doe was believed to be using was updated via D24.[52] Within 15 minutes, Casey Criminal Investigation Unit (**CIU**) had confirmed that vehicle was not at John Doe's usual address in Clyde North.[53] At 9.45am, Airwing advised an exhaustive search for the vehicle had not located it in Blind Bight.

36. At 9.55am, members of Casey CIU broadcast via D24 that John Doe's vehicle was parked on Goolagong Road, Blind Bight and appeared to be empty. Goolagong Road is a no through road entered from Warneet Road.[54]

37. A short time later, A/Sgt Justice arrived at the scene and coordinated units to cordon the area.[55] He also directed that CIRT and specialist Canine (**K9**) units attend to 'clear' the vehicle.[56]

38. S/Sgt Huth broadcasts that no-one was to approach the vehicle until Airwing was overhead.[57]

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[49] Coronial brief, page 411.

[50] Coronial brief, page 123.

[51] Coronial brief, page 123.

[52] Coronial brief, page 436. To this point, reliance had been placed on inadvertently outdated information about John Doe's vehicle provided by Partner 1.

[53] Coronial brief, page 123.

[54] Coronial brief, page 181.

[55] Coronial brief, page 124.

[56] Coronial brief, pages 124 and 469-470.

39. Around 10.18am, S/Sgt Huth arrived and as the most senior member at the scene assumed the role of Police Forward Commander after a briefing from A/Sgt Justice.[58] No D24 broadcast was made to that reflect this change.[59] Police vehicles were positioned on Warneet Road to block civilian access to Goolagong Road and its vicinity.

40. At about 10.20am, ESTA broadcast a 'hot agg burg'[60] about 250 metres south[61] of where John Doe's vehicle was located at a property 'possibly' on Warneet Road, its most distinctive feature was 'a horse float out the front.'[62] With the assistance of Airwing, the address of the 'hot agg burg' – where complainant Mr Anderson had barricaded himself in a bathroom of the house[63] – was established as a large rural block bounded by Warneet and Goolagong Roads (**the rural block**).[64]

41. A short time later, CIRT arrived and, following a briefing, cordoned an area closer to the rural block's perimeter.[65]

42. The effect of the arrangements was an outer cordon established by uniform members and vehicles, and an inner cordon maintained by CIRT members.

43. Around this time, SC Haig relayed via D24 that John Doe had posted on Facebook that police were 'close by' and there may be a 'live shootout'.[66] Police on scene accessed John Doe's posts, noting images depicting him in bushland, holding a firearm under his chin and his replies to messages encouraging him to desist.[67]

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[57] Coronial brief, pages 470-471.

[58] Coronial brief, page 124.

[59] Operational Safety Commitee Incident Review (OSCIR), page 22.

[60] Coronial brief, page 487.

[61] Coronial brief, page 128.

[62] Coronial brief, page 488.

[63]Coronial brief, pages 266-272.

[64] Coronial brief, page 181.

[65] Coronial brief, page 129.

[66] Coronial brief, page 117.

[67] Coronial brief, pages 129 and 350. Several members of the public called Triple Zero to report what was depicted in John Doe's live stream: Coronial brief, pages 273-290.

44. The intelligence that John Doe might use a firearm against police if confronted led to the deployment of SOG.[68] At 10.30am, K9 and SOG units were more than 30 minutes from the scene and Casey Local Area Commander, Inspector Brown, was en route. [69]

45. At about 11am, Airwing located John Doe lying in shrubs with a firearm to his chin on the rural block near a dam, about 40 metres from the house. The police operation then shifted to one of emergency response and management, with the establishment of a Forward Command Post and an Emergency Management Structure.[70]

46. Upon Inspector Brown's arrival at the scene at 11.05am, he formally assumed command of the incident and the functions of Police Forward Commander, broadcasting this via D24.[71] S/Sgt Huth broadcast that he had assumed the role of Emergency Response Co-Ordinator. When the SOG arrived at about 11.15am,[72] SOG 150 formally assumed the functions of Tactical Commander.[73] Together the Police Forward Commander and Tactical Commander developed the objectives of the police response, namely, the safe recovery of Mr Anderson from the house and the negotiated peaceful surrender of John Doe.[74]

47. The SOG started to form an inner cordon around the rural block and, at about 11.30am, SOG members extracted Mr Anderson from the house without incident.[75]

48. Airwing confirmed that John Doe had not moved from his position in shrubs. SOG 35 established that none of the SOG members in containment positions had line of sight to John Doe. The Tactical Commander aimed to ensure John Doe was adequately contained before any attempt was made to communicate with him directly.[76]

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[68] Coronial brief, page 138.

[69] Coronial brief, pages 134 and 498.

[70] OSCIR.

[71] Coronial brief, page 134.

[72] Coronial brief, page 139.

[73] These arrangements are set out in the applicable Victoria Police Manual, *Emergency and Incident Response Management*, 3.2 and 3.3.

[74] Coronial brief, page 134.

[75] Coronial brief, pages 508-509.

[76] Coronial brief, page 139.

49. By midday, SOG members had established an inner cordon to contain John Doe. CIRT negotiators at the Forward Command Post were on standby and live video feed from Airwing was used to maintain observations of John Doe.[77] By 12.30pm, State Surveillance Unit (**SSU**) members and paramedics were at the scene and an Incident Police Operations Centre (**IPOC**) was established at Dandenong Police Complex to perform planning and logical functions.[78]

50. From 12.45pm, with the authorisation of the Tactical Commander, several unsuccessful attempts were made to communicate directly with John Doe. Initially, CIRT negotiators tried calling his mobile phone, but it was switched off. Next, SOG members called out to John Doe using a public address (**PA**) system and received no response. SSU then deployed specialist surveillance equipment to deliver a mobile phone.

51. At about 1.05pm, John Doe saw the specialist surveillance equipment and damaged it before positioning his firearm and discharging it to inflict a head wound.

52. Upon hearing the gun shot, K9 and SOG members deployed.[79] A police dog was released first but when its application of force to John Doe's left lower leg garnered no response, SOG members moved forward and observed an obvious wound to John Doe's head.[80]

53. Paramedics were summoned and, on examination, found that John Doe's injuries were incompatible with life. John Doe was pronounced dead at the scene.[81]

54. SOG 150 advised the Police Forward Commander that a Critical Incident had occurred.

IDENTITY OF DECEASED

55. John Doe, born 2 April 1985, late of an address in Clyde North, was identified by fingerprint comparison.[82]

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

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[77] Coronial brief, page 139.

[78] Victoria Police Manual, *Emergency and Incident Response Management*, 2.1 and 2.2

[79] Coronial brief, pages 140 and 131.

[80] Coronial brief, page 140.

[81] Coronial brief, page 151.

[82] Coronial brief, page 710.

MEDICAL CAUSE OF DEATH

57. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and partial autopsy on 11 September 2018 and provided a written report of her findings dated 7 January 2019.

58. Among Dr Iles' anatomical findings were a contact range shotgun entrance wound to the right temporal scalp associated with devastating intracranial injuries.[83]

59. Routine toxicological analysis of post-mortem blood samples detected methylamphetamine[84] (~1.0mg), amphetamine (~0.08mg/L) and methylenedioxymethamphetamine[85] (~0.03mg/L).[86]

60. Dr Iles provided an opinion that the medical cause of death was 1(a) contact range shotgun injury to the head.[87]

61. I accept Dr Iles' opinion.

THE CORONIAL INVESTIGATION

62. Following John Doe's death at Blind Bight, and the formal conclusion of the police operation to apprehend him, a crime scene was established with members of the Victoria Police Homicide Squad commencing a coronial investigation with oversight provided by Professional Standards Command.[88]

63. Forensic examination of the areas in and around where John Doe was located, and of his vehicle,[89] was undertaken by members of the Victoria Police Forensic Services

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[83] Dr Iles also documented a mixed abraded and puncture wounds of the left lower leg with no associated haemorrhage indicating that the injuries occurred after death. The injuries were observed in association with damage to the overlying trousers worn by the deceased. Subsequent correspondence with police revealed that the injury likely occurred when the police search and rescue dog located the deceased.

[84] Methylamphetamine is known colloquially as 'ice'.

[85] Methylenedioxymethamphetamine is known by the abbreviation 'MDMA', or colloquially, as 'ecstasy'.

[86] VIFM Toxicology report dated 31 December 2018.

[87] Report of Dr Iles dated 7 January 2019.

[88] 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 incident involving police.

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

Centre. Among the items seized were a 12-guage Harrington and Richardson single shot shotgun (**shotgun**) and shotgun cartridges.[90]

64. When further examined, the shotgun's barrel and buttstock had been sawn off, the hammer was down, and the action was closed.[91] A fired cartridge case was in the chamber of the shotgun.[92] Ballistic analysis confirmed that the fired cartridge case was discharged in the shotgun.[93]

65. The shotgun was not registered to John Doe. It had been reported stolen between November and December 2017 from a residence in Tarwin Lower.[94] Further police investigation failed to reveal how (or when) the shotgun came into John Doe's possession.[95]

The Victoria Police operation to apprehend John Doe

66. The focus of my investigation into John Doe's death, following service of the brief of evidence compiled by D/Sgt Weaver, was on Victoria Police's operational response to the incident.

67. The operation at Blind Bight on 10 September 2018 was also the subject of a review by Victoria Police's Operational Safety Committee. The terms of reference for the review were decision-making during the operation to apprehend John Doe 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**).

[90] Coronial brief, 55. Shotgun cartridges were located within John Doe's clothing and in a 'bum bag' found near to where John Doe had been hiding: Coronial brief, 55-56.

[91] Coronial brief, page 55.

[92] Coronial brief, page 55.

[93] Coronial brief, page 171.

[94] Coronial brief, pages 168-169.

[95] Coronial brief, pages 178-179 and 711-743.

68. Though mindful of the obligation to avoid unnecessary duplication of inquiries,[96] I obtained additional materials from the Chief Commissioner of Victoria Police touching upon the following issues:

(a) information gathering, sharing and communication (including its timeliness and effectiveness) during the operation;

(b) timing of the request for K9 support and deployment of this specialist assistance; and

(c) accuracy of cordon placement.

Operational use of information

69. The operation to apprehend John Doe on 10 September 2018 commenced as a "job" to locate and assist a potentially 'suicidal male'[97] who might be a risk to his "in laws," and may be in possession of a firearm. It developed over the following six hours into an operation involving about 120 police members across multiple work units.[98] Information from sources including operational members, LEAP, people known to John Doe and members of the public was received and communicated within and between the units involved in the police response with obvious implications for (everyone's) safety and the operation's success.

70. Information use, sharing and communication by Victoria Police are delineated in the Victoria Police Manual and require the use of official police systems (IT infrastructure and D24) and processes commensurate with the security classification of the information and for legitimate purposes.[99]

71. Although the available evidence suggests some delays in the relay of pertinent information (such as details of threats John Doe allegedly made against his former

[96] Section 7 of the *Coroners Act* 2008.

[97] Coronial brief, page 375; 385.

[98] Correspondence to the Coroners Court on behalf of the Chief Commissioner of Victoria Police dated 21 June 2022.

[99] Victoria Police Manual *Information Sharing*; *Information use, handling and storage*; *Emergency Management*.

partners and his correct vehicle registration),[100] I am satisfied that these did not have a material effect on the police operation. Moreover, it is evident that management of the incident involved assessment and reassessment of known and available information.

72. I understand that Victoria Police's capability to access data in real time was enhanced in 2019 and 2020 by roll out of IRIS device technology (which integrates with central information management systems) to front line police members as part of its Mobile Technology Project.[101]

K9 unit deployment

73. The K9 unit provides specialist support for a range of policing activities on request.[102] Relevantly, when the K9 unit is deployed to an incident involving a person armed with a firearm it is done in preference to a confrontation between police members and the armed person[103] and the canine team will usually have demonstrated operational capacity to apprehend in any environment.[104]

74. To request deployment of a canine team for an unplanned operation such as the early stages of the operation involving John Doe, the request must be made via D24. The K9 request was made at about 9.55am,[105] when John Doe's vehicle was found on Goolagong Road.[106] When A/Sgt Justice followed up, he was informed that no canine team was available.[107] At about 10.25am, the K9 unit advised that a canine team was

[100] Correspondence to the Coroners Court on behalf of the Chief Commissioner of Victoria Police dated 21 June 2022.

[101] Correspondence to the Coroners Court on behalf of the Chief Commissioner of Victoria Police dated 21 June 2022.

[102] Victoria Police Manual *Specialist Support* (policy and guidelines).

[103] Deployment of a canine team is a use of force and so must not be disproportionate to the objectives reasonably believed to be necessary to (relevantly) assist in the lawful arrest of a person': section 462A of the *Crimes Act* 1958.

[104] Statement of Superintendent Watt dated 17 June 2022.

[105] Coronial brief, page 328.

[106] There was some confusion (among CIRT members) evident in police radio transmissions around 9.55am about whether a K9 unit request had already been made with a team on route (based on a transmission by a canine unit prior to 9.55am indicating they were in Werribee); this confusion was quickly remedied: Coronial brief, page 328.

[107] Coronial brief, page 471.

about 30 minutes away from the scene, but the dog did not have capability.[108] A canine team arrived at the command post at 11am, that is, around the time Airwing confirmed John Doe's location on the rural block.

75. Although A/Sgt Justice's intention was for CIRT and K9 to 'clear' John Doe's vehicle, the arrival of the canine team an hour after the vehicle was located did not delay safe clearance of the vehicle or establishment of cordons around John Doe's likely location. A canine team was present at an appropriate time for deployment for direct contact with John Doe. I am satisfied that the K9 request, it's timing and deployment of a canine team were appropriate in the circumstances.

Cordons

76. Once the focus of police operations was on Goolagong Road Blind Bight upon discovery of John Doe's parked car just before 10am, the area was cordoned initially to minimise danger to members of the public (that is, to keep them out of the area) and then, once his approximate location was known (near the 'hot agg burg'), to contain John Doe. Once the vehicle was cleared, it was appropriate to establish a cordon to ensure John Doe did not return to it.[109] The parameters of the cordons were set and re-set responsive to information available throughout the incident and its evolving operational objectives.[110] I am satisfied that the placement of cordons during the incident were appropriate to the circumstances.

Emergency Management Response – OSCIR

77. The OSCIR found that the operation in Blind Bight broadly complied with Victoria Police Manual polices including those relating to *Operational duties and*

[108] Coronial brief, page 497; Statement of Superintendent Watt dated 17 June 2022.

[109] Statement of Superintendent Watt dated 17 June 2022.

[110] Statement of Superintendent Watt dated 17 June 2022.

responsibilities, *Resource management and patrol supervision*, *Operational safety and use of force*, and *Emergency management response*.[111]

78. I note that the *Emergency Management Act* 2013 defines an emergency as occurring when there is an actual or imminent event that in any way endangers or threatens to endanger the safety or health of any person in Victoria.[112] Although the operation to apprehend John Doe met this definition by 8.32am, police did not believe they were responding to an emergency until they had located John Doe around 11am.[113] Nonetheless, many of the significant actions required by policy governing emergency responses were performed before 11am including application of a command structure, development of an emergency action plan, assessment of the impact of the operation, delegation of tasks to specialist units, and addressing the health and safety needs of first responders and the public.[114]

79. D24 broadcasts between approximately 10am and 11am suggest the command structure was not as robust as it might have been. In this period, operational directions were made by several senior police members rather than by a single Police Forward Commander, including two contradictory directions.[115] While I am satisfied that the operation to apprehend John Doe was not materially or adversely affected by this situation, it is easy to imagine operational situations that might be adversely affected by an insufficiently robust command structure. It seems likely that to some extent the situation arose because of the belief that police were not yet responding to "an emergency" and perhaps due to some conflict in descriptions of leadership roles in Victoria Police Manual guidelines relating to *Resource management and patrol supervision* and the policy relating to *Emergency management response*.[116]

80. Indeed, several opportunities to clarify Victoria Police policies relating to emergency management were identified in the OSCIR. Relevantly, recommendations were made to minimise the use of terms interchangeably (incident, event, emergency, situation,

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[111] OSCIR, pages 9-11.

[112] Paraphrased from section 3 of *Emergency Management Act* 2013 (as in force on 22 August 2018).

[113] OSCIR, page 29.

[114] OSCIR, page 35.

[115] OSCIR, pages 22-24.

[116] OSCIR, pages 29 and 30.

operation) to reduce confusion, resolve inconsistencies relating to the duties of the Police Forward Commander within the *Emergency management response policy* and address similar conflicting descriptions of duties between the *Emergency management response* policy and the *Resource management and patrol supervision* guideline.[117]

81. I am advised that the Committee's recommendations in relation to Victoria Police Manual clarifications were endorsed.[118]

FINDINGS

82. Having investigated the death of John Doe, and having held an inquest in relation to John Doe's death on 10 November 2023 at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

    (a) that the identity of the deceased was John Doe, born on 2 April 1985;

    (b) that John Doe died at Warneet Road in Blind Bight, Victoria on 10 September 2018 from a contact range shotgun injury to the head;

    (c) in the circumstances described above in paragraphs 18-54.

83. I find that given circumstance and the lethality of the means he chose, John Doe intended to take his own life.

[117] OSCIR, pages 12-13.

[118] Dated 28 April 2022.

ORDERS

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

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

    (a) John Doe's family;

    (b) Chief Commissioner of Victoria Police;

    (c) Detective Sergeant Glen Weaver,Coronial Investigator.

Signature:

Leveasque Peterson
Coroner
Date: 27 November 2023