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STATE

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CORONER

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VICTORIA

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7th June 2002

Case No: 3679/98

**RECORD OF INVESTIGATION INTO DEATH**

I, **NOREEN MARY TOOHEY**, Coroner,

**having investigated** the death of GREGORY DAVID COUPER with Inquest held at the Coronial Services Centre, Southbank on 2nd to 6th April, 16th to 20th, 23rd to 25th July and 27th and 28th August 2001<sup>1</sup>

**find that** the identity of the deceased was GREGORY DAVID COUPER and that the death occurred on the 6th December, 1998 at the Alfred Hospital from

1(a). HYPOXIC/ISCHAEMIC

ENCEPHALOPATHY

1(b). ASYSTOLIC CARDIAC ARREST

1(c). RESTRAINT ASPHYXIA

in the following circumstances:

1. The deceased, aged 43 years, was admitted to the Alfred Hospital Trauma Centre at 1.18pm on Wednesday 2nd December having suffered an asystolic cardiac arrest whilst

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<sup>1</sup> Counsels' Submissions and Replies were submitted to the Coroner's Court by 8th February 2002.

being apprehended by police at his residence earlier that afternoon. The deceased was subsequently transferred to the Intensive Care Unit where he was found to have a severe head and brain injury with severe global brain swelling on CT head scan. Following consultation with the deceased's family on 5th December mechanical ventilation was withdrawn and the deceased died at 8.50am on 6th December 1998.

## Witnesses

2. For ease of identification, the following witnesses were called to give evidence:

Gregory Lane (Proprietor of *"The Avenue"* Supported Residential Service)

Gregory Gardner (Manager of *"The Avenue"*)

Glenda Healy (Cook, Personal Carer at *"The Avenue"*)

Norma Ward (Cleaner *"The Avenue"*)

Joan Kikkos (Royal District Nursing Service Community Nurse at *"The Avenue"*)

Dr Ronald Kingston (The deceased's treating Psychiatrist)

Christopher Ross (Ambulance Officer who attended *"The Avenue"* and conveyed deceased to Alfred Hospital Trauma Unit)

Dr Genevieve Coney (The deceased's General Practitioner)

John Adams (Registered Psychiatric Triage Nurse at Alfred Hospital CAT team)

Dr Harry Karipis (Examined deceased on arrival at Alfred Hospital Trauma Unit)

Frances Draycott (Registered Psychiatric Nurse and Manager of Alfred CAT team)

Damian O'Neil (Registered Psychiatric Nurse, Alfred Hospital CAT team. Part of the on-call team on 2/12/98)

Fiona Smith (Social Worker and Duty Worker at Junction Clinic)

Dr Matthew Gelman (Psychiatric Registrar, attached to Alfred Hospital CAT team and part of on-call team on 2/12/98)

Senior Constable Paul Leighton (who was an Acting Sergeant and the first police member to arrive at *"The Avenue"* following police involvement with the deceased)

Dr Malcolm Dodd (Forensic Pathologist who performed post mortem examination on 6/12/98)

Assistant Commissioner Raymond Shuey (who gave evidence in relation to operational police training, critical incident management and difficulties experienced with CAT Services)

Dr Peter Doherty (Director of Alfred Hospital Psychiatric Services who gave evidence in relation to Alfred Hospital Records, CAT Services and the conduct of the CAT team on 2/12/98)

Senior Sergeant Andrew Miles (Victoria Police Operational Safety and Tactics Training Unit who gave evidence in relation to police training and provided an opinion in relation to the actions of police members on 2/12/98)

Detective Senior Constable Leigh Smyth (Attached to Homicide Squad who interviewed Senior Constable Cheasley)

Detective Senior Sergeant Paul Ross (Attached to Homicide Squad at the time who interviewed and took photographs of Constable Smith) and

Detective Senior Sergeant Philip Swindells (Attached to Homicide Squad - responsible for compilation of Inquest Brief).

Senior Constable Kylie Henman, Constable Shayne Jarvis, Constable Pauline Smith and Senior Constable Scott Cheasley did not give evidence or adopt their statements on legal advice and an application to be excused from giving evidence on the ground of privilege against self-incrimination was successful.

### **The Deceased's General History**

3. The deceased suffered from longstanding chronic schizophrenia. Dr Ronald Kingston was his regular treating psychiatrist from the age of about 14 years up until his death. He had multiple admissions to both private and public psychiatric hospitals over the years. According to Dr Coney, the deceased's general practitioner for a period of thirteen months from 29th September 1997, the deceased had been relatively stable over the period, but suffered relapses requiring admission to the Alfred Hospital between 6th and 13th May 1998 and 2nd and 21st October 1998.
4. In addition, the deceased suffered from chronic renal impairment, hypertension, dermatitis and was a heavy smoker. At the time of his death, he was prescribed 1 mg Gopten and 7.5mg Norvasc daily for hypertension, 200mg Tegretol, twice daily as a mood stabilizer, 20 mg Zyprexa (Olanzapine) at night as an anti- psychotic agent and Elocon cream as required for the treatment of dermatitis.
5. According to the deceased's father, David Couper, the deceased first left the family home when he was approximately 25 years of age and resided in many special accommodation homes. In 1990, the deceased became involved in a relationship with Sandra Shaw whilst residing at *"Ashmore Lodge"*, a supported residential care facility. Ms Shaw also suffered from schizophrenia. In April 1991, both took up residence at 6 The Avenue, Windsor (*"The Avenue"*), a supported residential service until May 1993. They returned in 1994 and continued to reside at *"The Avenue"* up until the deceased's death. Due to the nature of his illness the deceased was unable to obtain employment and received a disability support pension, in addition to a monthly allowance from his father.

### **Events Leading Up to the Attendance of Police on 2nd December**

6. According to Gregory Lane<sup>2</sup>, the proprietor of *"The Avenue"*, from time to time the deceased believed he was well enough and ceased taking his medication. Over the ten day period to 2nd December, it is believed the deceased was *"dodging around taking his medication"* leading to a gradual deterioration in his psychiatric state. Over the nights of Monday 30th November and Tuesday 1st December, Mr Lane became aware the deceased was experiencing auditory and visual hallucinations. The deceased had described a man

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<sup>2</sup> Mr Lane commenced to operate *"The Avenue"* in September 1989.

outside his unit banging on the pipe near the stairs and reported people outside his flat shining torches into the room and making threats to him.

7. Community nurse, Joan Kikkos, who was employed by the Royal District Nursing Service, had worked at *"The Avenue"* for a period of three years as part of a homeless persons program. Ms Kikkos saw the deceased between two and four days per week and had contact with his medical practitioners. In October 1998, Ms Kikkos and Mr Lane contacted the Junction Clinic due to the deceased's deteriorating state.<sup>3</sup> This resulted in the deceased's involuntary admission to the Alfred Hospital. He was subsequently discharged under the care of Dr Coney and Dr Kingston. The deceased's last consultation with Dr Coney was on 30th October where he appeared well and displayed no psychotic features. By Tuesday 1st December, Ms Kikkos was aware the deceased had experienced hallucinations at night and she had observed the deceased *"walking around with his dressing gown open, holding soft toys and chocolates"*. However, Ms Kikkos told the Court the deceased was quiet, spending quite a lot of time in his room. Later that afternoon Ms Kikkos observed him seated on a bench in the driveway appropriately dressed. At that stage Ms Kikkos did not consider the deceased to be floridly psychotic.
  
8. On the morning of 2nd December, Gregory Gardner, the manager and Glenda Healy, a cook and personal carer at *"The Avenue"*, observed the deceased in an agitated state. His behaviour was described as bizarre; he had spittle all down his face from yelling, he was making threats to kill; he accused Mr Gardner of sleeping with his girlfriend, and was stating that he owned *"The Avenue"* and the whole street. In view of the deceased's mental state, Mr Gardner and Ms Healy made a decision to contact the Alfred Hospital Crisis Assessment and Treatment team (CAT) to attend and conduct an assessment. From the nurse's office at the rear of the premises, Mr Gardner initially telephoned the Alfred Hospital Psychiatric Triage Service and spoke to registered psychiatric nurse John Adams, then telephoned social worker and duty worker Fiona Smith at the Junction Clinic.<sup>4</sup> It would appear the call to Ms Smith was made at approximately 11.15am.<sup>5</sup> Mr Gardner was informed the CAT team would be contacted but in the meantime he was advised to contact police. Mr Adams and Ms Smith each told the Court they paged the on-call CAT team (Damian O'Neil and Dr Matthew Gelman). It was Mr Gardner's recollection that Fiona Smith had told him the CAT team was already dealing with another serious problem elsewhere. He told the Court he was under the impression the CAT team was unable to attend and the police were to secure the deceased at the police station and they would later deal with him.<sup>6</sup> However, under cross-examination from Ms Hinchey, who appeared as Counsel on behalf of Bayside Health, Mr Gardner conceded Ms Smith may have said *"look the CAT team's busy but why don't you call the police and the CAT team will come"*

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<sup>3</sup> The Junction Clinic is the community based mental health service of Alfred Psychiatry.

<sup>4</sup> See Booklet of photographs *"A"* at photographs 23-34.

<sup>5</sup> See Community Team Referral. Exhibit N1.

<sup>6</sup> See Statement of Gregory Gardner 2/12/98 at page 74, Statement dated 18/12/98 at paragraph 17, and Transcript 4th April 2001 at pages 170, 193 and 195.

*when they can and the police should take Mr Couper off and tell the CAT team where he is when they've got him under control?"*<sup>7</sup>

9. Mr Gardner telephoned "000" at 11.21am. According to Glenda Healy, it was about this time when the deceased approached her. She explained to the deceased that Mr Gardner was on the telephone and would speak to him soon. Ms Healy told the Court she was standing approximately two steps inside the door at that stage when the deceased put his hands on her forearms and "*pushed*" her backwards some distance with a considerable amount of force. Ms Healy managed to take hold of a small table to prevent a fall. [see photographs A26 and A29<sup>8</sup>] Ms Healy told the Court, as a consequence she was "*shaken, shocked and her arms were sore*".<sup>9</sup> Mr Gardner witnessed this incident and told the Intergraph operator the deceased "*is attacking people here and we need assistance straight away please*" "*he's a psychiatric person and he's attacking, he's attacking everyone at the moment, he's uncontrollable*" "*he's punching people, hitting people, trying to hurt people, can we have some assistance please*" "*He's absolutely berko*."<sup>10</sup>
  
10. Following the incident with Ms Healy, Mr Gardner told Ms Healy to leave. He told the Court as Ms Healy was in the process of leaving the deceased approached him in a threatening manner. Mr Gardner stood up and the deceased said, "*I think that I should hit you now or should you hit me?*" Mr Gardner told the deceased, "*No, I don't think that either of us need to hit each other.*" The deceased then said, "*I think I'll hit you.*" The deceased attempted to punch Mr Gardner but Mr Gardner managed to block the punch which struck the back of his hand. He described the punch as "*surprisingly forceful for Greg.*"<sup>11</sup> He spun the deceased around and pushed him towards the open door but the deceased struck the mesh door, resulting in the door striking the wall and causing the glass to break. [see photograph A29] As a result of the scuffle the deceased's shirt was torn and he sustained a graze to his forehead from the impact with the door. Mr Gardner told the Court the deceased received a scratch to his chest when pushed towards the door.<sup>12</sup>
  
11. After exiting the office area the deceased appeared to calm down. He requested and was subsequently provided with his room key. A short time later the deceased was observed in the driveway and at the front of the premises pacing up and down, yelling at members of the public.

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<sup>7</sup> Transcript 4th April 2001 at page 186. Mr Adams told the Court the CAT team would not be able to attend immediately but would attend as soon as possible.

<sup>8</sup> The photographs in Booklet "A" were taken on 2nd December 1998 at approximately 2.40pm by Senior Constable Sears.

<sup>9</sup> Transcript 5th April 2001 at pages 248, 261-262, 275-277.

<sup>10</sup> See Intergraph Transcript "AF" and Tape recording of call.

<sup>11</sup> Transcript 4th April 2001 at page 209.

<sup>12</sup> Transcript 4th April 2001 at page 177.

12. At 11.41am Mr Gardner again telephoned "000". *"I requested some urgent assistance here. We've got a fellow who's attacking people and is absolutely off his tree and no-ones come" "he's attacking the staff, threatening to kill people and he's shouting out at the street for everyone to get off the street because it's his" "he's walking up and down the drive and out the street and back again. He's pacing."*<sup>13</sup> The operator could hear the deceased in the background and assured Mr Gardner the police would not be too long. Unlike the operator taking the first call from Mr Gardner who nominated the call as *"psychiatric patient"* a priority three call, this call was nominated as *"a serious domestic,"* a priority one call, the highest dispatch level.<sup>14</sup>
13. At about this time the deceased commenced to walk up the street towards Dandenong Road. Mr Gardner followed but once the deceased reached Dandenong Road he turned and walked back towards the hostel with Mr Gardner. The deceased was calm and apologized for his earlier behaviour. He indicated that he did not wish to be taken back to Larundel where he had been admitted on many occasions up to 1990.<sup>15</sup> Mr Gardner told the Court he assured the deceased he would not be taken to Larundel but believed he needed some assistance and may need to go to hospital. According to Mr Gardner the deceased became agitated on observing the two police members who had arrived and were at the front of *"The Avenue"*. Witnesses from *"The Avenue"* and the deceased's father, David Couper, maintained the deceased had a good relationship with the police.

### **The Arrival of Police**

14. At 11.44am Intergraph dispatched Senior Constable Kylie Henman<sup>16</sup> and Constable Shayne Jarvis<sup>17</sup> from Prahran, call sign 306, to attend 6 The Avenue in relation to *"a psychiatric patient who's gone off his tree."*<sup>18</sup> At 11.47am Prahran 306 requested information from Intergraph regarding the estimated time of arrival for the CAT team. One minute later, Intergraph advised:

*"Prahran 306 the only notation I can find re the CAT team and the job, apparently the complainant rang the CAT team and he then told them to ring 000. Don't know at this stage whether they're attending or not."*

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<sup>13</sup> See Intergraph Transcript "AG" and Tape recording of call.

<sup>14</sup> See Statements of Tracee Lee Matchett and Nanette Clare Gherardin at pages 124 and 127 of the Inquest brief.

<sup>15</sup> See Larundel Hospital Records.

<sup>16</sup> Senior Constable Henman completed Operational Safety and Tactics Training (OSTT) in March and July 1995, February and August 1996, February and September 1997 and 3rd September 1998. On 2/12/98 she was the driver of the marked divisional van.

<sup>17</sup> Constable Jarvis graduated from the Police Academy on 26 September 1997. She had been stationed at Prahran since January 1998 and completed OSTT on 26th September 1997 and 9th July 1998. On 2/12/98 she was the observer in the marked police divisional van.

<sup>18</sup> See Transcript of Intergraph radio transmissions 2/12/98 at "AH" Inquest brief and tape recording of call.

It would appear likely that Prahran 306 arrived at approximately 11.51am.<sup>19</sup> On arrival at the hostel, the divisional van was parked at the front of the premises. Mr Lane had returned to the hostel shortly prior to the arrival of police and had observed the deceased walking around aimlessly engaging in what he described as *"psycho babble"*?. According to Mr Lane, Mr Gardner briefly outlined the earlier incident involving the deceased and passed on information regarding the CAT team. Mr Lane spoke to Senior Constable Henman and Constable Jarvis at the police van.

According to their statements, Senior Constable Henman and Constable Jarvis were advised by Mr Lane this was the first time that the deceased had been physically violent and he had earlier thrown a female staff member across the room. In addition, Constable Jarvis stated she believed another staff member had tried to restrain the deceased. In her hand written notes, Constable Jarvis stated the manager had advised the deceased had also been physically aggressive with another staff member. Constable Smith stated she was told by Constable Jarvis that the deceased had been aggressive earlier.

In his statements, Senior Constable Cheasley stated he had been informed by other police members the deceased needed to go to hospital for assessment and they were concerned he may be aggressive.

Constable Jarvis stated Mr Lane had informed them the CAT team was not available. They had suggested calling "000" and arranging for the police to take the deceased to the Prahran Police Station.<sup>20</sup>

15. By this stage, the deceased and Mr Gardner had arrived back at *"The Avenue"*?. Senior Constable Henman and Constable Jarvis approached the deceased in an effort to engage him in conversation. At the time the deceased was wearing a red flannelette long sleeve shirt torn across the right hand shoulder, a singlet, blue jeans and shoes. According to Senior Constable Jarvis, the deceased shook her hand and apologized for his behaviour. In her statement she described the deceased as agitated and mumbling. According to her statement, Senior Constable Henman encouraged the deceased to sit and talk but he continued to walk towards the stairway leading to his room. The deceased pulled away when Senior Constable Henman reached out to take hold of the deceased's sleeve and proceeded up the stairs to the first floor to his room at number 32. [see photographs A35-A39] The deceased closed the door. He was alone in the room. Both police members followed the deceased. On becoming aware the portable radio was not operating, Constable Jarvis returned to the divisional van where she requested the attendance of another unit. That request was recorded at 11.55am:

*"Prahran 306 re your in "The Avenue", the CAT team apparently ....?. in touch with the complainant asked for transport the gentleman back to the Prahan Police Station,*

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<sup>19</sup> See Patrol Duty Return Prahan 306 (Exhibit P5) Time of Intergraph call recorded as 11.40am.

<sup>20</sup> See statement of S/C Henman at page 152 Inquest brief; statement of C/ Jarvis at page 162 Inquest brief and Exhibit W5 at page 49; statement of C/ Smith at page 174 Inquest brief; statement of S/C Cheasley at pages 180 and 183 Inquest brief.

*if they're tied up we're going to need another unit here. He's getting a bit agitated unfortunately."*<sup>21</sup>

16. Constable Jarvis stated at this time she heard via the police radio that there was another job involving a "*psych*" patient and she assumed that the CAT team may have been tied up that job.
17. At 11.55am Intergraph dispatched Senior Constable Scott Cheasley<sup>22</sup> and Constable Pauline Smith<sup>23</sup>, St Kilda Road call sign 307, to "*back-up the Prahan van with a psych patient*". St Kilda Road 307 arrived at "*The Avenue*" and sought assistance in locating the Prahan van. At 12.07pm, Intergraph contacted Prahan 306 to arrange for a police member to assist St Kilda Road 307.
18. In the meantime, Senior Constable Henman remained outside the deceased's locked door speaking with Mr Lane. They were then joined by Constable Jarvis who, a short time later, left to reverse the divisional van into the driveway of the premises. Constable Jarvis returned until requested by Intergraph to assist St Kilda Road 307 who had arrived at the premises. Whilst standing on the landing the deceased could be heard "*screaming at the top of his voice and talking as if someone else was in the room*". In his discussion with police, Mr Lane endeavoured to provide a snapshot insight into the deceased's history. Mr Lane believed he had adequate time to do this. I am satisfied the police were informed:
  - *That the deceased was a schizophrenic.*
  - *The illness had been coming on for about four days.*
  
  - *The deceased had stopped taking his medication, although Mr Lane had supervised the deceased in an effort to ensure he had taken his medication.*
  - *That the deceased had been "very good for the past couple of years but this year had not been so good."*
  - *That the deceased had spent considerable time in hospital.*
  - *That the deceased had not previously been violent but had been verbally aggressive.*
  - *That Mr Lane was usually able to talk to the deceased and "cajole him into doing anything that was necessary without the need for sending out the CAT team or the police."*
19. A short time later, Constable Jarvis escorted Senior Constable Cheasley and Constable Smith inside the premises and rejoined Senior Constable Henman and Mr Lane. Mr Gardner had provided a key to the room. I am satisfied at this stage it was agreed Mr Lane

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<sup>21</sup> See Intergraph Transcript at "*AH*" Inquest brief and tape recording of call.

<sup>22</sup> Senior Constable Cheasley was attached to St Kilda Road Police Station and had been a member of the police force for approximately 10 years. He completed OSTT in January and July 1995, January and August 1996, February and July 1997 and 25th March 1998.

<sup>23</sup> Constable Smith was a Probationary Constable attached to St Kilda Road Police Station since 18/5/98. She had been a member of the police force since 15/9/97 and had completed OSTT on 6th February 1998.

would speak to the deceased in an effort to persuade him to accompany police to hospital. Mr Lane knocked on the door and informed the deceased he was entering the room.<sup>24</sup>

20. There is no dispute the deceased's behaviour on this day was totally uncharacteristic and warranted psychiatric assessment. None of the witnesses at *"The Avenue"* had seen the deceased previously exhibiting physical violence. (I accept there are references to aggression and violence in hospital records, particularly whilst the deceased was a patient at Larundel Hospital. The deceased's father stated that he could not recall the deceased being violent at home. *"He was not a violent person. Certainly he would become noisy, cantankerous and difficult but it would be a misuse of the word to say that he ever got violent."*<sup>25</sup>)

### **Police Power to Apprehend the Deceased**

21. There would appear to be no doubt at this time that the deceased was a person suffering from a mental illness within the meaning of s.8 of the Mental Health Act 1986 ("*MHA*"). It is submitted by Counsel appearing on behalf of the police members and the Chief Commissioner that the power of police in this instance to apprehend is to be found in section 10 of the Mental Health Act and section 459 of the Crimes Act 1958.

Section 10 of the MHA authorizes a member of the police force to apprehend a person who appears to be mentally ill if there are reasonable grounds for believing (a) that the person recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person or (b) the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person. For the purpose of apprehending a person, Section 10 (2) authorizes a member of the police force with such assistance as necessary to (a) enter the premises; and (b) use such force as may be reasonably necessary.

Section 459 Crimes Act 1958 authorizes a member of the police force to apprehend a person where there is a reasonable ground for believing that person has committed an indictable offence.

By the time police members arrived at *"The Avenue"* the deceased had assaulted Ms Healy and attempted to assault Mr Gardner. On this basis it would appear the police had reasonable grounds for believing the deceased had committed an indictable offence and as such were entitled to exercise a power of arrest.

Given the nature of the assault on Ms Healy and Mr Gardner, in my view, it would be difficult to establish that deceased attempted to cause "**serious bodily harm**" to himself or some other person or was likely to do so pursuant to s.10 MHA.

**Although, it is likely in my view, the police members had power to apprehend the deceased, the real issue is whether they should have attempted to apprehend him at that time.**

22. It is perhaps useful at this stage to note that the events that occurred following the arrival of Senior Constable Cheasley and Constable Smith took place over a period of

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<sup>24</sup> See Photographs A40, 43 and 44 regarding location of room 32 and view of same.

<sup>25</sup> See Affidavit of David Couper sworn 2 July 2001. (Part of Exhibit X)

approximately ten minutes. The last Intergraph communication on their arrival at "*The Avenue*?" occurred at 12.07pm. The next communication where a request is made for another police unit and an ambulance is at 12.17pm.

### **Apprehension of the Deceased**

23. Once entry was gained to the room, the deceased was observed seated in a low lounge chair, in the southwest corner of the room between a double bed and a chest of drawers facing the doorway.<sup>26</sup> The deceased's hands were resting on the arms of the chair and his feet were on the ground. Mr Lane entered the room and sat on the bed next to the deceased. He reached forward and placed his hands on the back of the deceased's hands, which he described as "*really, really hot and clammy*".<sup>27</sup> Mr Lane calmly spoke to the deceased in an attempt to persuade him that he was not well and needed to be hospitalized. He attempted to distract the deceased by speaking about preparing his belongings to go to hospital, as such attempts had been successful in the past. On his estimate Mr Lane continued to speak to the deceased for a period of between "*three and five minutes, something like that,*"<sup>27</sup> to no avail.
24. The deceased commenced to repeat his earlier delusional conversation and his speech became quicker. At this time the deceased "*leaned forward*?" and said, either "*I'm going to hit you?*" or "*You're going to hit me*".<sup>28</sup> [There is no evidence at this time the police members were aware the deceased had used similar words towards Mr Gardner approximately one hour earlier.] Under cross-examination by Mr Lopez, who appeared as Counsel on behalf of Senior Constable Cheasley, Mr Lane told the Court "*the statement was violent but the way it was presented wasn't. This wasn't screamed out, I'm going to hit you?, I meant the whole thing fluctuates enormously*".<sup>28</sup> Mr Lane "*eased back*?" and told the deceased that was not going to happen. Under further cross-examination from Mr Lopez, Mr Lane told the Court the deceased "*leaned forward and I leant back*" "*probably because it was a break in the way things had been going and I was sort of a loss as to where to go next*".<sup>29</sup> Mr Lane then released the deceased's hands. I do not accept the deceased threw his arms up aggressively about this time, as suggested by Constable Jarvis in her statement.<sup>30</sup>
25. Mr Lane was then told by police to stand aside. Under cross-examination by Mr McKenna, who appeared as Counsel on behalf of Senior Constable Henman and Constables Jarvis and Smith, Mr Lane told the Court he was asked to step out of the way. "*I mean if Greg and I were there and the police were not there, then we would have continued trying to get him to go.*" "*But I think the police had reached the point where*

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<sup>26</sup> See Plan (Appendix A) attached to Inquest Brief for scale dimensions of the deceased's room.

<sup>27</sup> Transcript 2nd April 2001 at page 46.

<sup>28</sup> Transcript 4th April 2001 at page 126.

<sup>29</sup> Transcript 4th April 2001 at pages 126 and 127.

<sup>30</sup> Statement of Constable Shayne Jarvis 2nd December 1998 at page 167 Inquest Brief. See evidence of Mr Lane 2nd April 2001 at page 61.

*they were feeling like they wanted something to happen.*"<sup>31</sup> At that stage Mr Lane agreed it was not inappropriate for the police to intervene. I am satisfied at this time the deceased remained seated in the lounge chair and was not acting aggressively.

26. As Mr Lane made his way to the doorway area, it was his recollection that one policewoman was to one side of the doorway and two others at the end of the bed with Senior Constable Cheasley perhaps half way down the length of the bed. In their statements, each of the police members stated they remained outside near the doorway and did not enter the room until Mr Lane moved to the doorway but were in a position to see what was happening inside the room. In my view little turns on this conflict in the evidence. Given the deceased's good relationship with the police, Mr Lane believed the moment he stepped out of the way the deceased would give no resistance in any way and stand up and walk out with the police.<sup>32</sup> When Senior Constable Cheasley was within reasonably close proximity to the deceased, he said words to the effect "*Come on Greg it's time to go.*" Mr Lane agreed these words were not spoken in an aggressive manner.
27. There is a dispute on the evidence as to precisely what followed. On Mr Lane's account, there was no conversation or instructions issued to the deceased and at this time the deceased, began "*flailing his arms around in the air just like a small child does when it's parents tell them it's time to go to bed and it doesn't want to.*"<sup>33</sup> Mr Lane provided a demonstration to the Court on the 2nd April where he described the deceased "*throwing his arms around in a totally discoordinated manner*" and later he told the Court "*they were not an aggressive directed defence or attack. They were simply as I've described them, like a child flailing. There was no direction of a kick or anything. It was just aimless flailing. To stay away from me.*"<sup>34</sup>
28. He conceded it was possible Senior Constable Cheasley might have been kicked by the deceased a number of times and although he did not believe other police were within kicking distance, he conceded it was not impossible.<sup>35</sup> According to Mr Lane, Senior Constable Cheasley then shouted "*Don't shape up to me mate,*" lent forward, placing his left hand on the deceased's right shoulder and appeared to strike the deceased three times to the face with his clenched right fist. The deceased remained seated throughout. [Mr Lane's view of the deceased was partially obstructed and he conceded that he did not actually observe the blows make contact with the deceased.] Thereafter, Mr Lane believed all three policewomen commenced to strike the deceased's legs and arms with extended asp batons. However, in cross-examination he conceded he was not certain all three had their batons out but was very sure more than one did.<sup>36</sup>

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<sup>31</sup> Transcript 2nd April 2001 at page 43.

<sup>32</sup> Transcript 2nd April 2001 at page 49.

<sup>33</sup> Paragraph 35 of Statement of Gregory Lane to Mr Little 17/12/98

<sup>34</sup> Transcript 2nd and 3rd April 2001 at pages 19 and 62.

<sup>35</sup> Transcript 2nd April 2001 at pages 62, 63 and 4th April 2001 at page 132.

<sup>36</sup> Transcript 2nd April 2001 at page 71. In his contemporaneous daybook notes at "The Avenue", Sergeant Leighton made reference to "*3x Asps*". (Exhibit P6 entry at 1315 on 2/12/98) Under cross-examination from Mr Lawrie regarding the entry, Sergeant Leighton indicated he had a vague memory "*it may well have been how many members had asps out but not necessarily who had used asps*".

29. According to Mr Lane, Senior Constable Cheasley had the deceased's right arm, and the remaining policewomen each took hold of the deceased's left arm and both his legs. The deceased was then *"whooshed straight out of the chair on his back onto the ground and then rolled over ?..... within seconds of hitting the ground".*<sup>37</sup> *"Well, head straight back and just slid straight out of the chair ..... I mean the chair is extremely low so he just went straight down on to the ground".*<sup>38</sup> According to Mr Lane, he was not happy with what he had seen and momentarily left the room to get some air. At that time the deceased was face down on the ground facing in an east-west direction with his head nearest the western wall of the room. He made his way to the stairs and walked half way down the first flight of stairs, before deciding to return to the deceased's room. [see photograph A38].
30. On his return to the room, Mr Lane observed the deceased restrained on the ground with his left arm handcuffed behind his back. The deceased was calling for help while efforts were being made to remove his right arm from beneath his body. Mr Lane told the Court *"the left arm, as I said, was cuffed very quickly and that was behind his back and they were trying to get his right arm out. To do that I think the policewoman was hitting him on the upper arm and then using the baton to try and pry the arm out. She'd looped through his arm and then tried to pull it out."*<sup>39</sup> As the policewoman attempted to extricate the deceased's right arm, Mr Lane observed Senior Constable Cheasley *"sitting on top of him or with his knee on top of him, banging the floor in front of his face saying `Do you want some of this? Give us the arm."*<sup>40</sup> Mr Lane had indicated in his statements to police that Senior Constable Cheasley was *"banging a baton on the timber floor in front of Couper's face. He was swinging the baton in a downward motion with the tip hitting the floor boards."*<sup>41</sup> The baton did not strike the deceased. At about this time Mr Lane was instructed by Mr Cheasley to leave the room. According to his evidence, as he walked out the door, one hand was cuffed and the other was *"coming out from under him?".*<sup>42</sup> At that time Mr Lane felt the deceased appeared to be totally under police control.
31. Having left the deceased's room, Mr Lane stated that he walked down the stairs and outside the building for a period he estimated at approximately two to three minutes. [See photographs A35-38] It was Mr Lane's expectation the deceased would soon be escorted downstairs by police. Mr Lane told the Court he then returned to the room and observed Senior Constable Cheasley still on top of the deceased.<sup>43</sup> He said he observed the deceased lying with his left cheek against the floorboards facing towards the doorway. He described the deceased's face as *"covered in blood"* and *"distorted from the weight of being held down"*. He stated there was an eighteen-inch pool of blood in diameter around the deceased's head. He told the Court, whereas earlier the deceased's face had been a *"bright*

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<sup>37</sup> Transcript 2nd April 2001 at page 16.

<sup>38</sup> Transcript 3rd April 2001 at page 63.

<sup>39</sup> Transcript 3rd April 2001 at page 69.

<sup>40</sup> Transcript 3rd April 2001 at page 73.

<sup>41</sup> See Statements of Gregory Lane at pages 109 and 112 Inquest Brief.

<sup>42</sup> Transcript 3rd April 2001 at page 75.

<sup>43</sup> Transcript 3rd and 4th April 2001 at pages 80, 143, 144 and 146.

*reddish purple?*", on his return the deceased's face was *"whitish-grey"*. *"His hair was matted and wet with blood and that his eyes were looking at me and he looked to me as if he was dead."*<sup>44</sup> In his statement, Mr Lane described the deceased's eyes as *"glazed and did not move or flicker, although he was looking directly at me."*<sup>45</sup> He described the deceased as *"unconscious"* or *"already dead"*.<sup>46</sup> At that time, Mr Lane told the Court *"I feel from the way he was that he had both cuffs on, but I could not be totally certain if the second one was on him."*<sup>46</sup>

According to Mr Lane, Senior Constable Cheasley once again told him to leave the room. He told the Court *"I ran down stairs and asked Greg Gardner to go up and have a look because I said to him 'I don't want to be the only person that's seen this.'"*<sup>47</sup>

32. In his statement to Mr Little, the deceased's family solicitor, Mr Lane described the hold used by Senior Constable Cheasley to restrain the deceased. *"The male police officer was kneeling on top of him and had him in a judo hold. His knee was thrust between Greg Couper's shoulder blades at the base of his neck. The officer's left leg was out to the side with his left hand on Greg's left shoulder. He was in a pivot position holding him down. It is the type of position where you can put all your weight or practically none of your weight on the person you are holding down depending on how you are resting the pivot. The police officer was resting almost all his weight on Greg's body. Greg was being held down extremely tightly."*<sup>48</sup> Mr Lane estimated the male police officer weighed in excess of 15 stone and described him as *"a heavy set powerful sort of guy."*<sup>49</sup> [According to the post mortem report the deceased weighed 65kg and was 182cm in height.] *"He had a lot of weight and it was all being brought to bear on Greg Couper."*<sup>50</sup> During the course of his evidence, Mr Lane demonstrated the hold used by Senior Constable Cheasley to restrain the deceased. Mr Lane told the Court he had been Victorian judo champion in two weight divisions and came second in the Australian championships some thirty years ago.<sup>51</sup> According to a statement of Detective Sergeant Anthony Wemyss, Senior Constable Cheasley claimed to have been involved in martial arts over a number of years where he had attained a black belt in Tae Kwon Do and had studied Ju Jitsu.<sup>52</sup>
33. Greg Gardner immediately went up to the hallway outside the deceased's room, where he observed Senior Constable Cheasley with his knee on the deceased's upper back, pushing the deceased's head down with his left hand in the area of the deceased's neck. He observed the deceased's head on the side facing toward the door and appeared to be pushed hard against the floor. Mr Gardner described the deceased as motionless, making no sound, with blood on his face and around his head. He observed the deceased's hands

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<sup>44</sup> Transcript 3rd April 2001 at page 79.

<sup>45</sup> See Statement 15th December 1998 at page 113 Inquest Brief.

<sup>46</sup> Transcript 4th April 2001 at page 143.

<sup>47</sup> Transcript 3rd April 2001 at page 80.

<sup>48</sup> Statement dated 17th December 1998 at pages 8 and 9 (paragraphs 40 and 41).

<sup>49</sup> Statement dated 17th December 1998 at page 9 (paragraph 40).

<sup>50</sup> Transcript 2nd April at page 8.

<sup>51</sup> Transcript 4th April 2001 at pages 152 and 153.

<sup>52</sup> Statement of Detective Wemyss dated 23rd July 2001. Exhibit W4.

behind his back in an unnatural "V" position. He told the Court he did not see the handcuffs on the deceased, "*I only saw the arms obviously leading down to the hands but not the hands.*"<sup>53</sup> It was Mr Gardner's recollection Senior Constable Cheasley commented "*Don't worry we've got it under control here.*"

34. In their statements, the police members stated that the deceased was approached by Senior Constable Cheasley followed by either Senior Constable Henman or Constable Jarvis who spoke with the deceased regarding the need to attend hospital. The deceased is said to have refused to accompany police. As attempts were made to take hold of each arm, the deceased is said to have "*screamed, kicked and thrown his arms about*" "*kicked out violently with both feet*" "*kicked out and tried to punch out*" striking more than one police member. Senior Constable Cheasley stated he told the deceased to "*back off as he was shaping up to me with his fists and I said stop shaping up to me like that.*"<sup>54</sup> Senior Constables Cheasley and Henman stated they struck the deceased to the legs with police batons in an effort to prevent him kicking out. Constable Jarvis stated she also observed both members striking the deceased to the legs with batons. All three members stated Senior Constable Cheasley lost his baton at this stage. Constable Smith stated she observed only Senior Constable Henman using her baton but believed Senior Constable Cheasley may have had his baton drawn.
35. Senior Constable Cheasley stated the deceased then stood up, "*still violently kicking and yelling*" "*He was continuing to strike out with both his arms and legs.*" He said after assessing his options, he punched the deceased with a right clenched fist to the face two or three times, which stunned him. Senior Constable Henman made no reference to punches having been thrown by Senior Constable Cheasley. Constable Jarvis stated that Senior Constable Cheasley attempted to punch the deceased but she was not sure if the punches connected. In her statement, Constable Smith stated, "*I believe this person was punched in the face but I can't say by who.*" However, in her handwritten notes made soon after the incident she made reference to Senior Constable Cheasley punching the deceased in the facial area.<sup>55</sup>
36. None of the policewomen or Mr Lane refer to the deceased standing at any time. They refer to the deceased being removed from a seated position onto the ground where he was placed facedown. Given the events occurred over a very short period of time and Mr Lane's view was partially obscured by Mr Cheasley, I accept it is possible Mr Lane did not observe Senior Constable Cheasley strike the deceased to the legs with his asp baton prior to punching him to the face. However, I do not accept that the deceased "*shaped up*" to Senior Constable Cheasley with his fists or stood up at any stage as asserted by Senior Constable Cheasley. I am satisfied that the deceased remained seated in his chair until taken to the ground by police.

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<sup>53</sup> Transcript 4th April at page 242.

<sup>54</sup> Statement dated 2/12/98 at page 185 Inquest Brief.

<sup>55</sup> See Exhibit W7.

37. Once on the ground, both Senior Constable Cheasley and Constable Smith stated Senior Constable Cheasley knelt on the deceased's back. *"I then kneeled on his back approaching from his rear. I was unable to approach from his front due to the position of him on the floor in the room."* Senior Constable Cheasley stated he placed his full weight on the deceased.<sup>56</sup> In her statement Constable Smith stated, *"Senior Constable Cheasley had a knee on this persons back and two hands on his shoulders holding him down."*<sup>57</sup> Senior Constable Henman and Constable Jarvis do not refer to Senior Constable Cheasley kneeling on the deceased's back. There is no dispute that once on the ground the deceased's hand were *"locked underneath him".* According to Senior Constable Henman, she was positioned to the left side of the deceased also holding the deceased down whilst attempting to extract his left arm from beneath him. Constable Jarvis stated that she assisted in holding the deceased down and was positioned to the right side of the deceased attempting to extract his right arm. Constable Smith stated she assisted Constable Jarvis.
38. According to each of the police members the deceased continued to struggle up to and for a period of time after the handcuffs were applied. In his statement, Senior Constable Cheasley stated, *"This took quite some time to handcuff him successfully but eventually he was secured."*<sup>58</sup> In her handwritten notes Constable Smith stated, *"He was still struggling and resisting. Eventually, we were able to cuff him. The male was still very tense and stiff. Senior Constable Cheasley was talking to him. He told him that he was still going to maintain his position on his back until he calmed down. The two members from BPR (Prahan) were just holding his legs and buttocks down, so if he kicked they wouldn't get hurt. Once I cuffed the male I saw there was blood on his face. He was talking but I couldn't make it out. I was kneeling beside the male and told him to relax. We were all out of breath. A short time later there was concern that he wasn't breathing."*<sup>59</sup>
39. Reviewing the evidence, there is little doubt that the deceased required psychiatric assessment and treatment on this day. However, unlike the earlier behaviour of the deceased where he pushed Ms Healy and attempted to punch Mr Gardner, I am satisfied that prior to the attempt by Senior Constable Cheasley to remove the deceased from his seated position, the deceased had not acted aggressively towards Mr Lane or police. Whilst Mr Lane anticipated that the deceased would peacefully accompany police, it soon became evident that was not the case. Once approached by Senior Constable Cheasley, I am satisfied that the deceased commenced flailing his arms and legs in the manner described by Mr Lane and it is likely Senior Constable Cheasley and other police members were struck as they then attempted to remove the deceased from the chair. I am satisfied it is likely Senior Constable Cheasley struck the deceased with his asp baton. Senior Constable Henman also struck the deceased with her asp baton, before Senior Constable Cheasley punched the deceased to the face three times. At this time, I am also

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<sup>56</sup> Statement dated 2/12/98 at pages 185 and 186 Inquest Brief.

<sup>57</sup> Statement 2/12/98 at page 177 Inquest Brief.

<sup>58</sup> Statement dated 2/12/98 at page 186 Inquest Brief.

<sup>59</sup> Handwritten notes of Constable Smith at pages 32, 33 and 34. Exhibit W7.

satisfied Senior Constable Cheasley used the words "*Don't shape up to me mate*"? whilst the deceased remained in a seated position.

40. I am satisfied the deceased resisted the attempt to remove him from the chair and was taken to the floor in the manner described by Mr Lane and placed face down in a prone position where he continued to struggle and resist police attempts to handcuff him. I accept the evidence of Mr Lane, whom I regard as an impressive and entirely credible witness, as to his observations of the actions of police members, in particular, I am satisfied Senior Constable Cheasley placed his knee into the deceased's back exerting downward pressure, with his full weight on the deceased, who was being held down by him "*extremely tightly*".? I accept Mr Lane's evidence, whilst positioned on the deceased's back and in what I regard as a misconceived attempt to persuade the deceased to release his arms, Senior Constable Cheasley wielded an asp baton striking the tip of the baton on the wooden floor next to the deceased's head.<sup>60</sup> I am also satisfied a policewoman used an asp baton in the manner described by Mr Lane in an effort to extract the deceased's right arm from beneath his body. I accept the final observations of the deceased as described by Mr Lane and Mr Gardner whose evidence, in my view, is compelling. I am also satisfied Senior Constable Cheasley ordered Mr Lane to leave the room on the two occasions described by Mr Lane.
41. Senior Sergeant Andrew Miles, in charge of the Operational Safety and Tactics Training Section (OSTT) of the Victoria Police OSTT Unit, reviewed the actions of police during the incident and expressed the view that police planning was sound and the physical tactical options chosen by the members to control the deceased was also sound.<sup>61</sup> However, he conceded that his view was based on reading the various statements and having formed his own opinion as to what had occurred during the course of the incident. I do not accept his assessment.

### **Police Monitoring of and Efforts to Resuscitate the Deceased**

42. At 12.17pm Senior Constable Cheasley requested another unit and ambulance. According to Senior Constable Henman the deceased continued to struggle but then appeared to "*run out of energy or decided to comply and stopped resisting. Shortly after either Pauline or I decided to check his breathing, Pauline checked his pulse and said there was none.*"? Constable Jarvis stated the deceased "*continued to struggle violently even though he was now face down with his hands handcuffed behind his back? Couper appeared to be struggling less and less. Couper was asked if he was alright and there was a grunt in response. A short time later Couper stopped struggling and there was no verbal response when we asked him if he was alright.*"?<sup>62</sup> In her conversation with Detective Ross,

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<sup>60</sup> Senior Constable Cheasley's extended asp baton (no. 11612) was located on the floor in the hallway outside the deceased's room as depicted in photograph A43. Senior Constable Cheasley had Senior Constable Henman's asp baton (no.11717) on his equipment belt. See Statement of Senior Constable Huygen at pages 261-266 Inquest Brief. See also Statement of Detective Curran at page 232 Inquest brief.

<sup>61</sup> Statements dated 4th April 2001 and 24th July 2001. Exhibits T and T1.

<sup>62</sup> Statement of Constable Jarvis at page 169 Inquest Brief.

Constable Smith stated, *"After we had cuffed him I noticed blood on the floor. He was still talking and I could hear him breathing. We then called the ambulance and the 250. About a minute or two later he stopped talking and relaxed, initially I thought he had just calmed down, then we tried his pulse but we couldn't find any."*

43. At 12.23pm Senior Constable Cheasley made a further radio transmission advising that the deceased was not breathing and urgently requested the attendance of an ambulance. The last time Senior Constable Cheasley's voice is heard over the radio is at 12.24.10. Constable Smith contacted Intergraph at 12.25.50 with a further request in relation to the ambulance. According to the police members, the deceased was placed on his side in a coma position. In her statement, Constable Jarvis stated the deceased was placed in the recovery position lying on his side to assist with breathing. It was her recollection that Senior Constable Henman left the room to obtain a mask for resuscitation and at some stage the deceased's shirt was *"ripped open at the front in anticipation that CPR was going to be initiated."* Constable Jarvis removed the handcuffs from the deceased. She makes no reference in her statement to police members administering chest compressions.
44. Senior Constable Henman stated she left the room to obtain a *"resusa shield"* as Senior Constable Cheasley updated the radio request to urgent. Once she had obtained the shield and some cloth, she said she returned to the room to find the deceased in the coma position. She stated she ripped open his shirt and felt his chest but was unable to detect a heartbeat. She said she asked for a pillow and placed it beneath the deceased's head. She stated that she wiped the blood from his face and twice cleared his airway before opening the *"resusa shield"*. Senior Constable Henman did not commence pulmonary resuscitation as she heard the ambulance and decided to wait for them. Senior Constable Henman did not make any reference to chest compressions in her statement, although stated *"resuscitation was started?"* in her conversation with Detective Rodger.<sup>63</sup>
45. In their statements, Senior Constable Cheasley and Constable Smith both stated chest compressions were commenced by Senior Constable Cheasley. According to Constable Smith while Senior Constable Henman was downstairs *"we ripped his shirt open and Cheasley started chest compressions. At some stage we placed a pillow under his head. Henman arrived back with the mask and towel and we cleaned his face up as best we could. A short time later the Sergeant arrived with the ambulance."* According to Senior Constable Cheasley, a policewoman checked the deceased's airways and he commenced chest compressions after the deceased was rolled onto his back. It was his recollection a policewoman left the room to obtain a resuscitation mask and came back with a cloth. He did not see the mask. He said, *"a short time later the ambulance arrived and took over."*
46. It appears soon after 12.26.20, Sergeant Paul Leighton and the first ambulance arrived at the premises.<sup>64</sup> [Sergeant Leighton had been requested to attend at Beach Street, Elwood where the CAT team and police were in attendance dealing with the psychiatrically ill patient who had produced live ammunition and mortars from the second world war.

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<sup>63</sup> See Statement of Detective John Rodger at page 380 Inquest Brief.

<sup>64</sup> See Intergraph Transcript and tape recording. See also ambulance case sheet Exhibit E1. At the time Sergeant Leighton was the patrol supervisor for "B" District based at South Melbourne.

Sergeant Leighton had arrived at that address at approximately 12.15pm. He told the Court he continued to monitor radio transmissions and remained at the address for less than five minutes before responding to the Intergraph request to attend at "*The Avenue*".] Sergeant Leighton gave evidence that he was directed by Senior Constable Henman, who was downstairs on his arrival, to the deceased's room and attended at the doorway where he observed the deceased on his side in a coma position. He told the Court no resuscitation was being performed at that stage. It would appear ambulance officer Christopher Ross and his partner attended at the deceased's room shortly after Sergeant Leighton. Mr Ross observed the deceased lying in a supine position and his face was covered in blood and there was blood on the floor around the deceased. His pupils were fixed and dilated, there was no palpable carotid pulse. The deceased was non responsive and in asystole. His skin was warm, dry and cyanosed. No resuscitative attempts were being performed by police at that time.<sup>65</sup> At 12.34pm, MICA paramedic Don Alexander, arrived to find ambulance officers performing CPR. Treatment was administered and a heart beat returned. At 12.57pm breathing returned at a rate of two breaths per minute. At 1pm the deceased was conveyed to the Alfred Hospital Trauma Centre.

47. Senior Sergeant Andrew Miles expressed the view the deceased was monitored through the use of conversation by police members in the moments leading up to his loss of consciousness.<sup>66</sup> However, at the time Mr Lane and Mr Gardner made their final observations of the deceased, it was readily apparent he was seriously ill. I accept the evidence of each of these witnesses, that at that time Senior Constable Cheasley was still positioned on the deceased's back, tightly holding him down. Given these observations, in my view, it cannot be said that the deceased was adequately monitored by the police members.
48. As to resuscitative attempts, there are inconsistencies in the evidence of the police members and I cannot be satisfied that cardiac compression was commenced by Senior Constable Cheasley. Certainly by the time Sergeant Leighton and ambulance officers arrived no resuscitative measures were being undertaken. Given the amount of blood on the deceased's face, I accept that it was not possible for pulmonary resuscitation to commence until a "*resusa shield*" was obtained. It would appear that the shield packaging was opened by Senior Constable Henman in preparation for use which closely coincided with the arrival of ambulance officers.

### **Did Senior Constable Cheasley Speak with Mr Lane Following the Event?**

49. Mr Lane gave evidence that Senior Constable Cheasley approached him in the driveway of "*The Avenue*" while the ambulance was in attendance. He believed the conversation took place "*sort of behind the ambulance almost*".<sup>67</sup> Under cross-examination from Mr Gipp, who appeared as Counsel on behalf of the Chief Commissioner of Police and

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<sup>65</sup> See Ambulance Case Sheet. Exhibit E1.

<sup>66</sup> Statement of Senior Sergeant Miles dated 4th April 2001 at page 3.

<sup>67</sup> Transcript 2nd April 2001 at page 17.

Sergeant Leighton, Mr Lane told the Court he believed the conversation occurred standing at the rear of the ambulance before the deceased was brought down. He said, "*there is not one iota of possibility that that conversation did not occur.*"<sup>68</sup> According to Mr Lane, Senior Constable Cheasley asked him, "*So what do you reckon it was that you saw up there?*" ? Mr Lane stated he was angry at the time and replied, "*What do you reckon, I saw up there, you belting the shit out of him with your batons.*"<sup>69</sup> Sergeant Leighton gave evidence he separated each of the police members following this incident and he believed Senior Constable Cheasley sat in his vehicle. Under cross-examination from Mr Lawrie, Sergeant Leighton conceded it might have been possible for such an interaction to have occurred.<sup>70</sup> I accept the evidence of Mr Lane and I am satisfied that the conversation occurred in the manner outlined by him.

### **Medical and Post Mortem Evidence**

50. On arrival at the Alfred Hospital the deceased was initially treated by Dr Harry Karipis before being admitted to the Intensive Care Unit at approximately 5.20pm. As part of his examination, Dr Karipis noted the deceased had blood over his face from a resolved epistaxis (bleeding nose) and a large haematoma (blood clot) and a laceration on the back of his scalp. There were grazes and bruises to the left lower chest wall, left upper abdomen, right pelvis, both shins and right forearm. The deceased was later transferred to the ward where he remained until mechanical ventilation was withdrawn on 5th December and he died at 8.50am on 6th December. Dr Karipis expressed the opinion that the deceased had suffered an asystolic cardiac arrest resulting in severe hypoxic brain injury.
51. A post mortem was performed by Dr Malcolm Dodd, a Forensic Pathologist at the Victorian Institute of Forensic Medicine, on 6th December 1998.<sup>71</sup> He found the deceased died as a result of hypoxic/ischaemic encephalopathy as a result of an asystolic cardiac arrest. One of the four possibilities raised by Dr Dodd in his report for the underlying cause of the death was mechanical asphyxia.<sup>72</sup> After reviewing the circumstances surrounding the incident, and following a review of the literature, Dr Dodd told the Court it was his opinion the underlying cause of death was restraint asphyxia in a case of excited delirium.<sup>73</sup>

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<sup>68</sup> Transcript 4th April 2001 at pages 157 and 158.

<sup>69</sup> Statement dated 17th December 1998 at page 10.

<sup>70</sup> Transcript 23rd July 2001 at page 988. See also statement of Inspector Manley at page 239 Inquest Brief. Inspector Manley arrived at the scene at 1.03pm. After speaking to Sergeant Leighton he observed Senior Constable standing in the street on his own.

<sup>71</sup> See Post Mortem Report dated 17th February 1999 and Supplementary Report dated 27th October 1999. Exhibits Q and Q1.

<sup>72</sup> In the course of his evidence Dr Dodd sought to delete "*Nonconvulsive epilepsy*"? from his report as one of the possibilities listed as the underlying cause of the collapse. The deceased did not suffer from epilepsy as suggested by the deceased's medical records. The deceased had been prescribed Tegretol as a mood stabiliser and not for the treatment of epilepsy. The other possibilities raised by Dr Dodd in his report as the underlying cause of the collapse were Lethal Arrhythmia and Cardiac arrest secondary to carotid artery compression.

<sup>73</sup> Transcript 23rd July 2001 at pages 1071-1073. Dr Dodd referred to articles by O'Halloran and Lewman entitled "*Restraint Asphyxiation in Excited Delirium*"? and O'Halloran and Frank "*Asphyxial Death During Prone Restraint*

52. On external examination Dr Dodd found multiple bruises and healing abrasions were present over the deceased's forehead, cheeks and nose. Bruises of varying colouration were noted on the upper and lower limbs.<sup>74</sup> A zone of laceration was noted at the vertex of the scalp in keeping with either a blow or a fall against a firm surface. Fresh haemorrhage was noted within the left temporalis muscle (side of the head). His examination failed to disclose evidence of significant naturally occurring disease other than mild to moderate enlargement of the heart which he described as "*in all other respects healthy?*"<sup>75</sup> He presumed the cause of enlargement was hypertension as the deceased had been prescribed hypertensive medication. He found the coronary arteries were normal. Dr Dodd noted toxicological analysis of ante mortem (taken 2/12/98) and post mortem specimens indicated the presence of Carbamazepine (Tegretol) in levels somewhat less than the therapeutic range. No alcohol was detected.
53. A nasal fracture had been identified at post mortem. Under cross-examination from Mr McKenna, Dr Dodd told the Court it was likely the nasal fracture identified caused the bleeding from the deceased's nose and he would expect to see blood "*a matter of seconds after the impact?*"<sup>76</sup>
54. In the course of his evidence, Dr Dodd described the process involved in a positional asphyxia death and referred to a number of excerpts from the articles including the following passage from "*Restraint Asphyxiation in Excited Delirium?*" by Ronald O'Halloran and Larry Lewman:

? "*The mechanism of death appears to be a sudden, fatal cardiac dysrhythmia or respiratory arrest induced by a combination of at least three possible factors relating to increased oxygen demands and decreased oxygen delivery. First, the psychiatric or drug induced state of agitated delirium coupled with police confrontation undoubtedly places catecholamine stress on the heart. Second, the hyperactivity associated with agitated delirium coupled with struggling with a police and against restraints undoubtedly increases the oxygen delivery demands on the heart and lungs. This is supported by the several cases where rapid pulses were documented. Finally, the hogtied position clearly impairs breathing in situations of high oxygen demand by inhibiting chest wall and diaphragmatic movement.*"<sup>77</sup>

On reviewing the cases illustrated in each article, Dr Dodd told the Court "*the parallels to this event and the ones recorded in the literature are striking and compelling in my opinion.*"<sup>78</sup> Although he could not rule out the possibility of a high catecholamine level of

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*Revisited?*". Both articles were published in The American Journal of Forensic Medicine and Pathology at Vol. 14, No. 4, 1993 and at Vol. 21, No. 1, March 2000 respectively. See Exhibits Q2 and Q3.

<sup>74</sup> In his supplementary report Dr Dodd commented on the photographs of the deceased injuries. See page 3 Report dated 27/10/99. Exhibit Q1.

<sup>75</sup> Transcript 23rd July 2001 at pages 1107 and 1108.

<sup>76</sup> Transcript 23rd July 2001 at page 1095.

<sup>77</sup> O'Halloran and Lewman op. cit. at page 294.

<sup>78</sup> Transcript 23rd July 2001 at page 1073.

itself in rare cases bringing about death, Dr Dodd expressed the view it was more likely that mechanical asphyxia had contributed to the death in this case.<sup>79</sup>

55. Under cross-examination from Ms Hinchey, Dr Dodd told the Court that "*weight on the central part of the lower high back, would be tantamount to hog tying anyway, in terms of what it would do to the thorax and the diaphragm.*"<sup>80</sup> Later in evidence under cross-examination from Mr Lawrie, who appeared as counsel on behalf of the deceased's family, Dr Dodd stated "*the deceased was a tall man but the breadth of his chest was not that great, and I think a certain amount of weight would certainly compromise him more so (than) if he was a thickset person.*"<sup>81</sup> Dr Dodd suggested that it would be dangerous if a person's whole weight was applied to someone in a prone position on an unyielding wooden floor for a period of two to three minutes.<sup>82</sup>
56. On reviewing the evidence of Dr Dodd, I am satisfied on the balance of probabilities that the deceased died from hypoxic/ischaemic encephalopathy as a result of asystolic cardiac arrest caused by restraint asphyxia.

### **The Role of the CAT Team**

57. On 2nd December the Alfred Hospital CAT team had three clinicians (psychiatric nurses Damian O'Neil and Julie Edge and psychologist (Arnum Barbeski), a psychiatric registrar (Dr Matt Gelman) a manager (Fran Draycott) and a triage nurse (John Adams) on duty.<sup>83</sup> Much of the cross-examination during the hearing centred on the nature of the duties being performed by each CAT team at the time of Mr Gardiner's request and whether one or other of the teams should have attended "*The Avenue*" to assist police.
58. In the course of the hearing the Court was told that two CAT teams, CAT 1 or the "*on-call team*", comprised of Damian O'Neill and Dr Gelman and CAT 2, comprised of Julie Edge and Mr Arnum Barbeski, were involved in other CAT duties at the time Mr Gardner requested assistance. CAT 1 was in attendance at an address in Elwood in order to see a client who was ultimately medicated, conveyed and admitted as an involuntary patient to the Alfred Hospital Psychiatry Unit. According to Dr Doherty who reviewed the relevant patient file, this team was responding to an urgent crisis call.<sup>84</sup> Whilst it is not possible to determine the precise time the team arrived at the Elwood address, Intergraph communications reveal calls at 11.33.10am and 11.38am requesting police assistance to gain entry to the premises.<sup>85</sup> Police attended at the address at approximately 11.45am.<sup>86</sup>

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<sup>79</sup> Transcript 23rd July 2001 at pages 1093 and 1094.

<sup>80</sup> Transcript 23rd July 2001 at page 1090.

<sup>81</sup> Transcript 23rd July 2001 at page 1107.

<sup>82</sup> Transcript 23rd July 2001 at pages 1106 and 1107.

<sup>83</sup> Transcript 25th July 2001 at page 1384.

<sup>84</sup> Transcript 25th July 2001 at page 1368.

<sup>85</sup> See Intergraph tape recordings.

<sup>86</sup> See Statement of Senior Constable Treloar at page 254 Inquest Brief and Statement of Senior Constable Wyngarden at page 256 Inquest Brief.

Under cross-examination from Mr McKenna as to the team's involvement at the address between being paged by Fiona Smith at 11.19am and the arrival of police at 11.45am, Dr Doherty told the Court the file revealed the team could hear the client inside the premises but he would not allow them access to the front door. Dr Doherty explained once the crisis team knocked on the door it was not appropriate for them to leave. *"So I think it's entirely reasonable that they stayed and followed through with what they started."*<sup>87</sup>

59. According to Dr Doherty, CAT 2 were undertaking home assessments in Glenhuntly and Malvern on two persons who were in treatment by the crisis team and would otherwise have been in hospital. They were also involved in assessing two people on the in-patient ward.<sup>88</sup> Ms Draycott was not available at the time of Mr Gardner's request as she was attending a meeting in Brunswick. Dr Doherty rejected the suggestion that Mr O'Neil should have considered calling a CAT team from another catchment area *"It is just not within usual practice and not within the scope of activities of crisis teams to do that."*<sup>89</sup> Dr Doherty also expressed the view that it would be *"grossly abnormal practice and wouldn't be the usual practice in any shape or form" for the deceased's treating psychiatrist or general practitioner to perform the work of the crisis team.*<sup>90</sup>
60. Dr Doherty did not accept that it would have been appropriate for Mr O'Neil to contact CAT 2 once he became aware that he and Dr Gelman might be delayed at Elwood. Given Dr Gelman formed part of CAT 1, it was reasonable in my view for Mr O'Neill to have made the decision that his team would deal with the referral in relation to the deceased. Throughout his evidence Dr Doherty repeatedly stated that CAT teams are not emergency services:

*"CAT teams are not services set up to respond to emergencies, unlike other activities undertaken by police, ambulances or fire brigades."* He told the Court *"they were set up to provide an intensive, 24 hour treatment in the community for persons in crisis, who if they didn't have that level of intensive involvement may well be hospitalised and certainly their ongoing treatment in the community would be compromised if they couldn't be seen on a regular and frequent basis the CAT teams can provide."*<sup>91</sup> *"Crisis teams are not emergency teams ready to jump in cars and whip off to a psychiatric crisis in the community at a moments notice. They've a range of other activities to do, and I think there is a confusion still within our range of emergency and other services, health and other issues with regard to the role and functioning of CAT teams."*<sup>92</sup>

Ms Draycott also stated the CAT team was a limited resource and not an emergency service.<sup>93</sup>

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<sup>87</sup> Transcript 25th July 2001 at page 1371 and 1372.

<sup>88</sup> Transcript 25th July 2001 at pages 1258, 1259 and 1384.

<sup>89</sup> Transcript 25th July 2001 at pages 1265 and 1266.

<sup>90</sup> Transcript 25th July 2001 at pages 1399 and 1400.

<sup>91</sup> Transcript 25th July 2001 at pages 1260 and 1261.

<sup>92</sup> Transcript 25th July 2001 at page 1356.

<sup>93</sup> Transcript 16th July at page 525.

61. Reviewing the evidence, I accept that it is likely Mr O'Neil and Dr Gelman were already in attendance at the Elwood address when first contacted in relation to the deceased. They continued their involvement with the patient at Elwood until he was admitted to hospital. [Following that admission, Dr Gelman and Mr O'Neil were available and attended at *"The Avenue"* at 1.10pm.<sup>94</sup>] I am not satisfied that Mr O'Neil and Dr Gelman refused to attend at *"The Avenue"* on the basis that alcohol or violence might be involved. Given at the time Dr Gelman did not recall having any previous involvement with the deceased, I am not satisfied there is any merit in the suggestion he refused to attend as he did not wish to deal with the deceased. Both Sergeant Leighton and Assistant Commissioner Shuey gave evidence in relation to what they believed was a reluctance on the part of the CAT team to attend incidents where drugs, alcohol or violence were involved.<sup>95</sup> However, Dr Doherty, Ms Draycott and Dr Gelman strenuously denied such an assertion.<sup>96</sup>
62. Although there appears to be some doubt as to precisely what information was conveyed to Mr Gardner by Ms Smith, Mr Gardner was under the impression that the CAT team were busy and that the police should convey the deceased to the police station for assessment. The attending police members informed Mr Lane that they did not consider that course appropriate and indicated they would transport the deceased to hospital for assessment. Sergeant Leighton stated *"prior to October 1999 the usual response from the CAT team in regard to their attendance when violence was present was that the person be taken back to the police station and that they would attend the police station."*<sup>97</sup> In response to questions from Ms Hinchey, Dr Doherty told the Court there was never a directive from the CAT team that before they would assess violent persons they should be secured at a police station and left there until the CAT team finally arrived. He said such a directive would not be seen to be sound clinical practice and it was not the usual practice.<sup>98</sup>
63. A Protocol was developed between Victoria Police and the Victorian Department of Health and Community Services Psychiatric Services Division in 1995 to establish clear guidelines for police and mental health services staff on handling situations where either agency has requested assistance from the other.<sup>99</sup> The Protocol aimed to promote an adequate standard of care to the mentally ill person in situations which involve both police and mental health services staff. It outlined agreed procedures for management of psychiatric crisis and high risk situations involving people who have or are believed to have a mental illness.<sup>100</sup> It is clear Victoria Police are the *"lead agency"* where a person

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<sup>94</sup> See notes of Damian O'Neil 2/12/98 at 12.40pm and 13.10pm. Part of Exhibit N1.

<sup>95</sup> See Statement of Sergeant Leighton dated 20th July 2001 at page 2. (Exhibit P3) and Transcript Statement of Assistant Commissioner Shuey dated 20th July 2001 with annexure thereto. (Exhibit R)

<sup>96</sup> Transcript 25th July 2001 at pages 1266-1274, Transcript 17th July 2001 at pages 575-576, 578 and Transcript 18th July 2001 at pages 801-802, 829-830.

<sup>97</sup> Statement of Sergeant Leighton dated 20th July 2001 at page 2. Exhibit P3.

<sup>98</sup> Transcript 25th July 2001 at page 1276.

<sup>99</sup> See Dr Doherty's comments at Transcript 25th July 2001 at pages 1268 and 1269.

<sup>100</sup> See Protocol Between Victoria police and the Victorian Department of Health and Community Services Psychiatric Services Division dated September 1995.

is displaying or threatening violence. However, it is anticipated CAT service staff would be available to provide consultation to police members to assist them in managing situations.

64. Assistant Commissioner Shuey outlined in his statement an amendment to the protocol being sought by police through the Victoria Police /Psychiatric Services Interdepartmental Liaison Committee as a result of the death of Mr Couper. The amendment seeks to ensure the attendance of the CAT service staff at high risk/mental health crisis situations to provide consultation to police members as soon as practicable. A document entitled *"Using the Mental Health Act (1986)"* that follows the 1997 session plan *"Managing Mentally Ill People"* in the OSTT training material, acknowledges *"the experience of mental health service staff, in working with serious mentally ill people may be of assistance to police who are managing high risk situations with people who appear to be seriously mentally ill (ie. a psychiatric crisis)."* The document also acknowledges the caseload of the CAT service staff and states it is not on stand-by for psychiatric emergencies.<sup>101</sup>

## **Police Training**

### **(1) Mental Illness**

65. In his statement to the Court, Assistant Commissioner Shuey outlined the historical basis for the introduction of Operation Beacon in September 1994. He said the mentally ill featured prominently in critical incidents and a substantial focus of Project Beacon was aimed at assisting police in dealing with the mentally ill and those suffering from emotional disturbance and behavioural problems. He stated Project Beacon developed a comprehensive integrated approach for dealing with persons suffering mental disorders.<sup>102</sup> A training video entitled *"Similar Expectations"* was developed in 1995 and offered a range of methods for dealing with persons suffering mental disorders. That video tape was produced during the evidence of Senior Sergeant Miles and exhibited.<sup>103</sup> He said initiatives were undertaken which included mental health experts providing numerous lectures across Victoria to police members on better understanding and methods for dealing with the mentally ill. An examination of the training material provided to the Court by Senior Sergeant Miles reveals session plans dealing with mental illness. Session plan 4(a)/24 of 1996 recommended communications strategies to be adopted when dealing with a mentally ill person, including:

- establish rapport on one to one basis.
- introduce yourself informally eg. *"My names John, what's yours?"*

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<sup>101</sup> Exhibit T6. *"Using the Mental Health Act (1986)"* prepared by Mental Health Training Service for Victoria Police OSTTU April 1997.

<sup>102</sup> Assistant Commissioner Shuey referred to the chart setting out the initiatives for dealing with persons suffering mental disorders. See appendix "A" to statement dated 20th July 2001.

<sup>103</sup> Exhibit T2.

- Safety first-but try to reduce tension by turning police radio down or handing to another member, remove cap, reduce size by sitting down if person is seated (avoid impression of *"standing over?"*) Be aware of your own safety.
- Acknowledge their anger or distress and convey willingness to listen, ask how you can help.
- Be polite and respectful. A disturbed person is frequently very frightened. Abuse, threats and tough tactics will frighten them more and make them more likely to react aggressively and defend themselves.
- Stay calm and low key (but have your partner, if present, ready to come to your assistance).
- Reassure them that no harm will come to them.<sup>104</sup>

66. Session Plan 2 of 23 for the period July to December 1997 entitled *"Managing the Mentally Ill?"* was conducted over one hundred and five minutes. That session was aimed at developing skills in identifying and communicating with people who appear to be mentally ill.<sup>105</sup>

## (2) Positional Asphyxia

67. Senior Sergeant Miles outlined to the Court, Victoria Police training conducted in relation to positional asphyxia from 1996 to date. Up until 2nd December 1998, positional asphyxia was taught as part of Oleoresin Capsicum Spray training. As early as 1996 reference was made to positional asphyxia in this context in Session Plan 15 of 21.<sup>106</sup> Session Plan 20 of 23 for the period July to December 1997 and Session Plan 6 of 29 during 1998, conducted over a forty minute and fifty minute period respectively, included the following reference:

### ? Positional Asphyxia

Due to the possibility of inducing positional asphyxia (ie. Asphyxia caused when the position of the body interferes with normal breathing) members must ensure that a person is not restrained in a manner in which the face is covered and/or is left lying face down with hands cuffed behind the back.

Factors	<ul style="list-style-type: none"> <li>*spray dose</li> <li>*weight</li> <li>*alcohol/drug affected</li> <li>*arm/body position</li> <li>*airflow</li> <li>*need for monitoring</li> </ul>
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<sup>104</sup> See Session Plan no. 4a /24 Part of Exhibit T6.

<sup>105</sup> See Exhibit T6.

<sup>106</sup> See Exhibit T6 July to December 1996 Syllabus.

Emphasise that members must be aware that positional asphyxia is not confined to OC Spray incidents, but can occur at any time when a person is restrained or controlled."<sup>107</sup>

Senior Sergeant Miles told the Court, the reference to members being aware that positional asphyxia is not confined to OC spray incidents was supposed to be emphasised, regardless of the amount of time this aspect took in training.<sup>108</sup> In response to questions from Ms Hinchey and Mr Hillman, Senior Sergeant Miles agreed that even in 1998 police members should have been aware of the risks of positional asphyxia once the person is on the ground, such as to require monitoring.<sup>109</sup> Under cross-examination from Mr McKenna, Senior Sergeant Miles conceded positional asphyxia training may not have assumed any great significance or great emphasis other than in an OC spray context. That was one of the reasons, he said it was removed from that context and made a stand alone topic in 1999.<sup>110</sup> He said, "*as time unfolded more information came to light which prompted more research and better understanding.*"<sup>111</sup>

68. According to the statement of Acting Chief Inspector Robert Sitlington, in the revised Victoria Police (Operating Procedures) Manual promulgated on 1st December 1998, the likelihood of occurrence of positional asphyxia was broadened and removed from the context of OC spray. He said, "*The term "positional restraint asphyxia" was used and it linked positional asphyxia to restraint techniques and the physical condition of the subject. To reinforce the new policy and increase awareness of positional asphyxia to operational police, a training session dealing with positional asphyxia was authorised by Force Command on 12th November 1998 for delivery during the 1999 January to June two day OSTT course.*"<sup>112</sup> From January to June 1999, a separate fifteen minute training program was conducted.<sup>113</sup> The most recent training program for the period January to June 2001, Session Plan No. 11 of 16, taught over a period of thirty minutes, examined how to avoid positional asphyxia and included analysis of the risk factors involved, the various stages of the positional asphyxia process known as "*the Downward Spiral*", the signs and symptoms along with strategies designed to reduce such deaths by identifying those at risks, avoiding prone restraint, identifying the danger signs, ensuring constant monitoring of the person and seeking medical attention.<sup>114</sup>

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<sup>107</sup> Part of OSTT Training material. Exhibit T6.

<sup>108</sup> Transcript 27th August 2001 at pages 1538 and 1539.

<sup>109</sup> Transcript 27th August 2001 at pages 1496-1503 and 1540. See also "*Medical conditions/Respiratory Distress Symptoms*" included as part of Session Plan 6 of 20.

<sup>110</sup> Transcript 27th August 2001 at page 1511.

<sup>111</sup> Transcript 27th August 2001 at page 1487.

<sup>112</sup> Inquest Brief at pages 308 and 309.

<sup>113</sup> See Session Plan 15 of 18, Part of Training Material Exhibit T6 or Exhibit T1. See also paper prepared by Sergeant M.A. Toppin part of Exhibit T6.

<sup>114</sup> See Exhibit T6, Session Plan 11 of 16 with attached material. Also Exhibit T Appendix I.

69. Up until 1999 police members had been provided with only one method of restraining a subject on the ground, known as "*the three point hold*".<sup>115</sup> This is the hold Senior Constable Cheasley stated he applied in restraining the deceased on this occasion. Senior Sergeant Miles told the Court it was considered there was a need for some additional training to be provided to members when dealing with subjects on the ground and in 1999 additional control positions, namely "*the side mount*" and "*leg control*" were introduced into police training.<sup>116</sup> A training video entitled "*Defensive Tactics Team Tactics, Decentralisation and Control*"<sup>117</sup> was developed and that recording was produced during the evidence of Senior Sergeant Miles and exhibited.<sup>117</sup> Under cross-examination from Ms Hinchey, Senior Sergeant Miles told the Court the process of tasking an individual police member to monitor a subject if a risk factor is identified as being one where positional asphyxia death might occur, is a more recent practice and not something that was taught to members in 1998.<sup>118</sup>
70. Senior Sergeant Miles told the Court a session in relation to positional asphyxia, drawing on the most current literature on the subject, has been included in the "*Defensive Tactics Training Manual*" for 2001. He agreed that the principle referred to under the heading "**Prevention**" at paragraph 2.4 of that document "*In line with the 'Safety First' philosophy, physical restraint should be used only when the situation clearly justifies it and when there is no other way to prevent physical harm to the person or to others. Sometimes it may be better to wait things out than to intervene*" was in line with police training as at December 1998.<sup>119</sup>
71. Senior Sergeant Miles and Assistant Commissioner Shuey both told the Court at some stage during such incidents police members need to take control. In response to a question from Mr Hillman regarding consideration of other options prior to reaching the situation where the possibility of restraint is necessary, Senior Sergeant Miles said:
- "It certainly does but there's also a need at some stage for some form of control to take place and if the options are exhausted or have been taken to the point in time where we have, in this particular incident, we have got some control or advantage that we didn't before, well then a decision has got to be made and that is a decision that the operational members have to make."*

## Conclusion

72. There is little doubt that the deceased required psychiatric assessment and treatment on this day. Mr Lane told the Court it was not viable to just leave the deceased without intervention and Mr Gardner, who also agreed it was not viable to leave the deceased to

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<sup>115</sup> See police training video "*Defensive Tactics*" Exhibit T3.

<sup>116</sup> Transcript 27th August 2001 at pages 1436, 1442 and 1443.

<sup>117</sup> Exhibit T5

<sup>118</sup> Transcript 27th August 2001 at page 1503.

<sup>119</sup> Transcript 27th August 2001 at page 1543.

his own devices in his room, told the Court he needed to be taken for treatment.<sup>120</sup> The police members were aware that the deceased suffered from schizophrenia and had been informed that his condition had deteriorated in the preceding days. However, once it became clear the deceased would not leave peacefully as had been anticipated, other options should have been considered. As Mr Lane told the Court he believed "*it went very rapidly from a fairly easy situation to a very difficult situation.*"<sup>121</sup> Given their police training, the experienced police members should have been aware that it was likely the deceased, who was demonstrably disturbed, would be very frightened and if "*tough tactics*" were employed, he would be more likely to react aggressively and defend himself.<sup>122</sup> As Mr Lane told the Court, there was nothing to prevent the deceased being left in his room to enable attempts to be made to contact the CAT team.<sup>123</sup> No attempt was made by police to contact the CAT team to update the earlier information provided to Mr Gardner. Constable Jarvis stated she had heard via the police radio that there was a job involving a psychiatric patient and assumed that the CAT team may have been tied up at that job but no attempt was made to ascertain when they would be available to attend. Ultimately, both Dr Gelman and Mr O'Neil became available and attended at "*The Avenue*" at approximately 1.10pm.

73. Under cross-examination from Mr Lawrie, Sergeant Leighton reviewed the patrol duty returns that revealed police members at "*The Avenue*" did not have any other pressing commitments at the time they were dealing with deceased.<sup>124</sup> As I have already stated, a period of only ten minutes elapsed from the time Senior Constable Cheasley and Constable Smith arrived at "*The Avenue*" to the time a request was made for another unit and ambulance. Other than Mr Lane's attempts to persuade the deceased to accompany police, no real consideration was given by police to any other non-confrontational means of dealing with the deceased. The deceased could have been kept in view to ensure that he was not at risk of harm while further options were considered. Although the deceased had behaved in an aggressive fashion towards Ms Healy and Mr Gardner earlier at approximately 11.15am that day, at the time the attempt was made by the police members to apprehend the deceased he was unarmed and seated in a chair in his room. I am satisfied he presented no immediate threat to police, Mr Lane or any other person.
74. What followed, in my view, was an ill advised and unnecessary attempt by the police members to remove the deceased from that seated position. Whilst seated, the deceased was struck with police batons and punched to the face three times. Once removed from the chair, he was positioned face down on the wooden floor with Senior Constable Cheasley placing his full weight on the deceased's back for some period of time, whilst being assisted by Senior Constable Henman and Constables Jarvis and Smith to restrain and handcuff the deceased. During this time, Senior Constable Cheasley struck the floorboards

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<sup>120</sup> Transcript 2nd April 2001 at page 58 and 4th April 2001 at page 216.

<sup>121</sup> Transcript 3rd April 2001 at pages 82-83.

<sup>122</sup> See 1996 Victoria Police Operational Safety and Tactics Program Session Plan No. 4a/24 under the heading "*Communication Strategies*". Exhibit T6.

<sup>123</sup> Transcript 4th April 2001 at page 165.

<sup>124</sup> Transcript 20th July 2001 at pages 962-970. See Patrol Duty Returns Exhibit P5.

next to the deceased's face with an extended asp police baton using the words, "*Do you want some of this? Give us the arm.*" I regard this as inappropriate conduct which is likely to have exacerbated which was already a frightening experience for the deceased. At the time Mr Lane left the room for an estimated two to three minutes the deceased was apparently unharmed. On his return, the deceased's facial pallor had changed from a "*bright reddish purple*" to a "*whitish grey*". The deceased appeared unconscious, and was lying in a pool of blood with Senior Constable Cheasley still positioned on his back. Given Dr Dodd's evidence, it is likely the deceased suffered a fractured nose during this period resulting in the bleeding from his nose and an asystolic cardiac arrest as a result of restraint asphyxia.

75. Despite submissions to the contrary, in all the circumstances, I am satisfied that the deceased was restrained for longer than what was necessary and more than reasonable force was used. For the reasons I have already outlined, I am satisfied the police members failed to adequately monitor the deceased leading up to the time he lost consciousness and I am not satisfied that cardiac compressions were performed by police members prior to the arrival of ambulance paramedics. Given the deceased's face was covered in blood, it was reasonable in my view to delay pulmonary resuscitation until a "*resusa shield*" was obtained. It would appear that this closely coincided with the arrival of ambulance officers. Following the incident, as I have already found, I am satisfied that Senior Constable Cheasley approached Mr Lane and asked "*So what do you reckon it was that you saw up there??*" In my view, the only inference to be drawn from this conversation is that Senior Constable Cheasley had reason to believe that Mr Lane would provide a different account of the event to that provided by him.
76. I do not accept the submission by Mr Gipp that the failure of the CAT team to attend "*The Avenue*" placed the police in a position where force was inevitable. Force was the means chosen by police on this occasion to deal with the deceased.

### **The Issue of Causation and Contribution**

77. In his final submissions, Mr Lawrie contended this was not a case where the provisions of Section 19 (1) (e) of the Coroners Act 1985 ("*the Act*") applied. Pursuant to Section 19 (1) (e) of the Act, a Coroner must, if possible, find the identity of any person who contributed to the cause of death. Section 19 (1) (e) of the Act was repealed by the Coroners (Amendment) Act No.7 1999. The transitional provisions inserted by Section 76, Part 10 of the amending Act, provide:
- "Section 19, as amended by section 10 of the Coroners (Amendment) Act 1999, applies only to investigations into deaths commenced after the commencement of section 10 of that Act."* That is, from 1st July 1999.
78. As "*the investigation*" in this case commenced from the date the matter was reported to the Coroner on 6th December 1998, it follows in my view that this case is governed by the former provision.

79. I accept, as a result of the judgment in *Keown v Khan and West* (1999) VR 69, an inquiry into contribution to death is solely a factual inquiry and questions of blameworthiness, or culpability do not enter into it. The leading judgment in the case was delivered by His Honour Mr Justice Callaway who said in relation to the meaning of contribution:

*"The test of contribution is solely whether a person's conduct caused the death. It may have been the only cause or one of several causes. There are also cases where no one satisfied the description in s. 19 (1) (e), as in the case of a death solely from natural causes. In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether that act departed from a norm or standard or the omission was a breach of a recognised duty, but that is the only sense in which para (e) mandates an inquiry into culpability."*

80. I accept that this decision has not altered the position with respect to the applicable standard of proof to findings of contribution to a death in this jurisdiction. The *"Briginshaw"* standard of proof still applies to findings of contribution and to any findings of fact that may lead to such a finding. I have given careful consideration to these matters in making the findings in this case.

81. It has been submitted by Mr McKenna and Mr Lopez in their joint submission that no finding of contribution should be made in relation to the four police members, however a finding of contribution should be made in relation to the deceased. I do not accept these submissions. Although the deceased had behaved in an aggressive fashion towards Ms Healy and Mr Gardiner earlier at approximately 11.15am that day, at the time the attempt was made by the police members to apprehend the deceased he was unarmed and seated in a chair in his room. As I have already stated, I accept what I regard as the compelling evidence of Dr Malcolm Dodd that the deceased died from hypoxic/ischaemic encephalopathy as a result of an asystolic cardiac arrest due to restraint asphyxia. I am satisfied that the deceased's death occurred as a result of the attempts by Senior Constable Cheasley, assisted by the three policewomen, to apprehend him in circumstances where such attempts were inadvisable and unnecessary. Accordingly, I am satisfied and find that Senior Constable Scott Cheasley, Senior Constable Kylie Henman, Constable Shayne Jarvis and Constable Pauline Smith contributed to the death of the deceased. In my view, it cannot be said that the deceased contributed to his own death and I find no other person contributed to the death.

### **Comments and Recommendations**

I propose to forward a copy of my Findings and the Comments and Recommendations to the following:

- Minister for Police and Emergency Services
- Chief Commissioner of Police
- Minister for Health
- The Director, Australian Institute of Criminology

## General Comments

In his statement to the Inquest, Assistant Commissioner Shuey said the mentally ill featured prominently in critical incidents and a substantial focus of *"Project Beacon"* was aimed at assisting police in dealing with the mentally ill and those suffering from emotional disturbance and behavioural problems. The police members in this instance were aware that the deceased suffered from schizophrenia. The deceased was not affected by drugs or alcohol at the time. I have already referred to a police training session in relation to the mentally ill which warned that a disturbed person is frequently very frightened. *"Abuse, threats and tough tactics will frighten them more and make them more likely to react aggressively and defend themselves"*.<sup>125</sup> Had the *"Safety First"* philosophy enunciated in the ten Beacon Operational Principles which include *"Avoid Confrontation"*, *"Avoid Force"*, *"Minimum Force"* been adopted by the operational police members on this occasion and greater emphasis placed on waiting rather than intervening, it is likely in my view that the deceased would not have died. Police training emphasises that physical restraint should only be used when the situation clearly justifies it and when there is no other way to prevent physical harm to the person or others. Whilst unarmed and seated in his room the deceased did not present an immediate threat to Mr Lane, police members, himself or to other residents. As I have already stated the deceased could have been contained within his room whilst other options were considered, including efforts to contact the CAT team. I note that paragraph 2.4 of the *"Defensive Tactics Training Manual"* for 2001 makes the following reference to psychiatric illness *"In cases of psychiatric illness, the use of seclusion or containment may be less confrontational and cause less stress to the affected person."*<sup>126</sup>

Whilst I am satisfied that police training through *"Project Beacon"* is aimed at providing police with appropriate skills in dealing with the mentally ill, adopting a *"safety first"* approach to incidents of this nature, this case in my view highlights the need for greater emphasis to be placed on the benefit of waiting rather than intervening unless immediate intervention is required to prevent actual or imminent violence. Standing back, and taking a non-confrontational approach should not be seen by police as displaying weakness or a failure to take control on their part. Greater emphasis in police training needs to be placed on adopting an approach which does not involve restraint. Given the serious risks associated with restraint, it must be seen as an option of last resort.

## Positional Asphyxia

Prior to 1999, the risk of death from positional asphyxia had been addressed by Victoria Police as part of training in relation to Oleoresin Capsicum Spray. However, on 1st

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<sup>125</sup> See Exhibit T6 Session Plan 4 (a) /24 of 1996.

<sup>126</sup> See Exhibit T6 Defensive Tactics Manual 2001 *"Positional Asphyxia"* at page 5.

December 1998 in the revised Victoria Police (Operating Procedures) Manual, the likelihood of occurrence of positional asphyxia was broadened and removed from the context of OC Spray. A separate training session in relation to positional asphyxia was conducted from January to June 1999. A training program for the period January to June 2001 was conducted over a period of thirty minutes and examined the process leading to death by positional asphyxia including the risk factors, the need for monitoring and the importance of avoiding prone restraint. In my view, given the very real risk of death associated with prone restraint greater time and emphasis should be given to this topic.

## **Recommendation 1**

**That Victoria Police ensure that all operational police are trained and retrained to a sufficient degree to ensure a proper understanding of the dangers of positional asphyxia, in particular ensuring that any new or updated techniques are drawn to the attention of police members.**

### **Restraint Technique**

Up until 1999 police members had been provided with only one method of restraining a subject on the ground, the *"three point hold"*. This was the method said to have employed by Senior Constable Cheasley to restrain the deceased on this occasion. Senior Sergeant Miles told the Court it was considered there was a need for some additional training to be provided to members when dealing with subjects on the ground and in 1999 additional control positions, namely *"the side mount"* and *"leg control"* were introduced into police training.<sup>127</sup> I understand the *"three point hold"* is still considered to be an appropriate restraint technique and forms part of current police training. Dr Dodd, Dr Gelman and Dr Doherty each expressed concerns about the risk of asphyxia where the method of restraint involves kneeling on a person's back whilst that person is in a prone position on a hard surface.<sup>128</sup> It would appear the subject is at greater risk where the full weight of the person exercising restraint is applied.<sup>129</sup> Dr Dodd told the Court that *"weight on the central part of the lower high back, would be tantamount to hog tying anyway, in terms of what it would do to the thorax and the diaphragm."*<sup>130</sup>

Although current police training in relation to the *"three point hold"* encourages police to minimise the time a subject spends under restraint and requires constant monitoring of the subject, given the medical evidence of the very real risks associated with the application of downward pressure on a subjects back, in my view, consideration should be given to reviewing the use of this technique.

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<sup>127</sup> Transcript 27th August 2001 at pages 1436, 1442 and 1443.

<sup>128</sup> Transcript 19th July 2001 at page 904 and Transcript 25th July 2001 at page 1424.

<sup>129</sup> Transcript 19th July 2001 at page 904 and Transcript 23rd July 2001 at pages 1106 and 1107.

<sup>130</sup> Transcript 23rd July 2001 at page 1090.

## Recommendation 2

**That Victoria Police in conjunction with the appropriate medical experts undertake a review of the restraint technique known as the "*three point hold*".**

### The Role of The CAT Team

Over the course of the inquest it became apparent that there appears to be an entrenched perception on the part of police that the CAT team will not attend incidents where violence is involved. However, those associated with the Alfred Hospital CAT team strenuously deny that is the case. There is no dispute that where a person is displaying or threatening violence the police are the "*lead agency*" with the responsibility for making decisions regarding public safety. However, the existing Protocol between Victoria Police and the Victorian Department of Health and Community Services Psychiatric Division anticipates that the CAT service would be available to provide consultation to police members to assist them in managing situations involving psychiatric crisis. In the course of his evidence Assistant Commissioner Shuey outlined amendments to the protocol being sought by police through the Victoria Police/Psychiatric Services Interdepartmental Liaison committee as a result of the death of the deceased. The amendment seeks to ensure the attendance of the CAT service staff at high risk/mental health crisis situations to provide consultation to police members as soon as practicable. Mr Gipp, on behalf to the Chief Commissioner of Police, submitted that a recommendation be made amending the Protocol to "*ensure that CAT takes a proactive role in assisting police with persons suffering psychiatric illnesses where violence is present or imminent. Further, any practice of CAT staff not attending to incidents where a person who appears to be suffering a psychiatric illness has displayed violence, be discouraged.*"

Dr Doherty told the Court he believed some confusion still exists in relation to the role and function of the CAT team. He said the CAT team, unlike emergency services such as police, ambulance and fire brigade, was not set up to respond to emergencies. "*They were set up to provide intensive, 24 hour treatment in the community for persons in crisis, who if they didn't have that level of intensive involvement may well be hospitalised and certainly their ongoing treatment in the community would be compromised if they couldn't be seen on a regular and frequent basis the CAT teams can provide.*"<sup>131</sup> In the course of his evidence Dr Doherty said "*the police should go there and use the training that they've had with regard to *Operation Beacon*?, with regard to conflict resolution, with regard to communication and with regard to safe handling of persons who are at risk in such situations and make an assessment of how they should deal with the situation.*"<sup>132</sup>

Whilst police training aims to equip operational police with the necessary skills in dealing with the mentally ill, it is imperative that police are provided with the professional assistance and advice of the CAT team in the management of psychiatric crisis situations.

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<sup>131</sup> Transcript 25th July 2001 at page1261

<sup>132</sup> Transcript 25th July 2001 at page 1300.

It is not suggested that the CAT service should be subjected to violence but their attendance at a scene to assist and advise police would in my view prove a valuable resource. Whilst I am cognisant of the intensive nature of the CAT team work and given the number of mentally ill persons being managed in the community, in an effort to ensure the best possible outcome is achieved for this group, it is desirable that a CAT team is available to respond to emergency crisis situations. In my view, it would be useful at this time to review the role of the CAT team with regard to emergency response.

### **Recommendation 3**

**That the Office of Chief Psychiatrist, in conjunction with Victoria Police, review the emergency response role of the CAT team to ensure police have the necessary support when dealing with the mentally ill.**

**Noreen Toohey**  
**Coroner**  
7th June 2002

Mr R. Gipp appeared on behalf of the Chief Commissioner of Police and Sergeant Leighton,

Mr A. McKenna appeared on behalf of Senior Constable Henman, Constable Jarvis and Constable Smith,

Mr R. Lopez appeared on behalf of Senior Constable Cheasley,

Ms S. Hinchey appeared on behalf of Bayside Health,

Mr P. Lawrie appeared on behalf of the deceased's family, and

Mr C. Hillman S.C. appeared to Assist the Coroner.