



Review of fatal shootings by Victoria Police

Office of Police Integrity Victoria

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REVIEW OF FATAL SHOOTINGS BY VICTORIA POLICE

Report of the Director, Police Integrity

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To

The Honourable the President of Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

There can be no winners when an officer of Victoria Police fatally shoots a member of the public. The consequences are far reaching, not only for the individual who has lost his or her life, but also for the families and friends of both those who die and the police involved. Similarly, the broader community may experience an erosion of trust in Victoria Police, which in turn affects the way Victoria Police is regarded by the community. This is particularly so when people shot are in some way touched by mental disorder.

In April I initiated an investigation to review the six fatal police shootings since 1 January 2003. I determined to evaluate the circumstances surrounding each death and to review the Victoria Police policies, practices and procedures relating to the use of force, operational safety and tactics training, equipment and education and assistance to police in managing the symptoms of mental illness or disorder and the extent to which they may have had an impact on the deaths.

Owing to the seriousness of the issue, this review was begun prior to the coronial inquests into five of the six deaths included in the study. For this reason, I have taken care not to make comment on the appropriateness of the level of force used by officers during the incidents. I may review that later but consider it necessary to present this report now so that Victoria Police can address the issues already identified as a matter of urgency.

I am satisfied that Victoria Police has the capacity to address the issues raised in this report. It did, in fact, successfully address many of them during the mid-1990s under Project Beacon. Project Beacon ushered in the current Victoria Police 'Safety First Philosophy' that *'the success of an operation will be primarily judged on the extent to which the use of force is avoided or minimised'*. The project was brought about by an untenable number of fatal police shootings, particularly in the few years before 1994, much like the genesis of this review.

It is my view that a gradual shift in attention since the implementation of Project Beacon could allow the re-emergence of a culture among police which is overly reliant on firearms. Such a reliance grew within Victoria Police in the mid 1980s when the actions of a number of particularly violent people, coupled with the Russell Street bombings, exposed officers to a level of physical threat not previously experienced by officers of Victoria Police. Victoria Police responded at that time by retraining officers in methods of controlling violent criminals.

That training had a strong focus on firearms and defensive physical tactics. Regrettably, it lacked a complementary component to train officers in how to control violence without physical confrontation. It certainly did not consider the particular difficulties for police in dealing with people presenting with symptoms of mental illness or disorder. Project Beacon went a long way to redressing this imbalance by equipping officers with techniques in non-physical conflict resolution. It was effective in raising such awareness amongst Victoria Police for a number of years.

It is important to acknowledge the broader context of police work. Victoria Police has advised me that in the two years from July 2003 to June 2005, there were some 5.89 million contacts with members of the public. Of these, 1.57 million required the despatch of officers. There were 8437 incidents involving the use of force and 5862 assaults against police. There is no doubt that the situations police face can be very threatening and place those involved or nearby in great danger. Quick judgements must be made in unpredictable, often hostile, situations.

In this context, it is imperative that police carefully plan their actions and assess the risks associated with them so as to not allow a firearms-dependent culture to take hold, the result of which could be a loss of focus on protecting the safety of themselves and the community. When police are under-prepared for danger, there is a risk that they can overreact. In a number of the incidents I have investigated, the Operational Safety Principles were not brought into play as they should have been. Had the 'Safety First Philosophy' and the Operational Safety Principles been considered and applied during these incidents, some of those who have been shot and killed since the beginning of 2004 might well be alive today.

Many of the recommendations arising from this review are designed to assist Victoria Police to refocus on the fundamental concepts of ensuring the safety of the community and themselves. Renewed emphasis on safety is required across the board: from the risk management philosophy of the Victoria Police Corporate Committee and its Standing Committees right through to training of recruits. Shaping this will have cost implications for Victoria Police, particularly in instances where patience and access to specialist resources could bring about better conclusions to confrontational incidents and in seeing that regional Victoria has access to the resources available in metropolitan areas.

The recent increase in the frequency of police shootings has been fostered by a gradual diminution in the training of Victoria Police officers. I have established that some training deficiencies exist across all levels of Victoria Police and have made recommendations for reinvigorating operational safety and tactics training of recruits and of higher-ranking officers, including Sergeants and Senior Sergeants. Particular emphasis and immediate attention is required to equipping officers with the skills and confidence to manage people presenting with

symptoms of mental disorder. Increased awareness of specialist support areas within Victoria Police and how they can help to resolve critical incidents are also required.

Within this report I have addressed the four fatal shootings by operational police and, separately, the two fatal shootings by the Special Operations Group (SOG). Both of the attempted arrests and subsequent shootings by the SOG were planned operations by a specialist unit. I have detailed my observations on the circumstances of these shootings within this report. I have come to the view that to reflect the responsibilities of the SOG, the level of the officer responsible should be upgraded and a Superintendent be placed directly in charge. This should provide the required oversight, given the increase in strength and the greater responsibilities now placed on the SOG.

I strongly encourage the Victoria Police Corporate Committee to evaluate the level of engagement with other government agencies responsible for assisting people in crisis, particularly those suffering from a mental disorder, and to work more closely with these agencies in the future.

My office will actively monitor implementation of measures flowing from the recommendations in this report.

A handwritten signature in black ink, appearing to read 'G E Brouwer', written in a cursive style.

G E Brouwer
DIRECTOR, POLICE INTEGRITY

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1. Introduction

Scope of the review

On 6 April 2005, I determined that, pursuant to section 86NA of the *Police Regulation Act 1958*, I would investigate the following matters:

- a. the circumstances surrounding the fatal shooting of Mr. Mohamed Chaouk by an officer or officers of the Victoria Police on 5 April 2005;
- b. the fatal shooting of persons in Victoria by officers of the Victoria Police which have occurred between 1 January 2003 and 6 April 2005, being a review of the practices, policies, procedures and conduct of officers of Victoria Police; and
- c. the adequacy of policies, procedures or practices of Victoria Police and resources available to it, particularly in the areas of, but not limited to:
 - (i) use of force;
 - (ii) operational safety;
 - (iii) operational safety equipment;
 - (iv) operational safety and tactics training; and
 - (v) education and assistance in dealing with mental health issues,

that may have been factors in the fatal police shootings referred to in (a) and (b) above.

Fatal shootings by Victoria Police: background

The issue of fatal shootings by Victoria Police was the subject of considerable attention during the mid 1990s. This arose from a number of fatal police shootings in quick succession and the significantly higher rate of fatal shootings in Victoria than in other states (see Appendix Two). In mid 1994, Victoria Police launched five independent reviews to identify the reasons for the high number of shootings and to find ways of reducing the number of people shot and killed by police.

In total, 219 findings arose out of the five reviews conducted. The findings largely reflected an apparent imbalance in skills relating to communication, conflict resolution, risk assessment, tactical planning, decision-making and defensive tactics. During the reviews, the then Chief Commissioner decreed that 'the success of an operation [by Victoria Police] will be primarily judged by the extent to which the use of force is avoided or minimised'. This philosophy is now embedded in the Victoria Police Manual.

On 19 September 1994, the Chief Commissioner initiated Project Beacon to implement the 'Safety First Philosophy' as a key element of all planned and unplanned operations and adopted the 'Operational Safety Principles' for Victoria Police. The changes Project Beacon brought to Victoria Police policies, procedures and training are detailed comprehensively in later sections of this report.

There have been 16 fatal shootings by Victoria Police in the ten years since the implementation of Project Beacon (see Appendix Two). There had been 32 shootings in the previous 15 years (see Appendix Four).

Impact of Project Beacon

When considering the impact of Project Beacon, it is important to examine the characteristics of the people who have been fatally shot by Victoria Police since its implementation. This can help to determine whether the Operational Safety Principles that arose from Project Beacon address all areas of concern. This analysis is consistent with the findings of this review and indicates that there remain aspects of policy and practice where Victoria Police performance against the 'Safety First Philosophy' requires improvement.

Of particular concern is that, since Project Beacon, the proportion of victims who have had a history of mental disorder has increased from 31 per cent to 44 per cent. This element was particularly evident in three of the six police shootings examined in depth as part of this review. While it is important that these figures not be considered in isolation - as such an increase could be due to factors such as raised community awareness of mental health issues and higher levels of diagnosis - they do indicate that the proficiency of Victoria Police officers in managing people presenting with symptoms of mental disorder requires further attention. Training, procedures, policies and support mechanisms in tactical situations do not appear to adequately support operational police when they are faced with a person exhibiting violent behaviour as a symptom of mental disorder.

The profile of the situations in which members of the public have been fatally shot by Victoria Police has also changed. As a proportion of the total number of victims before and after Project Beacon, there was a 25 per cent decrease in the number of victims carrying firearms coupled with a 44 per cent increase in those carrying edged weapons (knives, swords etc). This interesting shift in the types of weapons being carried by the victims is likely to be a reflection of reduced access to firearms and an increase in the prevalence of edged weapons within the community.

Since the implementation of Project Beacon in the mid 1990s, none of the victims of fatal shootings by police were unarmed, whereas previously five of the 32

victims had been so. None of the victims carrying firearms have shot at police since the implementation of Project Beacon.

This sort of analysis can provide some insight into the current environment in which police shootings are occurring but it is not possible to draw conclusions about the value or otherwise of aspects of Victoria Police policies, procedures and training and the impact of Project Beacon from it alone. It does, however, provide some useful information about the kinds of situations with which Victoria Police may be faced and how practices, policies and training might need to be reviewed and adjusted to reduce the number of incidents in future. Examples include dealing with people with a mental disorder and the 44 per cent increase in incidents involving edged weapons which suggests that Victoria Police officers may need additional support in learning to plan and respond to members of the public carrying these weapons.

Use of force by Victoria Police: guiding philosophy and principles

Sections 462A and 463B of the *Crimes Act 1958* and Section 10 of the *Mental Health Act 1986* each provide authority for officers of Victoria Police to use force. The relevant provisions are set out in Appendix One.

The Victoria Police ‘Safety First Philosophy’ is embedded in the Victoria Police Manual, Operational Procedures at Section 101-1 and reads:

The success of an operation by Victoria Police will be primarily judged by the extent to which the use of force is avoided or minimised.

To achieve this Victoria Police has adopted ten Operational Safety Principles. They are as follows:

1. **Safety first** – the safety of police, the public and offenders or suspects is paramount.
2. **Risk assessment** – is to be applied to all incidents and operations.
3. **Take charge** – exercise effective command and control.
4. **Planned response** – take every opportunity to convert an unplanned response into a planned operation.
5. **Cordon and containment** – unless impractical, adopt a ‘cordon and containment’ approach.
6. **Avoid confrontation** – a violent confrontation is to be avoided.
7. **Avoid force** – the use of force is to be avoided.

8. **Minimum force** – where use of force cannot be avoided, only use the minimum amount reasonably necessary.
9. **Forced entry searches** – are to be used only as a last resort.
10. **Resources** – it is accepted that the ‘safety first’ principle may require the deployment of more resources, more complex planning and more time to complete.

During this review, a considerable number of Victoria Police officers expressed the opinion that the increase in fatal shootings was the result of subsequent changes to the policies, practices and procedures put in place during Project Beacon. This review has examined the operational safety policies, practices and procedures since that time and has established that this is not the case in the general policing areas. My investigators found only very minimal changes to policies, practices and procedures have occurred since this time. Indeed, a number of recommendations for change by the Coroner have not been acted upon.

The ‘Safety First Philosophy’ and the Operational Safety Principles are sound. Their effective application by police was well demonstrated in an incident which occurred at the foot of the Westgate Bridge on 16 September 2003: a man with a mental disorder had produced a gun in the course of a random traffic check and it was eleven hours before police were able to conclude the incident peacefully. During this time, there was traffic chaos in Melbourne and an unfortunate rush of calls to radio stations by frustrated and angry motorists calling for the police to do whatever was necessary to remove the problem; some callers even called for the police to shoot the man.

However, the extent to which the Philosophy and the Principles were not applied during the incidents examined in the course of this review indicates that they need to be reinvigorated and reinforced to Victoria Police operational officers to ensure they remain uppermost in officers’ minds when confronting a situation which might involve danger.

Recommendations

1. Victoria Police reinforce to officers that:
 - the objectives of Victoria Police are to protect life and property and to help those in need of assistance; and
 - the success of an operation will be primarily judged by the extent to which the use of force is avoided or minimised.
2. Victoria Police continue to adopt the ten Operational Safety Principles currently included in the Victoria Police Manual.

Approach to review

In undertaking this review, my investigators drew on a variety of sources. To examine each of the shootings, they utilised the Coronial Brief of Evidence prepared by Victoria Police, the Coroner's findings where available, Victoria Police Incident Debriefing materials and communication logs. These included the sworn statements of Victoria Police officers and independent witnesses. Investigators visited all of the Australian families of those who had lost their lives and had two telephone conversations with members of the family of Mr. Jason Chapman, who reside in New Zealand.

An invitation to meet with investigators was extended to many officers involved in the shootings through their senior officers. The officers declined these invitations and because the Coroner has not yet had the opportunity to investigate five of the six deaths, officers were not required to provide additional information for this review. Consequently, this review has not explored the state of mind of the officers involved in the incidents or the considerations which guided them. For the same reason, investigators and I have been careful in the conduct of the review not to comment on the appropriateness of the level of force used during the incidents. However, depending on the outcomes of the coronial investigations, I may seek further information about the specific incidents at a later time and make further comment in due course.

The examination of the fatal shootings by the Special Operations Group (SOG) was undertaken in three stages. After the fatal shooting of Mr. Mohamed Chaouk on 5 April 2005, one of my investigators was assigned to work in conjunction with the Victoria Police Homicide Squad while they prepared the Brief of Evidence for the coronial investigation. Information relating to Mr. Chaouk's death was obtained through this attachment. At the conclusion of the attachment, this investigator then liaised with the Police Ethical Standards Department (ESD) which had the responsibility for the preparation of the Coronial Brief of Evidence relating to the death of Mr. Wayne Joannou. The investigator remained in regular contact with ESD as the Coronial Brief of Evidence was being prepared. During the third stage, investigators had discussions with the Inspectors and Commander responsible for the SOG and questioned them extensively regarding the incidents under review, and the policies, procedures and practices of the SOG.

The documented policy, procedures and practices were evaluated in the course of the review. There were discussions between my investigators and a wide range of Victoria Police officers responsible for policy and education. The review also commissioned and oversaw an internal audit by Victoria Police of the Use of Force Register. Investigators observed training sessions for recruits, Operational Safety

and Tactics (OST) training and the Mental Illness Workshop in Victoria Police Region Three.

I invited submissions from organisations that may have had an interest in providing information to this review. This included the Police Association, the Department of Human Services, Mental Health Branch, the Law Institute of Victoria and Liberty Victoria. I received a number of very informative submissions, particularly those from the Springvale Monash Legal Service and the Mental Health Legal Centre which have informed my consideration of the issues arising from the review.

My investigators and I also had the advantage of examining an extensive and frank submission made by Victoria Police in response to this review. I have taken into account many of the issues it raised.

2. Fatal shootings since 1 January 2003 by uniformed operational officers

The ‘Safety First Philosophy’ and the Operational Safety Principles demonstrate a strong commitment on the part of Victoria Police to the use of minimal force in instances where legislation permits its use. It is, however, inevitable that the decision to employ force rests with the officers responding to incidents. As such, officers need to be confident they are making the right decision to employ force before they do so. Recognising that the situations in which police must make these decision can be volatile and very unpredictable, it is plain that the only way to achieve such confidence is for officers involved to have planned and evaluated the options and resources available at the time to the best ability of the most senior officer available at the time, drawing on training, thorough knowledge of the Operational Safety Principles and experience. My review has determined that this did not occur in three of the incidents examined.

This section, which deals with shootings by operational police and not the SOG, describes what occurred in light of the Operational Safety Principles. The fatal shootings by the SOG will be addressed in the next section of this report.

Mr. Peter Hubbard

Mr. Peter Hubbard was shot at 3.16am on Tuesday, 10 February 2004 by a Constable of Victoria Police from Ballarat Police Station, when he and three other Constables attended his residence in Wendouree in response to a call from Mr. Hubbard’s former partner. Mr. Hubbard died in hospital at 3.45am. His death is the only case considered in this review where the Coroner’s inquiry has been completed.

According to the findings of the Coroner, Mr. Hubbard was well known to Victoria Police as a violent person with an antipathy towards police. He was a chronic alcoholic, who suffered from a serious personality disorder.

The Coroner determined that on arrival at the residence, police were met by Mr. Hubbard's former partner and were also confronted by Mr. Hubbard who threw a tomahawk and knife at them. Victoria Police escorted Mr. Hubbard's former partner to safety and ascertained from her that he had been drinking and making threats against police. During this time, Mr. Hubbard retrieved the tomahawk and threw it again at Victoria Police officers. He did not heed directions to step away from the weapon and was doused with Oleoresin Capsicum spray (OC spray) by two Constables to no effect. The Constables retreated after using the OC spray and Mr. Hubbard went back into the house. The Sergeant, who then attended the scene, was briefed by the Constables already in attendance.

The Sergeant attempted to negotiate with Mr. Hubbard through the closed front door. Mr. Hubbard ran on to the front veranda and threw a hammer at the Sergeant, after which the Sergeant deployed Oleoresin Capsicum foam (OC foam – for further explanation of the use of OC spray and OC foam see Section 4 – Equipment and procedures). The foam also did not have any obvious effect on Mr. Hubbard and he again retreated into the house.

Mr. Hubbard stated his intention to kill a police officer and to commit suicide. The Sergeant deployed the remainder of his OC foam at Mr. Hubbard through the wire screen door and then a further canister of OC spray. Mr. Hubbard came out of the house carrying what looked like a silver bar and chased a Constable and the Sergeant. Another Constable drew his firearm and warned Mr. Hubbard to stop. Mr. Hubbard continued to move. The Constable fired two shots, but Mr. Hubbard continued to advance. The Constable fired a third shot and Mr. Hubbard collapsed into the gutter at the front of the house.

Observations

Operational Safety Principle Two requires that the risk involved in a situation be assessed. Principles Three and Four respectively require that effective command and control be exercised and that every opportunity be taken to plan the police response.

My investigators found that while the four attending Constables in two divisional vans had an initial meeting in a nearby street, they did not sufficiently assess the risk or plan their approach in accordance with the Operational Safety Principles. This was despite the fact that the officers either knew Mr. Hubbard personally or by reputation and were aware that he suffered from a serious personality disorder, the symptoms of which had presented violently in the past.

This review determined that although the Ballarat Police Communications Centre provided information, including details of extant intervention orders, the information passed to the two police units did not include the allegation that Mr. Hubbard was armed with an axe. Mr. Hubbard's former partner told the officer at the Ballarat Communications Centre that Mr. Hubbard was so armed yet the officer did not communicate this to the officers who attended. The officer's failure to do so demonstrated a cavalier attitude toward his duties. It appears that the officer took a casual approach to communicating the circumstances due to his familiarity with previous police attendance at the house. Had this information been appropriately communicated, it could have assisted an initial risk assessment and may have led the officers to adopt a less confrontational approach after arriving at the scene. The actions of the officers on the scene were a clear result of the absence of an initial risk assessment and planned response by the supervising Sergeant. In all likelihood, this was also the result of the Sergeant's familiarity with Mr. Hubbard.

My investigators also found that there was no line of containment effected during this incident until after the shooting had taken place and a crime scene perimeter was established. Operational Safety Principle Five requires police to cordon and contain a situation unless it is impractical to do so. It is acknowledged that options involving closing the street were limited due to the small number of officers available. Nevertheless, my investigators concur with the findings made by Coroner Hendtlass:

All operational police on duty in Ballarat that night were involved in the response to Mr. Hubbard's direct or indirect request for police attendance at his house in Elizabeth Street. However, without more evidence, I am unable to say whether this knowledge that there were no more operational police in the area is one of the reasons why (the Sergeant), given his knowledge of Mr. Hubbard's propensity for violence against police, did not seek assistance from, say, the Bacchus Marsh divisional van crew that was in the Ballarat Police Communications Centre monitoring the incident or the Ballarat Crime Response Detective for the Ballarat area who was on call. These crews were able to reach the scene within five and 10 minutes respectively of being deployed. With their assistance, (the Sergeant) could have maintained the cordon that he and his crew had established at the front of the house in Elizabeth Street and/or secured the perimeter of the building for an extended period of time.

Further, I cannot explain why (the Sergeant) did not use one of the opportunities created by Mr. Hubbard's withdrawal into the house to call for reinforcements from outside the Ballarat area, including specialist negotiators and/or the Special Operations Group who could enter the premises. In the information provided to me, the Victoria Police Use of Force Register does not seem to

code for O/C use that causes the offender to withdraw from the confrontation but fails to incapacitate them. Arising from this, there does not seem to be any acknowledgement in the OSST (sic) program or elsewhere that, in situations where O/C spray or foam fails to incapacitate an offender, it may encourage him or her to withdraw into a situation that is able to be secured. This in turn can provide police with an opportunity to force an otherwise fluid engagement into a cordon and contain operation which could be better managed using specialist expertise.

Coroner Hendtlass recommended that:

Victoria Police include a segment in their Sergeants' training program which increases awareness of the option to establish a cordon and contain or perimeter operation to provide time for re-assessment and/or arrival of specialist expertise when the offender's propensity for violence is known and the current risk is high.

The manner in which the officers approached Mr. Hubbard's premises precipitated a confrontation with him from the outset. The officers arrived at the scene, parked immediately outside the premises, and alighted from their vehicle directly in front of Mr. Hubbard. Mr. Hubbard had a known antipathy towards police, and the officers were aware of previous violent behaviour and threats to kill Victoria Police officers. It is evident that there was little regard to Operational Safety Principle Six: avoid violent confrontation. Although important information had not been communicated by the Ballarat Police Communications Centre, the decision to approach Mr. Hubbard was nonetheless ill-conceived, particularly as the immediate threat to his former partner had been resolved.

Mr. Gregory Biggs

Mr. Biggs, who suffered from a mental illness, was fatally shot by a Victoria Police officer at 6.30pm on Saturday, 22 May 2004 in Lygon Street, East Brunswick. Mr. Biggs was found dead under a nearby footbridge at approximately 7.38pm that evening.

The Coronial Brief of Evidence indicates that Mr. Biggs had been seen by a Sergeant and a Leading Senior Constable attacking pedestrian lights with what was thought to be two swords, one in each hand, as they travelled past in a marked Victoria Police vehicle. In their statements, the officers said they commenced a U-turn to attend to the situation but prior to completing the turn, the Sergeant exited the vehicle and called 'Police don't move. Drop the weapons'. At the same time the Sergeant drew his firearm and held it in a ready position pointed to the ground. The Sergeant walked towards Mr. Biggs, who then raised a sword and pointed it at the Sergeant.

The Sergeant stated that Biggs' eyes were wide open and pronounced and he appeared as someone 'possessed'. The Sergeant further stated that Mr. Biggs was

totally focused upon him and was moving towards him. The Sergeant, who was by now standing in the southbound lane of Lygon Street started to move back, realising he was too close and fearing that he was going to be stabbed. As the Sergeant continued to step backwards he became conscious of the northbound traffic behind him, preventing further retreat.

By this time, the Leading Senior Constable had executed a U-turn in the vehicle and was now stationary in the southbound lanes of Lygon Street. The Sergeant moved to place the vehicle between himself and Mr. Biggs. The Sergeant states that he feared for the safety of the Leading Senior Constable who was still seated in the vehicle and, with the view of drawing his attention away from the vehicle, continued to speak to Mr. Biggs. The Sergeant was concerned that the Leading Senior Constable would not be able to see Mr. Biggs or the weapons from where he was seated.

Mr. Biggs is said to have raised one of the swords above his head in a hacking motion and struck the rear window of the vehicle, smashing the glass. The Leading Senior Constable drove the vehicle forward turning into Park Street. This action removed the cover between the Sergeant and Mr. Biggs, who then advanced towards the Sergeant waving and pointing one sword with one hand and thrusting with the other. The Sergeant stated he was prevented from retreating further due to the traffic travelling north to his rear in Lygon Street and at this point discharged his firearm.

Mr. Biggs momentarily stopped before he ran off in an easterly direction towards a park area. The Sergeant attempted to notify the Police Communications Centre and after he was eventually able to do so, he endeavoured to secure the scene and locate any witnesses. He also requested the assistance of a police dog. The Leading Senior Constable stated he was unaware that the Sergeant had discharged his firearm until he heard the broadcast over the police vehicle radio. He stated that he returned to the location of the Sergeant on foot and assisted in identifying witnesses.

A statement contained in the Coronial Brief of Evidence detailed how, on the day prior to the incident in which he was fatally shot, Mr. Biggs left a blue backpack containing an antique sword and a pistol crossbow with a small laser sight outside the Police Transport Branch in Dawson Street, Brunswick. When questioned by Victoria Police about his actions, Mr. Biggs told them he had wished to hand the property in, but as he could not gain access to the building had left the bag outside the front. He later signed a notice of abandonment for the two items and no charges were laid.

Observations

Several Operational Safety Principles were not applied to the police response to this incident.

From the Coronial Brief of Evidence it appears that the actions of the Sergeant in exiting the vehicle were ill-considered and the risks were not appropriately assessed. By separating himself from his colleague and calling on Mr. Biggs to drop the swords, he immediately precipitated a confrontation and placed himself at a considerable tactical disadvantage by confronting him alone. The Sergeant appears to have left himself little or no avenue of retreat. By exiting the vehicle in this manner the Sergeant became engrossed with resolving the incident immediately and was no longer in a position to develop a plan, work in partnership with his colleague or even direct his colleague to seek assistance.

In his statement, the Leading Senior Constable states that he was concentrating entirely on the safety of the Sergeant and driving the vehicle and, therefore, did not request any assistance. My investigators have come to the view that unless there was an urgent need to confront Mr. Biggs, such as the immediate endangerment of a member of the public, the Sergeant would have been better to remain in the vehicle with the Leading Senior Constable. Observance of the Operational Safety Principles and the officers' training in operational safety and tactics should have led them to place themselves in a position where they could observe Mr. Biggs while they called for assistance and formulated a basic plan.

Mr. Jason Chapman

Mr. Chapman was fatally shot by Victoria Police officers close to his residence in Yarraville at 2.26pm on Wednesday, 13 October 2004. He was suffering from a mental illness. The officers who initially responded to the incident were a Senior Constable of five years experience and a Constable of just six months experience. They received a call to attend to a report of a male observed in Yarraville who had entered a block of units armed with a knife. The two officers promptly attended at the location, made some enquiries with a person nearby and, acting on that information, proceeded to the address of Mr. Chapman.

According to their statements, the two policemen were confronted by Mr. Chapman in the driveway of the units. He presented to the police with horizontal wounds across his neck, blood coming down from the neck to his shirt. He also had blood on his hands and a large carving knife in his right hand. He was waving the knife around, at times, in a thrusting motion towards the officers. He walked towards the officers and shouted in a very aggressive manner that he was going to kill them. After walking five or six paces, the officers reported that he started to run straight towards them.

The Senior Constable, with firearm drawn, withdrew behind the police vehicle for protection, but the Constable remained at risk trapped on the side of the police vehicle closest to Mr. Chapman. The Senior Constable reports having waved away two approaching pedestrians who were at risk, drawing his OC spray and attempting to spray Mr. Chapman. According to his statement he was aware that it might be ineffective because of the wind.

Both officers reported having sprayed Mr. Chapman with OC spray. Mr Chapman retreated into his unit and then came out again wearing only a singlet, having removed his shirt. During this time the officers advised Communications of the exact location of the incident and that they were out of OC spray.

The statements indicate Mr. Chapman came out of the unit again and approached the officers without a weapon in his hands. Mr. Chapman was asked where the knife was and he then ran back into the unit and returned with the same or a similar knife to the one he had previously. He ran at a fast pace towards the officers who were standing at the letterbox of the units. The shift supervisor, an Acting Sergeant, who had arrived at the scene by this stage, deployed OC foam. Mr. Chapman immediately turned his back and appeared to shield his face with his free hand. The foam is said to have connected with the back of his head and not touched his face. A second deployment of the foam had the same result.

The Acting Sergeant states he then withdrew to the roadway and Mr. Chapman advanced on the police officers calling 'just shoot me or I'm gunna kill you'. He gestured with the knife across the front of his neck, simulating the cutting of a throat. The officers began to fear for their lives and Mr. Chapman was shot twice by one officer and once by the other. Officers administered first aid until the Metropolitan Ambulance Service arrived. Mr. Chapman died at the scene.

Police Communications recorded that 11 minutes and 12 seconds passed from time police arrived at the scene until the message that 'Man down with bullet strikes,' was relayed.

Observations

Again, analysis of what occurred shows that aspects of the Operational Safety Principles were not brought into play.

In my view, the Senior Constable and Constable who were first despatched to the incident were not appropriately supported by their supervising officers, whose duty it was to attempt to turn an unplanned operation into a planned one.

The supervising Senior Sergeant was monitoring the incident from Melton and the supervising Inspector was monitoring from Altona North. From statements examined in the course of this review, it would appear that neither took an active

role in managing this incident. I also note from his statement that the afternoon supervisor, an Acting Sergeant, was unaware of the incident from its outset because he did not have his radio turned on while he was commencing duty and obtaining his equipment. Once he became aware of the call out, he proceeded to the scene where the only function he performed was to spray Mr. Chapman with OC foam, after receiving direction from the Senior Constable that he should prepare to do so. The Acting Sergeant also advised both attending officers to put on their ballistic vests and be aware of cross fire. The statements show that the supervisors did not adequately plan and co-ordinate backup units to support the efforts of the attending officers. This had a direct impact on the officers' ability to resolve the situation without confrontation.

This incident took place on a busy road yet despite this the supervising officer appears to have not attempted to cordon and contain the area, a key Operational Safety Principle. Statements by police indicate that a large number of officers had gathered on the footpath so placing themselves at risk from Mr. Chapman and the passing traffic. Had the supervising officers taken a more proactive approach to managing this situation, they would have made attempts to cordon and contain the area. The oversight in this instance meant that the police could not withdraw onto the roadway and de-escalate the situation.

Under such circumstances, cordoning and containing an area plays a crucial role in limiting the dangers posed to the individual who is armed, officers who are attempting to resolve the situation and members of the public. Such action also creates the time and space required to attempt to de-escalate the conflict. This becomes even more important when managing a person presenting with the symptoms of mental disorder.

Mr. Lee Kennedy

Mr. Kennedy was fatally shot by a Victoria Police officer at approximately 3.35pm on Tuesday, 19 April 2005, when a male Senior Constable and a female Constable attended his residence in Shepparton. Mr. Kennedy was pronounced dead at Goulburn Valley Health, Shepparton at 4.15pm that day. The officers were responding to a call from Mr. Kennedy during which he had claimed there was a male person refusing to leave his premises. The premises are both the residence of the Kennedy family and a business run by his wife. From the statements contained in the Coronial Brief of Evidence prepared by Victoria Police, Mr. Kennedy was suffering from a mental disorder. He was also experiencing marital difficulties.

The Coronial Brief of Evidence indicates the two officers were met at the door by Mr. Kennedy, who held the door open for them. They stated that they walked past him and into the lounge room of the house, where his young children were. The Senior Constable, who had preceded his colleague into the lounge room, stated

that he heard a noise and turned around to face Mr. Kennedy. He saw that Mr. Kennedy had placed his left arm around his colleague's left shoulder in a kind of bear hug. He stated that Mr. Kennedy was also pressing a black handgun into her chest bone.

The two officers stated that Mr. Kennedy threatened them both and refused to comply with repeated requests to surrender the firearm. Both officers reported that a struggle ensued, during which the children were crying. Mr. Kennedy is then said to have grabbed hold of the younger child and held him and the Constable with one of them in each arm in a type of bear hug. The struggle continued and Mr. Kennedy and the Constable both fell to the floor. The Constable stated that she could feel Mr. Kennedy trying to remove her firearm from its holster and she pushed down on it to prevent him from doing so. She managed to break free and regain her feet. The Senior Constable, who had his firearm drawn, wrestled with Mr. Kennedy who was still armed with a handgun. The Constable stated that her attempts to use her OC spray were not successful. During the struggle, the Senior Constable struck Mr. Kennedy to the head or shoulder with his firearm.

The Constable then discharged her firearm at Mr. Kennedy but the shot missed and lodged in the wall. The Constable stated that Mr. Kennedy started to move towards her with his firearm pointed at her, picking up one of the children as he did so. Mr. Kennedy lost grip of the child and as he continued to move towards her was shot by the Constable. Both officers said in their statements that they were in fear of their lives and the lives of the children. The firearm in the possession of Mr. Kennedy was an unloaded air pistol.

My investigators' examination of the Coronial Brief of Evidence and the Incident Debriefing carried out following Mr. Kennedy's death indicates that, in managing the confrontation, the two officers showed restraint in their use of tactical options until circumstances forced their hand. It appears the officers made every attempt to resolve the situation other than by shooting, but that Mr. Kennedy did not heed their repeated calls to put his firearm down. The officers themselves were not only in fear of their lives, but also feared for the lives of the children and the need to use force was increased by their presence. The two officers displayed significant courage and should be commended despite the tragic outcome of the incident.

Observations

Although the officers demonstrated an initial lapse in turning their back to Mr. Kennedy, thereby giving him the element of surprise, they both drew on their OST training throughout the incident. Lessons will always be able to be learnt from an incident such as this and in this case illustrates the vulnerability of officers when they have their backs turned to members of the public.

After evaluating the statements from the Coronial Brief of Evidence, it became apparent that the receipt of the phone call from Mr. Kennedy at Shepparton Police Station was not dealt with as well as it might have been. Only scant details were taken and recorded and there was also initial confusion with radio communications. More significantly, when urgent assistance was requested by the divisional van crew, the Sergeant and Senior Sergeant on afternoon shift initially failed to react or assume command of the operation.

Observations on the four shootings by operational police

As the above accounts reveal, many of the issues identified in this review have been identified previously but have not been adequately addressed.

Although it occurred outside the time frame in which the shootings examined in this review occurred, the Coroner's findings on the fatal shooting of Mr. Mark Kaufmann on 19 January 2002 have assisted. According to the Coroner's findings, Mr. Kaufmann suffered from a mental illness and was presenting with paranoid delusions when he was fatally shot by a Victoria Police officer. He was carrying two knives and threatening the group of officers who had been despatched to manage the incident. The Senior Constable who shot Mr. Kaufmann was forced to do so after he had been directed by the officer in command to enter the property of Mr. Kaufmann's parents from the back and lock up the house to prevent him from returning to the home. As the Senior Constable came around to the front of the house, Mr. Kaufmann became aware of his presence and, holding the knives, approached him. When he continued to approach and did not drop the weapons, as he was instructed to, Mr. Kaufmann was fatally shot by the Senior Constable.

The State Coroner handed down his findings into this shooting in August 2005. He found that Mr. Kaufmann's death would probably have been avoided were it not for issues associated with the management of the incident by the officer in command. He further found that the officer in command did not appropriately control the situation or plan and communicate his plan for a safe and peaceful resolution. The Coroner's findings regarding Mr. Kaufmann's death are in the most part identical to the conclusions that have been drawn during this review regarding three of the four shootings by operational uniformed officers. If a thorough and constructively critical evaluation of the police actions that culminated in Mr. Kaufmann's death had occurred at the time, some of the deaths included in my terms of reference may have been prevented. Clearly, a delay of two and a half years between the time that an incident occurs and recognition of any possible deficiencies in Victoria Police actions, practices and policies is not acceptable.

All four of the victims of fatal shootings by operational uniformed officers of Victoria Police examined in the course of this review were suffering from mental

disorders. Three were armed with edged weapons. Two were repeatedly doused with OC spray and foam to no effect. In three of the incidents, supervising officers did not appropriately assess the risk involved, develop and communicate plans and take adequate command and control to minimise this risk. In all four of the incidents, issues associated with communications arose.

This review has determined that the Incident Debriefings undertaken after three of the four shootings addressed in this section were very inadequate and tended to focus on peripheral issues at the expense of critical ones. The only effective Incident Debriefing that was undertaken related to the shooting of Mr. Kennedy, an incident during which the officers made every effort to resolve the conflict without the use of force. Were effective Incident Debriefing and ongoing analysis of the fatal use of force undertaken, Victoria Police would be able to identify and address any skill and training deficiencies that may have contributed to the shootings. One such issue is the absence of scenario training to practise Operational Safety Principle Five relating to cordon and containment.

The apparent reluctance to evaluate these incidents and learn from them is of concern and it sets a poor example for less senior officers of Victoria Police. The cases described point to poor command and control, inadequate risk assessment, limited understanding of the symptoms of mental disorder and police being unprepared when OC spray proves ineffective. Such factors should be identified through the searching evaluation of what occurred and lead to improvements in training, policies and procedures so police can be better prepared to deal with comparable situations in future.

The high proportion of people with symptoms of mental disorder being fatally shot by Victoria Police officers in my view reveals a need for further support and training to manage situations involving them. Mental Illness Fellowship Victoria advised my investigators that one in five people in the community will at some time suffer from a mental disorder, a factor which highlights the importance of the issue for policing. This is discussed in some detail later in the report (see Section 6 - Addressing situations involving people with a mental disorder). Further, Victoria Police training, policies and procedures do not appear to be keeping abreast of the increased prevalence of edged weapons in the community. Similarly, the repeated use of OC spray and foam during two incidents to little or no effect while officers remained in dangerous proximity to the subjects raises questions as to the adequacy of current training in the OC spray and foam, including the officers' knowledge of tactical positioning, distance and limitations, particularly where people with a mental disorder are involved. These issues have not yet been addressed, despite being apparent since the shooting of Mr. Hubbard in February 2004.

This review has also revealed an apparent lack of assistance and support by way of ongoing liaison and counselling services to the families of people fatally shot by Victoria Police. My investigators spent some time with several members of Mr. Kennedy's family, including his wife and father. They were farewelled at the door by Mr. Kennedy's four-year old child saying 'My daddy was shot by a policeman'. No ongoing counselling or support had been offered to this family. This matter has since been raised with both the Department of Human Services and senior officers at the Shepparton Police Station for urgent attention.

In summary, in reviewing the circumstances of the fatal shootings by operational uniformed officers, my review team noted a number of similarities and recurring issues, including:

1. A lack of initial risk assessment and planned response by officers, and in particular by supervising officers;
2. Significant shortcomings in the understanding and application of the Operational Safety Principles, in particular Principle Five: cordon and containment;
3. Inappropriate responses to incidents involving edged weapons; in particular the tendency to use OC spray and foam on members of the public carrying edged weapons, requiring officers to be in dangerous proximity to the subject;
4. The continued use of OC spray and foam on people who have not been affected by the substance, often escalating the conflict;
5. Poor understanding of the symptoms of mental illness or disorder and how to respond to people presenting with these symptoms;
6. Difficulties related to communications;
7. An apparent unwillingness to examine critically and in a timely manner the events that led to fatal shootings and to learn from these events; and
8. A lack of attention to the welfare of the families of people who have been fatally shot by Victoria Police.

These issues are addressed and recommendations made later in this report.

3. Fatal shootings since 1 January 2003 by the Special Operations Group

The SOG provides the Victorian community with an armed offender and counter terrorism response capability. It also deals with the safe disposal of explosive devices. It responds to unplanned operational critical incidents, such as situations involving armed offenders including sieges and hostage situations, and it also assists in planned operations involving the arrest of dangerous suspects. The SOG provides specialist assistance in performing tasks that are beyond the scope of general policing. In the period encompassed by this review, the SOG has fatally shot two members of the public during planned operations when attempting to arrest them.

Management of the SOG rests with the Victoria Police Specialist Support Department which is headed by a Commander. An Inspector is in charge of the SOG.

Mr. Wayne Joannou

To review the circumstances surrounding the death of Mr. Wayne Joannou, one of my investigators liaised with ESD, which had the responsibility for the preparation of the Coronial Brief of Evidence relating to the death of Mr. Wayne Joannou. The investigator remained in regular contact with ESD as the Coronial Brief of Evidence was being prepared and examined statements as they became available.

From this, it was established that Mr. Joannou was confronted by the SOG while he was crouching in the rear of a motor vehicle in Bank Street, South Melbourne on Friday 18 February 2005 at approximately 7.15pm. He was shot during the confrontation and died as a result of his injuries.

Criminal history checks undertaken as part of the operation revealed that Mr. Joannou, a drug addict and daily user of heroin, had criminal convictions dating back to 1995. He had served terms of imprisonment for violence offences. During 2004, he was involved in serious offences relating to aggravated burglary, reckless conduct endangering life and firearms offences.

According to statements made by officers of the Homicide Squad, it is alleged that Mr. Joannou shot and killed a person, dismembered the body and then disposed of it on the morning of 2 February 2005. The body has never been found but information provided by the Homicide Squad indicated strong and compelling evidence implicating Mr. Joannou in this murder. It was for this crime that the Homicide Squad was seeking to arrest him.

The statements that form the Coronial Brief of Evidence indicate that a person known to Mr. Joannou informed Victoria Police that he had attended their home

and said he was on the run in relation to a murder. Victoria Police was advised that Mr. Joannou was in possession of a silver coloured shotgun and that he had said something to the effect that if the police were going to catch him, then they would have to shoot him.

Although approval to deploy the SOG had been granted, Mr. Joannou's whereabouts could not be established, so the operation was put on hold until known. On 18 February 2005, information came to hand which suggested that Mr. Joannou was staying with his half brother in Deer Park.

The statements of the SOG operatives indicated that at about 6.30pm on 18 February 2005, Mr. Joannou departed the house in Deer Park and entered the rear of a sedan, which contained a male driver and female passenger in the front seat. When leaving the house, Mr. Joannou was in possession of a silver coloured sawn-off shotgun wrapped in a coat. When he entered the rear of the vehicle he was apparently sitting in a crouched position on the left hand side of the rear seat behind the female passenger, leaning against the door.

During discussions with the officer in charge of the SOG, my review team was advised that the SOG decided to intercept the vehicle if and when suitable and safe circumstances arose. Statements indicate that the motor vehicle containing Mr. Joannou, a female and another male person, who was driving, was placed under surveillance with the SOG following in unmarked police vehicles. Under surveillance, the vehicle was followed from Deer Park and eventually 'angle' parked beside another vehicle in Bank Street, South Melbourne. The driver left the vehicle for a short period of time and went to a nearby house and then returned to the vehicle. At that time, Mr. Joannou was still lying in a crouched position along the back seat. It could not be determined why the driver left the vehicle; it may have been an anti-surveillance measure.

It was at this stage that the SOG Tactical Commander gave the order for his operatives to initiate a vehicle intercept. According to the statements provided for the Coronial Brief of Evidence, the SOG then moved their vehicles into pre-arranged positions. A number of SOG operatives stated that they saw Mr. Joannou in the rear seat of the vehicle and in possession of the sawn-off shot gun. Mr. Joannou was also seen to level the shotgun in their direction. Their statements indicate they believed he was about to fire upon them. As a result, four SOG operatives fired a considerable number of shots at him, causing critical injuries that led to his death. Between 20 and 25 shots were fired during the incident and at least five distraction devices were deployed.

It is evident that Mr. Joannou was aware that Victoria Police officers were endeavouring to locate, arrest and charge him with murder. Police had no doubt that he was a violent man and frequently armed himself with firearms. He had

sought and gained assistance to avoid being arrested, and a number of witnesses mentioned both his paranoia and his carriage of guns. This included the silver coloured sawn off shotgun, which he took into the vehicle on that evening. In all probability Mr. Joannou could have been expected to be armed and there was consequently a need to deploy the SOG in this 'high risk' operation.

Observations

Mr. Joannou was confined within a motor vehicle with another man and a woman who, while potential hostages, were also members of the public whose safety was at issue. A considerable number of bullets entered the interior of the vehicle in close proximity to the head and body of the two people in the front seats and one bullet penetrated through the seat occupied by the woman. As well, other bullets entered, then exited the vehicle in the direction of occupied houses. Projectiles impacted with a tree and the front wall of a nearby house. Several shots ricocheted off the vehicle, potentially placing police and members of the public in danger.

The positioning of one of the SOG vehicles placed the operatives in the vehicle in a vulnerable position, and caused them to experience difficulty opening doors to exit the vehicle.

From within that police vehicle, a SOG operative fired a bullet through the windscreen at the target vehicle. This caused the windscreen of the police vehicle to shatter. The bullet penetrated the rear windscreen of the target vehicle causing it to shatter as well. As a result, the occupants of the target vehicle were obscured from SOG operatives at the rear of the vehicle. The bullet itself fragmented as it went through the windscreen of the police vehicle and the rear window of the target vehicle.

What occurred was a direct confrontation which placed the safety of the SOG operatives and members of the public at risk. The decision to confront Mr. Joannou in a parked vehicle containing two members of the public was, at best, questionable.

Mr. Mohamed Chaouk

This section specifically addresses the term of reference (a) in my determination of 6 April 2005 (see page 1).

At approximately 6.00am, 5 April 2005 the SOG executed a search warrant at 663 Geelong Road Brooklyn with the aim of arresting a suspect. The simultaneous execution of this and a number of other warrants formed the arrest phase of an Organised Crime Squad (OCS) investigation known as 'Operation Vapor'. 'Operation Vapor' was a justified Victoria Police OCS investigation into the criminal activities of various people. Approval was sought for the use of the

SOG to effect the arrests after sufficient evidence was gained to arrest and charge individuals with serious offences.

Mr Chaouk was shot and killed during the operation.

One of my investigators worked with the Homicide Squad investigating the shooting and much of the following information was obtained from this attachment.

Preparations

To conduct a level three forced building entry, there must be either:

1. A probability of confrontation with a person who is armed, or is reasonably suspected to be armed with a firearm or other lethal weapon;
2. Prior history of significant violence (including history of mental disorder manifesting in violent behaviour);
3. Safety of a third party is at risk; and/or
4. A high level of security present or hazardous entry likely (eg man traps) where specialist, skills, equipment or entry techniques are required.

On 1 April 2005 the Commander, Specialist Support, after conducting verification checks and satisfying himself that the application to deploy the SOG met the criteria, approved an application by the OCS to deploy the SOG to arrest the main suspect.

Prior to the execution of the search warrant, the SOG conducted a risk assessment of the various options available to effect the arrest. They relied on information and intelligence provided by the OCS. They knew that the suspect also frequently used a nearby address in Brooklyn as a residence and considered how to ensure the execution of warrants at both premises was simultaneous. This assessment was included in materials considered by the Commander.

The SOG considered a number of options to effect the arrest and determined the safest option was simultaneous level three entries on 663 Geelong Road Brooklyn and at the associated nearby address. The Incident Debriefing prepared by the Police Corporate Management Review Division states that the Commander, Specialist Support did not sight nor approve the tactical plan prepared by the SOG and does not routinely do so.

In accordance with standard SOG tactics, primary and secondary entry points were identified for entry into the house. A cursory rehearsal of the plan was undertaken, during which issues such as how to achieve speedy access for the team of operatives designated to secure the first floor appear to have been

overlooked. My investigators consider that the rehearsal did not take full advantage of the resources and facilities available to the SOG for this purpose.

The operation

From statements provided by SOG operatives and the Homicide Squad, my review team understands that shortly after 6am on 5 April 2005, the SOG Tactical Commander gave permission to conduct the planned level three entry at 663 Geelong Road, Brooklyn - a two-storey brick veneer dwelling. Apart from light filtering in from outside sources, the house was in darkness. In police terminology the action could be described as a 'dawn raid'.

The plan was for both identified entry points to be breached simultaneously. The small courtyard at the front of the house was obstructed by a large number of SOG operatives and the obstruction resulted in the primary entry point being breached prior to the first floor team reaching their entry point. One of the SOG operatives claims to have made a tactical decision to break the window closest to him because of this but entry through that window proved to be obstructed by a cabinet and television. Both teams then entered via the front door, the ground floor team preceded the first floor team. As a result, valuable seconds were lost by the first floor team, who needed to move through a lounge room to a narrow staircase and ascend it.

Many SOG operatives reported that they made numerous and continuous calls of 'Police don't move' once the entry had been effected.

Two SOG operatives commenced up the staircase to clear the first floor. These two SOG operatives allege that Mr. Chaouk confronted them and was yelling at them. He is said to have withdrawn a large sword from a scabbard and raised it above his head with both hands on the hilt. Both operatives stated that he swung the sword downwards with full force, making contact with the left forearm of the first SOG operative causing him to fall against the stairwell wall. Mr. Chaouk is then said to have raised the sword again in a two-handed grip.

A SOG operative, fearing for his life, discharged his firearm at Mr Chaouk. At the same time, a second SOG operative discharged his firearm, also fearing for his life and that of his colleague. The sword has since been found to be a ceremonial sword that was blunt, although plainly still capable of inflicting serious harm when used with force.

Observations

It is my view that the Commander authorising deployment of the SOG in planned operations should sight and approve the risk assessments and tactical plans for the operation before it proceeds. My review has revealed that the actual planning

and implementation of the forced entry at 663 Geelong Road was less than satisfactory and that the SOG Tactical Operations Order was not as detailed as it might have been. It appears the SOG team allocated to enter and clear the first floor area of 663 Geelong Road may have taken too long to reach their objective. I believe the delay in breaching the secondary entry point may have occurred because of the number of SOG personnel in the courtyard.

The Forward Commander of this incident (and the Forward Commander of the fatal shooting of Mr. Joannou) does not appear to have acted in accordance with the responsibilities specified in the Victoria Police Manual (VPM) 104-1 which deals with Incident Management. This charges the Forward Commander with giving appropriate direction on the conduct on the operation. In both cases examined in my review, it appears that the SOG commenced the operations prior to receiving instruction to do so from the Forward Commanders. It is possible that this was due to the fact that the Forward Commanders were operating at the same rank as the SOG Tactical Commander.

The Incident Debriefing conducted by the Victoria Police Corporate Management Review Division which followed the shooting of Mr. Chaouk was most comprehensive. An incident debriefing took place on 13 May, more than a month after the incident, but the report was not finalised until September 2005, five months after it occurred. It is my view that such a delay in debriefing diminishes the value of the process.

Observations on the two shootings in SOG operations

Mindful of the difficulties and danger inherent in the kinds of operations for which the SOG is called to assist, it remains that SOG operatives must act in ways consistent with Victoria Police's stated mission 'to provide a safe, secure and orderly society by serving the community and the law' and its objectives 'to preserve the peace; to protect life and property, to prevent offences; to detect and apprehend offenders; and to help those in need of assistance'.

The actions of the SOG, particularly during the attempted arrest of Mr. Joannou, demonstrated a greater regard for some objectives than for others. Certainly, the planning and conduct of both of these SOG operations did not adequately consider the safety and security of the families and associates of Mr. Joannou and Mr. Chaouk.

Leadership and management of the SOG

In exploring the circumstances surrounding the deaths of Mr. Joannou and Mr. Chaouk, my investigators had extensive discussions with senior Victoria Police officers who have or had responsibility for the SOG, as well as current and former SOG operatives.

During the course of this review, Victoria Police advised that issues involving training, deployment, management and supervision of the SOG had recently been reviewed internally. This process had determined that, in general terms, the SOG was functioning well, with a high level of commitment by all operatives. However, some concerns had been raised by current operatives of the SOG regarding recent changes to management. In addition, a number of former operatives were critical of the current SOG management and leadership.

This criticism has been examined as part of this review along with the leadership and management of the two operations that resulted in the deaths of Mr. Chaouk and Mr. Joannou.

This review found that neither of the Inspectors at the SOG were OST (Operational Safety and Tactics) qualified, and that three SOG operatives involved in level three entries on 5 April 2005 and who were armed with full OST equipment were likewise not qualified. It is clearly unacceptable that the leaders and operatives of the SOG, while they are experienced officers with a high level of skill in handling dangerous situations, do not hold the standard current police qualifications in operational safety techniques. It is OST training which covers tactical options for the resolution of incidents. It is in my view incumbent on the leadership and management of the SOG to ensure all its operatives have current OST qualifications.

While the steps taken internally by Victoria Police to acknowledge and redress issues involving the SOG are encouraging, I am unable to support the recommendation of that internal review that there should be no changes to the current command arrangements. I am of the view that changes to the structural arrangements of the SOG should be made - including command and control and protocols for deployment. I have concluded that to reflect the responsibilities of the SOG, a Superintendent must be placed directly in charge. This move would enable a higher level review of risk assessments and tactical plans than is possible under the present arrangement where the SOG Inspector reports direct to the Commander in charge of Specialist Support, a position with management responsibility for a broad range of functions.

My investigators have also identified a need to amend VPM Instruction 106-2 – SOG Attendance to include a requirement that the deployment of the SOG is to be immediately communicated to the Regional Assistant Commissioner. In the case of an incident tasked by the Crime Department, the Assistant Commissioner Crime should also be informed.

Recommendations

3. A Superintendent be placed directly in charge of the SOG to reflect the current responsibilities of the unit.
4. Victoria Police amend VPM Instruction 106-2 – SOG Attendance to include the requirement that the deployment of the SOG is immediately communicated to the Regional Assistant Commissioner. In the case of an incident tasked by the Crime Department, the Assistant Commissioner Crime should also be informed.
5. Victoria Police brings to the attention of all officers, including the SOG, the responsibilities of the Forward Commander.
6. VPM Instruction 104-1 be amended to provide that, in circumstances where it is practical, the Forward Commander should always be an officer senior in rank to the SOG Tactical Commander. The instruction should also specify that the Forward Commander always retains control of the incident.

4. Equipment and procedures

My review identified a number of issues concerning the equipment available to police and the operational procedures adopted in situations which may involve violence.

The VPM specifies what operational equipment police need to carry (see Appendix Three). All police on uniform duties must carry a firearm, OC spray, an extendable baton, handcuffs and an equipment belt. OC foam, which has a stronger concentration of the active ingredient than the spray, is carried in the boot of vehicles and deployed only by Sergeants who have been certified in its use.

Firearms

There is a misconception among some police that it is a requirement for all officers to carry a firearm when they are on duty. It is not. Current policy (see Appendix Three) is that police officers ‘whose duties may bring them into contact with an armed person may carry firearms’. The policy specifically states that firearms must not be carried for crowd control/sporting event situations.

No change to the existing policy is proposed.

OC spray and foam

OC spray and foam provide officers who are carrying firearms with a less-than-lethal option for managing violent confrontations. There is no doubt that its

introduction has changed for the better the way police deal with conflict and potential violence but there are aspects of its use which could usefully be reviewed.

Current policy states that OC spray and foam may only be used in situations where there is a violent and serious physical confrontation; where a person is engaging in conduct likely to seriously injure themselves or result in suicide; where a person is actively resisting arrest; or where there is a need to deter attacking animals.

Both the spray and foam provide certain tactical advantages and disadvantages according to the specific conditions applying at the scene.

OC spray is ideal for rapid deployment and acts as a barrier between the police officer and the person involved thus blocking the person's advance. But it can be dispersed by wind and so must be used carefully to ensure that the spray affects the target while others in the vicinity, including the police officer involved, are not. It can be drawn into air conditioning ducts and circulated throughout buildings. Its range is limited to three metres. On the other hand, OC foam, due to the size of the canister, has a range of between five and seven metres under ideal conditions and is not dispersed widely as spray can be.

OST qualified officers should know and understand the implications of environmental conditions for the effectiveness of OC spray and foam. They also need to know that a small proportion of people are not affected by the substance. Anecdotal evidence is that people who are frequently mentally ill or have a mental disorder are among those who can appear unaffected.

There is a need to boost Victoria Police officers' knowledge of tactical positioning, distance limitations of the spray and foam and of the criteria for evaluating whether deployment is appropriate. Training should be designed to enable police to recognise readily when the use, and in particular continued use, of OC spray and foam are likely to be ineffective and could escalate the conflict. The practice of deploying OC foam where OC spray has proven ineffective needs close examination.

My investigators identified a further issue concerning the deployment of OC foam which also warrants attention. Under the current policy, only officers in the ranks of Sergeant or above are trained and permitted to carry and deploy OC foam. In effect, this places senior officers attending critical incidents directly at the front line and requires them to engage with the people involved. Their ability to assume overall control or identify and consider appropriate options for resolution of the situation is therefore affected.

Radios

Analysis of two of the incidents not involving the SOG which were studied in my review showed that the use of radios was ineffective. While officers are encouraged to carry portable radios, they are not mandatory equipment or included in the Carriage of Operational Equipment policy (see Appendix Three). Prior to commencement of this review, radios were rarely used during scenario training. Mobile telephones do not generally have the advantage of portable radios in being able to communicate to a number of people simultaneously and keep large groups of officers abreast of developments. The poor use of radios was highlighted during the incident in which Mr. Kaufmann died and is evidence of the importance of this issue.

The carriage of portable radios by operational police is further supported by the impending introduction of digital portable radios for police in the metropolitan area in time for the Commonwealth Games in March 2006. I am advised these radios have an emergency button, which gives priority on the network to an officer in an emergency situation. I commend this initiative and recommend their introduction statewide as a matter of priority. I am of the view that portable radios are a fundamental tool for police operations and that they should be considered mandatory. All scenario training should be undertaken with access to portable radios to ensure that officers learn to use them instinctively.

Taser X26

Use of the Taser X26 (known as Taser) has been the subject of much debate. Taser X26 devices transmit controlled electrical pulses which impair the conscious control of the skeletal muscles without affecting the heart or other vital organs. The Taser X26 is considered a less-than-lethal option, although its use is not without risk.

On 16 November 2004, an exemption was granted under the *Control of Weapons Act 1990* to allow officers of the Victoria Police SOG and the Critical Incident Response Teams (CIRTs) to possess, carry and use the Taser X26 during a trial period. Since then, the Taser X26 has been used on 18 occasions in operational situations where the use was planned. Deployment in each case was effective. Victoria Police determined that the SOG and CIRTs would be permanently issued with Tasers and this has been implemented.

In New South Wales, Queensland, South Australia, Tasmania and West Australia, the Taser X26 is issued to the equivalents of the SOG. The Australian Federal Police (AFP) is also currently trialling its use by the Special Response Security Team in the Australian Capital Territory. It has been used by the Queensland equivalent of the SOG five times in planned operations with 100 per cent success.

The New South Wales State Protection Group and the State Protection Support Unit have used the Taser X26 on 12 occasions; on one occasion the probes from the Taser X26 failed to penetrate and lodge in the target. The Northern Territory and the New Zealand Police do not use the Taser X26.

I am advised that no police service in Australia has any immediate plan to equip officers undertaking general operational duties with the Taser X26. There are several reasons. Training of sufficient staff in its use has not been practical;

there are number of options already available to officers and introduction of a new tool might risk further complicating the decision-making process; carrying such equipment on equipment belts is impractical; and as well there are concerns that the Taser X26 might malfunction and cause an officer serious injury.

The use of Taser X26 in Victoria has been supported by coronial recommendations as recently as August 2005, when the State Coroner in handing down his finding into the police shooting death of Mr. Kaufmann recommended that '*Victoria Police consider making the Taser X26 generally available to senior officers (Sergeants and above) for use as an alternative option to lethal force ...*'. In my view, Sergeants should play a key role in managing critical incidents and it would be inappropriate for them to deploy the Taser X26 (as I consider it is for OC foam). I support the continued use of the Taser X26 by Victoria Police SOG and CIRTs, with the Taser X26 being securely located in a more accessible area of the CIRT vehicles to facilitate its use.

I also recommend that a working party be formed to review the use of Taser X26 by the SOG and CIRTs since the beginning of the trial and to consider the State Coroner's recommendations. I further recommend that the working group report to the Chief Commissioner about the use of Tasers and procedures for carriage and deployment within twelve months. Its membership should include the Superintendent, OST, an officer of the Ballistics Unit, Forensic Services Centre; and a Senior Sergeant or Sergeant from both the SOG and CIRTs.

Critical Incident Response Teams (CIRTs)

In 2003, Victoria Police identified skills gap between the capabilities of officers performing general duties and those of the SOG in resolving critical incidents. This skills gap was particularly evident in 2003 when, according to information provided by the CIRT, 57 per cent of the metropolitan officers who attended critical incidents did so in their first year of policing.

To redress this Victoria Police created two 24 hour CIRTs to provide metropolitan police with specialist support in circumstances where it is not appropriate to task the SOG. This did not include critical incidents where members of the public were armed with firearms, which remains the responsibility of the SOG. Each

CIRT consists of a Sergeant and three other officers, one of whom is a trained negotiator. Each CIRT has available for use a number of less-than-lethal weapons, including the Taser X26. CIRTs provide:

1. A first response capability to threats to state security, terrorism, suspect packages, threats to public buildings or dignitaries, armed offenders or prisoners;
2. An immediate response to any critical incident with a primary focus on safety and negotiation supported by a greater range of less-than-lethal options that are not currently available to general duties police;
3. A consistent approach to responding to reports of armed offenders and improved efficiency by timely determination of the veracity of the report and implementation of a cordon and containment policy to minimise impact on service delivery by local patrol units;
4. Timely and consistent advice to Forward Commanders at critical incidents to maximise safety to officers, the community and the subjects;
5. Provide security to the Dog Squad officers while tracking potentially armed or violent offenders; and
6. Limited, trained and properly equipped officers to assist with a riot, affray or violent confrontation, including troublesome prisoners and suicide intervention.

The CIRTs commenced operations in March 2004 and as at 31 August 2005 had responded to 286 critical incidents, of which 86 involved people who were suffering from a mental illness or disorder. It is significant that of these, 42 were successfully concluded using negotiation. I consider it essential that the CIRTs maintain their level of negotiation skills, as well as the ability to recognise and manage critical incidents involving people presenting with symptoms of mental disorder. To this end, further training in understanding mental illness and disorder should be considered.

One of the objectives of the CIRTs is to provide timely and consistent advice to police Forward Commanders at critical incidents to maximise safety to officers and the community. Although the CIRTs primarily service the Melbourne metropolitan area, they are available to provide advice and can be deployed to country areas in cases of urgent unplanned critical incidents if required (see Section 8 - Specialist support for regional areas). My investigators came to the view that many police in both metropolitan and country areas are not as aware as they might be about the capabilities of the CIRTs to provide advice and assistance during critical incidents where it is possible and practical for them to do so. Increased awareness among police of this valuable and effective service is required.

Dog Squad

The Dog Squad currently has 21 general purpose teams and six specially-trained siege teams. They provide support for police operations by tracking, searching, apprehending offenders, assisting at sieges and detecting narcotics and explosives. The six siege teams are preferred for critical incidents because of their superior capabilities in these environments.

A team consists of one dog and one handler. Each dog is graded as level one, two or three. Where a Canine Team is required for attendance at a critical incident, a level three dog must be deployed. Each team is based at the residence of the handler and, as a result, all of the general purpose teams are located throughout the Melbourne metropolitan area – the majority within a 40 kilometre radius of the Melbourne General Post Office. The six siege teams are also located at the handlers' residences, which does not necessarily provide for consistent coverage of all metropolitan areas. Canine teams primarily service the metropolitan area but are available for deployment to country areas for planned operations and urgent unplanned critical incidents. However, deployment to the country does cause logistical difficulties (see Specialist Support for Regional Areas).

An application to deploy a Canine Team must satisfy the legal requirement that the use of force is necessary and is not disproportionate to the harm sought to be prevented. Deployment must be in accordance with the Operational Safety Principles, unless extreme danger exists. The authorising officer must also consider whether the deployment might cause a third party to be at risk and whether the confrontation might be more safely resolved through direct confrontation with officers. When injury or damage is caused by a Canine Team, the handlers are required to submit a report on the use of force to the Use of Force Register.

Recommendations

Equipment

7. A portable radio be carried at all times by all operational officers.
8. The use of the Taser X26 by Victoria Police SOG and CIRTs continue.
9. The Taser be carried securely in the front of CIRT vehicles to enable immediate access.
10. A working party be formed as proposed in this report to review the use and deployment of the Taser X26, to consider the Coroner's recommendations and to report to the Chief Commissioner within twelve months.
11. The current policy of Sergeants and above being the only officers permitted to deploy OC foam be discontinued.

12. OC foam be distributed across the state for carriage in police vehicles.

Critical Incident Response Teams

13. Victoria Police promotes to operational units the capability and capacity of the Critical Incident Response Teams to attend and assist in resolving critical incidents and to provide timely advice to Forward Commanders across the State during critical incidents.

14. That CIRT staff be provided with additional training in understanding people with a mental disorder to enhance their capabilities to resolve critical incidents involving people with such a condition and to provide timely and consistent advice to Forward Commanders across the State. The Memphis Model, described briefly on page 38, may provide a useful model for the provision of such training.

5. Incident debriefing and review: policy and practice

Post-incident drug and alcohol testing

It is my understanding that, in some other Australian jurisdictions, arrangements are in place which require police officers to undergo alcohol and drug testing after certain classes of critical incidents. In Victoria, officers driving a police vehicle which is involved in a collision are routinely breath-tested. Officers of some police forces are subject to random drug testing; in New South Wales, this was introduced as a result of a recommendation by the Wood Royal Commission into the New South Wales Police Service. It was also reported that a test for the presence of illegal drugs undertaken in respect of a New South Wales police officer who was involved in shooting a member of the public returned a positive result.

In my view, best practice would be to require police who have fired shots leading a member of the public to be fatally wounded to be routinely tested for the presence of illegal drugs and alcohol as soon as practicable, but within hours, after the incident occurred. Police have the authority to employ force and such an integrity measure would reassure the community that the decision to do so was not made while the officer was affected by illegal drugs or alcohol.

The introduction of testing after critical incidents would also protect the police involved in the event that they were alleged to have acted while affected by alcohol or illegal drugs. I note that Victoria Police has already initiated discussions with the Police Association about establishing such testing protocols and I urge the early implementation of the policy.

Debriefing

Incident Debriefings are undertaken in compliance with VPM Instructions 104-4. This review has examined several Incident Debriefings concerning fatal police shootings.

It is clear that Incident Debriefings can play a useful role in ensuring officers understand what happened during an operation or incident. However, my review has detected some reluctance on the part of senior officers to undertake a critical and objective review of fatal police shootings. The Incident Debriefings for three of the four shootings by operational uniformed officers covered by this review were inadequate. I consider this to be a serious shortcoming in existing procedure.

Unlike the thorough Incident Debriefing relating to the death of Mr. Kennedy, the Incident Debriefings relating to the deaths of Mr. Chapman, Mr. Biggs and Mr. Hubbard focussed on the actions of Victoria Police officers following the shootings and failed to raise and address the actions that preceded them. These Incident Debriefings did not address how officers' actions, or the absence of action, may have affected the outcomes of the incidents. Incidents involving shootings by police are of great concern and require the critical examination of what unfolded.

Critical Incident Review Panels

Critical Incident Reviews – a process involving the more independent and comprehensive review of incidents associated with use of force - originally came about during Project Beacon. Regrettably, they are no longer undertaken by Victoria Police in that form.

The State Coroner has long and strongly advocated for the reinstatement of Critical Incident Reviews by Victoria Police. The Coroner has been supportive of such Reviews carried out by Corrections Victoria and my investigators had extensive discussions with the Corrections Commissioner and the Director, Corrections Inspectorate about the process as it is applied in their organisation.

In April this year, Victoria Police established a Critical Incident Management Review Committee (CIMRC) chaired by a Deputy Commissioner. CIMRC has subsumed two previous committees; one dealt with pursuits and the other with police shootings. The CIMRC reviews all critical incidents where police are present at situations involving deaths, serious injury or other life-threatening circumstances, including fatal shootings. It tasks senior officers (Commanders and above) to investigate incidents and oversees these investigations and debriefings. It monitors trends in the use of force and forced entry; recommends policy or procedural change which arise from the analysis of the incident; and

oversees the Victoria Police response to or submissions to the Coroner and other external review bodies. Officers conducting investigations for CIMRC are supported by the Police Corporate Management Review Division and the OST Training Unit.

A far more considered and robust process for evaluating the circumstances surrounding fatal police shootings is required within Victoria Police. I note the recent Victoria Police initiative in establishing the CIMRC but am concerned that the model adopted may not facilitate the searching examination of what occurred at particular incidents nor the consideration of necessary procedural or training changes, both essential to give effect to the 'Safety First Philosophy' and the Operational Safety Principles and to ensure their continuing priority and relevance.

In my view, better investigations will result from having a Critical Incident Review Panel. I urge Victoria Police to adopt the practice of establishing such a Panel in each case chaired by the Assistant Commissioner, ESD and including the Commander, Corporate Management Review Division. The panel should draw on the knowledge, experience and insights of a range of officers, including the Superintendent, Academy OST; the Homicide Squad officer responsible for preparation of the Coronial Brief of Evidence; the officer responsible for the preparation of the Incident Debriefing; and any other officers who may be in possession of relevant information.

The role and responsibility of Critical Incident Review Panels enquiring into a fatal shooting should be to:

1. Establish the circumstances surrounding the death;
2. Assess whether the resources allocated to investigating the fatal shooting are sufficient to ensure a timely submission of the Coronial Brief of Evidence and make recommendations to redress situations where this is not the case;
3. Assess the strategy and tactics employed during the incident against the 'Safety First Philosophy' and the Operational Safety Principles;
4. Identify and make recommendations about lessons to be learned from the incident so as to improve police practices;
5. Identify, review and make recommendations for improvements to systems, policies, processes, practices and training;
6. Report on the trends of the use of force and forced entry to premises where appropriate; and
7. Ensure that all parties who may require support and counselling as a result of the incident have access to appropriate services.

Reports of critical incident investigations should make no conclusive finding as to the cause of the death or factors contributing to it, so as not to prejudice coronial investigation. The report of the panel should be submitted to the Chief Commissioner and to me as Director, Police Integrity within three months of the incident.

The availability of the Critical Incident Review Report to the State Coroner for the purpose of the coronial investigation should be examined and discussed with the Coroner's Office. While there are potential benefits in making the information available to the Coroner, there may be legal ramifications to providing all of the information.

Coronial investigations

In discussions with the Coroner in the context of this review, he was critical that ongoing themes in some Coroners' findings about shootings and police vehicle pursuit deaths appear to have been ignored by Victoria Police. I regard this as a matter of concern which may require further inquiry.

The State Coroner has previously recommended amendment to the *Coroners Act 1985* so that essential witnesses can be required to give evidence in coronial investigations with proper protection of their right to silence in other jurisdictions. In her findings at the inquest into the death of Mr. Hubbard, Coroner Hendtlass supported the need to amend the Coroners Act to require witnesses to give evidence when requested to do so and protect them from the use of the evidence against them in other legal proceedings.

It is my view that the recommendations of the State Coroner and Coroner Hendtlass should be acted upon.

Recommendations

15. It be a requirement that police who have fired shots leading to a member of the public being fatally wounded be routinely tested for the presence of illegal drugs and alcohol as soon as practicable, but within hours, of the incident and in circumstances which ensures the integrity of testing.
16. Victoria Police Manual 104-4 on Incident Debriefing be amended to require that debriefings occur where a person has died or been seriously injured as a consequence of police use of force or vehicle pursuit, that debriefings occur as soon as possible, and in any case within three days of the incident occurring; and the convenor of the debriefing to be either the Operations or Forward Commander and attendees include all, or a representative group of officers and supervisors from, units involved and or reporting emergency services or organisations.

17. All fatal or near fatal incidents as a result of Victoria Police use of force or vehicle pursuit be thoroughly and impartially examined by a Critical Incident Review Panel with the role and responsibilities outlined in this report.
18. The *Coroners Act 1985* be amended so that essential witnesses can be required to give evidence in coronial investigations with proper protection of their right to silence in other jurisdictions.

6. Addressing situations involving people with a mental disorder

People suffering from a mental disorder, which include people with a diagnosed mental illness and some individuals with acquired brain injury or an intellectual disability, exhibit a broad spectrum of symptoms, ranging from those who are in emotional distress to extreme psychotic behaviour, including the drug and alcohol affected and those with organic presentations of mental disorder, such as dementia. Police, by the very nature of their mission ‘to provide a safe, secure and orderly society by serving the community and the law’, come into regular contact with such individuals.

Seventeen of the 32 people fatally shot by Victoria Police since 1 January 1990 were considered to have a mental disorder at the time of the shooting. It is important to note that, of the six fatal police shootings which are the subject of this review, three of the deceased suffered from a mental illness, while a further two could be described as people suffering from a mental disorder. People with a mental disorder are clearly over-represented in critical incidents that result in fatal police shootings.

In November 1996, Victoria Police released a report entitled *Project Beacon: a synopsis*. The report noted that some experts had linked the de-institutionalisation of mentally ill people to the increase in fatal police shootings but commented that there was not a marked increase in fatal police shootings when similar policies were implemented in other Australian states.

From the material examined during this review, it seems to me that there are two factors which have contributed to the high representation of people with a mental disorder among people who have been shot by Victoria Police: a diminution in training and a lack of effective partnerships and protocols between Victoria Police and other government agencies responsible for the care of people with a mental disorder.

Diminution of training

The gradual diminution in the training of police officers in the fundamentals of handling critical incidents is addressed in detail in the next section of this report. This has diminished the currency, relevance and confidence in the Operational Safety Principles. As a consequence, the Principles tend to be poorly observed during the most confrontational situations, when they could in fact be of greatest benefit, particularly in situations involving people presenting violently with symptoms of mental illness or disorder.

There has been some recent training in Police Region Three [Broadmeadows] and officers who have attended attest to the usefulness of this training. The Moonee Ponds Police have been working with the local Crisis Assessment and Treatment Team (CAT Team). But overall, the training at both recruit and in-service level in dealing with people who have a mental disorder falls well short of what is required. That one police region has itself initiated supplementary training about mental disorder and its implications for policing lends weight to the finding of my investigators that further attention to training of all operational police is justified.

Partnerships with other agencies

The second major factor arises from issues surrounding the effectiveness of partnerships and protocols between Victoria Police and other government agencies responsible for the care of people with a mental disorder.

There is an Inter-Departmental Liaison Committee (IDLC), comprised of the Victoria Police and the Department of Human Services, Mental Health Branch that meets and monitors relationships between the respective operational areas. The Committee has generally met on a quarterly basis. Victoria Police is represented by its Education Department.

The IDLC has developed protocols for transporting patients with a mental disorder who come to the attention of Victoria Police. It has established protocols for managing violent psychiatric inpatients and considered protocols to flag the Law Enforcement Assistance Program (LEAP) database with information about the mental condition of certain individuals. The Committee has also developed protocols for involving families of the sufferer (who is considered violent), and/or notifying families of the person's contact with police.

My review has found that in recent years the IDLC has become somewhat moribund and has not been addressing major policy issues adequately, particularly in relation to the CAT Teams and the extent to which they can support Victoria Police in operational incidents involving members of the public with mental disorders.

CAT Teams

CAT Teams are responsible for assessing and treating people suffering from an acute mental disorder in the community. In the metropolitan area there are 17 CAT Team Service Contacts, while in country Victoria there are 31.

I note that a protocol between Victoria Police and the Department of Human Services, Mental Health Branch was put in place during 2004 that sets out the functions of the CAT Teams during critical incidents. The intention of this protocol was to ensure that people with mental disorder receive the highest standard of care in situations involving both police and mental health staff. It was intended to enable both police and mental health services to clarify their different roles and responsibilities.

The protocol states:

It is important to note that although CAT triage services will always give top priority to urgent referrals from police, they are not an emergency service and can only provide assistance as soon as practicable...

As CAT Teams are not an emergency service, they are not required, nor resourced or organised, to respond to critical incident emergencies as police may wish. They are not always able to respond to private residences after hours. Therefore, CAT Teams and indeed other mental health professionals will decide on the basis of information provided by police what an appropriate response should be. Attendance at the request of police depends on availability. More often than not, the CAT Team will request police meet them at the nearest hospital or police station and not at the scene of the incident police are attending.

It appears that the aims of the protocol are not being fulfilled and that the current working arrangements are less than optimum. Mental health services staff request assistance from police in managing a person who has, or is believed to have, a mental disorder and police request assistance from mental health services staff for the same reasons. My investigators found that Victoria Police officers' knowledge of the protocol is poor.

As Professor Paul Mullen states in a Victoria Police training video titled 'Similar Expectations':

The situations where mental health professionals and police come together are situations where we do have a role to contain as well as care. The police are not and should not be mental health professionals. Mental health professionals make pretty poor policemen. But together, hopefully we can provide for the mentally disordered the care and the treatment they need, and the occasional containment that they, and society, require.

In the course of this review, the issue of CAT Team attendance was discussed with the Department of Human Services, Mental Health Branch, which has indicated an intent to consider this issue. They have advised, and I accept, that it is a complicated area, as a number of the incidents requiring a CAT Team occur in rural or outer metropolitan areas and occur spasmodically. They are currently considering whether there should be additional resources and training provided to currently configured CAT Teams, or whether a more specialist response could or should be able to be accessed by Victoria Police during critical incidents.

Memphis Model

In making their inquiries, my investigators explored the approach taken by the Memphis Police Department in the United States. There, a number of officers participate in specialist training under the instructional supervision of mental health professionals. Once trained, the officers form a unit known as the Crisis Intervention Team (CIT). The CIT is made up of volunteer officers from each uniform patrol precinct. CIT officers are called to respond to critical incidents where officers are presented with complex issues relating to mental disorder. CIT officers also perform their regular duties as patrol officers.

In its submission to my review, 'Police Training and Mental Illness – A Time for Change', the Springvale Monash Legal Service suggested:

The implementation of a CIT program into Victoria would be a logical step and one which would minimise miscommunication and would reduce violence between police officers and individuals suffering from a mental illness.

The submission also noted:

Another important factor to recognise is that every state is different. A system that works for Memphis may not suit another city and so it is important to not only look at one but to look at a broad range of successfully implemented CIT programs (or related programs) from various cities and then to break each program up into steps, judging which are the more important and relevant steps for Victoria. Adequate training is essential for all parties involved.

The Law Institute of Victoria (LIV) stated similarly in its submission:

The LIV is aware of a model formed by the Memphis Police Department and adopted by some Police bodies throughout the United States. The concepts of the Memphis Model provide a good framework from which the Police can design training programs for current officers and recruits to better identify, communicate and negotiate with individuals suffering from mental illness.

After evaluating the Memphis Model closely, I believe that it is not suitable for implementation here and that other structural arrangements designed specifically for Victorian circumstances are necessary. There is, however, much to be learnt from the Model about how police can provide quality assistance to people presenting with the symptoms of mental disorder and about how police and mental health professional can engage.

Pressing need for further action

I have come to the view that Victoria Police officers' knowledge and understanding of people suffering from a mental disorder is, generally speaking, limited. It follows that the management of people with a mental disorder who come to the notice of Victoria Police could be improved and there is an urgent need for officers to develop skills in identifying, communicating with and managing people who are presenting with the symptoms of mental disorder.

In my view, operational police officers need to have a good basic understanding of mental disorder, including the types, causes and the kinds of treatments applied. They need to be able to recognise common symptoms and their associated behaviours and have an appreciation of the indicators of suicidal behaviour. They need to have flexible communication skills, protocols for strategies and intervention and a very good understanding of the legal framework guiding the role of Victoria Police in relation to people with a mental disorder. A new focus on training police in these areas is necessary.

The work of the IDLC as it is currently structured is not effective and the protocol between Victoria Police and the Department of Human Services, Mental Health Branch does not appear to be well understood by significant numbers of police and mental health professionals. CAT triage services are vital in assisting police at critical incidents and in providing advice to police on how to manage themselves as well as the person at the heart of the incident.

I consider that there is a strong case for overhauling the framework for liaison between Victoria Police and the Department of Human Services, Mental Health Branch to ensure police needs in resolving critical incidents involving individuals with a mental disorder are met. In particular, the availability of experienced trained mental health professionals to both support and, where necessary, be present and advise incident commanders at critical incidents needs to be addressed.

To this end, I recommend that the IDLC be rejuvenated to focus on policy matters in areas where the organisations' concerns overlap. Police representation should be at a senior level - Commander or Assistant Commissioner. The Committee should be supported and informed by a sub-committee of appropriate operational people from both Victoria Police and the Department of Human Services so

that practical matters affecting police and mental health professionals at critical incidents can be dealt with. Operational issues that have arisen in critical incidents should be analysed and policies and protocols assessed.

Recommendations

19. Victoria Police develop strategies to redress deficiencies in the understanding by police of mental disorder and how to respond to situations involving people with such a condition, including education and training for all operational officers; investigation of how the concepts underlying the Memphis Model could assist in responding to crisis calls involving complex issues about mental disorder; and co-operative arrangements with other organisations involved in responding to the particular needs of these individuals.
20. The IDLC develop and implement a protocol for the availability and deployment, on a 24 hour basis, of a senior mental health professional to advise, support and, where necessary, attend to assist Victoria Police Forward Commanders to resolve critical incidents involving people with a mental disorder.
21. That the role of the IDLC as the key body to oversee improved co-operative arrangements between Victoria Police and the Department of Human Services be reinforced and that Victoria Police be represented at Commander or Assistant Commissioner level.
22. A Sub-Committee of the IDLC be formed by Victoria Police and the Department of Human Services, Mental Health Branch, comprised of operational officers to immediately focus on practical operational issues of concern, including issues relating to the deployment of CAT Teams.

7. Education and training in resolving critical incidents

Education in Victoria Police has traditionally been undertaken by the organisation itself but a transition towards developing partnerships with the higher educational sector is planned which would see police able to access nationally accredited educational programs. Victoria Police is a registered training organisation and already conducts courses leading to the Diploma of Public Safety (Policing) for probationary training and the Diploma of Police Supervision.

I note that the Education Department is currently developing a foundation training model (recruit training), which will lift the basic educational level of the Constable to a degree level qualification. It is expected that a higher education partner and a new curriculum will be developed during 2006-2007. This will further enhance education and training of recruit and constable level officers and allow greater attention in the curriculum about social and legal issues confronting police.

I support these initiatives but believe it is important to ensure that the programs being delivered now also meet the needs of police and the community. The syllabi relevant to managing critical incidents have therefore been evaluated as part of this review and training sessions for recruits and OST training have been observed by my investigators.

Operational Safety and Tactics Training

The concept of OST training has its origins in mid 1986, when Victoria Police, concerned by the rising level of violence confronting operational police, formed the Firearms Operational Survival Consultative Committee (FOSSCC). The FOSSCC identified a requirement to establish a central unit with a brief to upgrade, standardize and manage firearms and operational survival training across Victoria Police. The Firearms Operational Survival Training Unit is now known as the Operational Safety and Tactics Training Unit (OST Training Unit).

My investigators found from their enquiries that some of the lessons learnt during Project Beacon about ensuring that OST training is current, relevant and well-accepted by officers have been overlooked in recent times. In some areas, the training is not having the required impact due to a lack of understanding by instructors and operational police alike regarding its background and the rationale for it. There is a concern that OST training lacks currency and has not been adapted to reflect changes in the kinds of situations in which the skills and techniques are used. For OST training to have the necessary impact, it must be dynamic, relevant and robust. The concepts taught in the training need to be so

much a part of police work that officers instinctively and confidently move to resolve critical incidents with professionalism, compassion and in safety.

As part of Project Beacon all operational Victoria Police officers received five days intensive training in the use of minimum force and operational safety tactics in 1994 or 1995. This training provided officers with a range of tactical options to resolve an incident, depending on the nature of the situation they confronted. To support and reinforce that training, a two-day recall training regime every six months was introduced in 1995. The two-day twice per annum recall training regime has existed since that time, apart from one three-day once per annum training period in 1998.

My investigators have found that the OST component of the two-day OST training program has been diluted, in part owing to the introduction of a full-day component of first aid training that commenced in the July 2000 training cycle and is scheduled to occur every three years. A further half-day for Cardio-Pulmonary Resuscitation is to occur every 12 months. In effect, OST training has been reduced by four days for each officer since the year 2000. This, and the inclusion of other non-OST subjects, has further decreased the time available for the training and practice in operational safety tactics.

In its submission to this review, Victoria Police recognised this:

Victoria Police acknowledges that the OST training program has been diluted at times through the inclusion of various non-OST subjects in the training due to a requirement to assist Victoria Police in meeting other organisational priorities. These issues are currently being reviewed by the Education Department.

The Assistant Commissioner Education Department has begun a best practice review of OST training. This will be a 'back to basics' approach and include evaluation of the Operational Safety Principles, the 'Safety First Philosophy' and how to use the available training time most productively. At the suggestion of my investigators, OST training will in future be reinforced on a regular basis with the use of testimonials, that is accounts of situations which actually occurred, from officers who have successfully resolved critical incidents using skills from OST training.

Recall training syllabus matrix

At the request of my investigators, Victoria Police provided a training matrix detailing the syllabus of OST recall training. The matrix detailed every subject taught since the inception of Project Beacon and from this a number of gaps in OST training in recent times were evident. These included:

- Training in addressing the mentally ill was last taught in January 2002 in a non-examinable format;

- Tactical communications - last taught in January 2000 in a non-examinable format; and
- Cordon and containment – has not been taught as an OST subject nor practised in the two-day training course.

The benefits of using such a matrix for the planning of OST recall training are clear. For example, from the matrix it was determined that the topic positional asphyxia (when the position in which a person is held can prevent them from breathing and lead to their death) has been appropriately included on three separate occasions and was examinable in January 2002. It would be timely for the topic to be re-delivered. I am hopeful that the Education Department will continue to use such a matrix to plan the syllabus for future recall training. This approach, together with intelligence from the Use of Force Register, meaningful incident debriefings and critical incident reviews will enable Victoria Police to focus on the most pressing training issues in the future.

It is noted that the Education Department is developing an updated OST training package to address the circumstances of people with a mental disorder for the January 2006 OST training cycle. This will be the theme over the next three OST training cycles. Cordon and containment will be the first principle to be fully covered during the January 2006 cycle, as this principle is fundamental to the successful resolution of incidents involving individuals presenting with the symptoms of mental disorder. I support these initiatives.

Firearms training

Since its implementation, OST training has maintained a particular focus on firearm skills. With the exception of two cycles, every OST training cycle has included a full session on the use of firearms. It is my view that this need not be the case. I suggest that in every second cycle of the OST training curriculum, officers undertake a competency shoot in firearms as opposed to the full training in the use of them. This will allow more time to be given to the other training issues, including tactical communication, cordon and containment, addressing issues associated with mental disorder, command and control and managing and communicating with personnel. It would bring the amount of firearms training undertaken by Victoria Police into line with police services in other Australian states. I note that the firearm component of OST training is already being reviewed by the Education Department.

Tactical communications

There are a number of programs which teach how to look creatively at conflict and apply negotiation strategies to resolve tense situations. Verbal Judo is one such program.

Victoria Police introduced this subject in 1998 and since that time it has been taught to recruits. OST instructors are very enthusiastic about tactical communication techniques and their benefits. They appeared to my investigators to be frustrated that this training has not been refreshed since its introduction. The general comments of the OST instructors can be summed up by the following comment made by one instructor:

‘Verbal Judo, was a great concept...It should be reintroduced in some form ... as an organisation, we didn’t embrace the concept that increasing officers’ knowledge directly relates to their sense of confidence in critical situations and therefore contributes to their safety and propensity to use lower use of force options.’

Training facilities

The standard of training facilities is inconsistent across the state, something acknowledged by Victoria Police in its submission to this review. Poor quality training venues reflect a negative image to the officers under instruction and to the instructors themselves.

Facilities are excellent at the Police Training Academy and Wangaratta, good at Essendon, fair at Geelong and barely satisfactory throughout the rest of the state. But even the state-of-the-art OST facility and scenario village at the Police Training Academy lacked Closed Circuit Television to allow officers to watch their actions during scenario debriefing sessions. I understand that funding has been now provided for the inclusion of Closed Circuit Television at the Police Training Academy. Video equipment to assist other OST facilities to provide a better training capability is also necessary.

In my view, it would be worthwhile to set minimum standards for OST Training facilities and that OST training venues across the state be audited against that standard. Venues that do not meet the minimum standards should be refurbished or decommissioned. Good facilities should be used to their capacity. It is of concern that the very good facility at Wangaratta often lies empty while training goes on at very poor facilities elsewhere such as Seymour.

Scenario training

For officers of Victoria Police to understand and assess risks, historical data, intelligence and analysis play a significant part in providing an appreciation of the

real situations officers face in the course of their work. With appropriate scenario training, coping strategies and tactical options, officers would be better equipped to confidently and safely resolve critical incidents. The more realistic the training, the more the officers will learn from it.

My review has identified the need for the OST Training Unit to devise and implement contemporary scenarios for use in training. A lack of data relating to use of force over the past two years (see Section 10 on the use of force records management) has meant that the scenarios being developed have not been validated by analysis of the actual operating environment and the real situations faced and so do not necessarily relate to the most pressing operational issues. This needs to be addressed so that every officer has participated in quality, real-life scenarios that will prepare them for critical incidents. The scenarios should have regard to input from a range of sources – Coronial findings, analysis of the Use of Force Register, testimonials and the findings of Critical Incidents Reviews. So that police officers are trained consistently, there should be a core set of scenarios identified for delivery to all officers as part of their OST training.

My investigators' limited observation of debriefing of training scenarios at the Police Training Academy suggested to them that scenario training debriefings could be improved to get the maximum learning benefit. A formal scenario training debriefing methodology would be of benefit. Deconstruction of actions and events using video footage should in my view be a key part of the debriefing methodology.

Some OST instructors who are not located at the Police Training Academy believe that they have limited opportunity to have input into the ongoing development and quality assurance of OST training. There are no formalised processes to obtain information from the OST instructors regarding the recurring skill deficiencies they are observing during scenario training and which are not being specifically addressed by the current syllabus although there is nothing to stop such instructors advising the relevant people of their observations or suggestions. Regular debriefing of OST instructors could be of benefit.

Edged weapons (knives, swords etc)

It is significant that since 1990, nine out of the 16 people with a mental disorder who have been fatally shot by Victoria Police were in possession of an edged weapon at the time. This issue was addressed during Project Beacon and was highlighted by Coroner West on 31 January 1996 in his findings into the death of Ms. Colleen Richman. One of a number of recommendations made by the Coroner included the following:

That a critical evaluation be undertaken as to the merits of a firearm being the only effective weapon to counter an attack by an assailant using an edged

weapon. I am concerned that there appears to be a universally held belief among operational officers that all edged weapons should be treated equally and that in defence from attack, it is necessary to shoot until the threat is neutralised.

Following the Richman Inquest, the then Chief Commissioner sought and gained assistance from the then National Police Research Unit (NPRU) to conduct a review of Project Beacon. In his detailed report, the Director NPRU made a number of recommendations, including:

More emphasis be given to the proper appreciation of the real threat facing operational officers from edged weapons and that the full range of options and tactics apply to edged weapons as it does to all other types of threats.

At that time, Victoria Police taught in their OST training that the first response to a person armed with an edged weapon should be to disengage, cordon, contain and negotiate. This should continue to be the case today.

The number of recent fatal police shootings involving members of the public carrying edged weapons is evidence that Victoria Police training in this area requires renewed attention. Victoria Police must ensure that police are equipped and trained to understand the real threat facing operational officers from edged weapons.

Recruit training

The training provided to recruits is the fundamental building block which guides the way new police officers approach their work. Recruit training for Victoria Police is a twenty-week course covering, among other things, law and policing procedures, defensive tactics and tactical communications, communications and firearms training.

My review has found that there are aspects of recruit training which could benefit from change to emphasise and demonstrate the ‘Safety First Philosophy’ and the application of the Operational Safety Principles as well as the Victoria Police Mission Statement and the five objectives underpinning it. New police officers need to gain a sound appreciation of the community’s expectations regarding the appropriate use of force and of the commitment of Victoria Police to ‘Safety First’.

I am advised that Victoria Police are reassessing the way in which they are delivering training in communication techniques to recruits as a matter of priority. Given the extent to which police can expect to come into contact with people who have a mental disorder, greater attention to incorporating relevant training into the recruit program is required.

One additional issue raised with Victoria Police by my investigators related to the requirement for recruits to wear equipment belts, complete with aluminium

replica firearms, from their second day at the Police Training Academy. The message this policy was communicating to recruits should not be underestimated. It is pleasing to note that the Assistant Commissioner, Education has now taken steps to address this.

My investigators were told of a shortage of qualified instructors to deliver various specialist areas of training to recruits. Fatigue and occupational health and safety restrictions on the OST instructors' exposure to noise and lead were raised. Some squads can be in excess of 24 recruits and there are difficulties in conducting non-classroom based training with the squads of such size. There is also an issue regarding the availability of OST instructors to assist the instructors of other subjects to assess practical exercises against the Operational Safety Principles. This could be easily addressed by ensuring that all instructors maintain current OST qualifications.

Training for Sergeants, Senior Sergeants and Inspectors

Sergeants, Senior Sergeants and Inspectors have a key role to play in the resolution of critical incidents.

By way of background, the selection process and training programs for officers promoted to the ranks of Sergeant, Senior Sergeant and Inspector changed in 2004. Previously, officers were required to pass examinations. Senior Constables seeking to advance to the rank of Sergeant also undertook a six week classroom-based training program before doing so. Under the current system, which has only been in place for a year, Senior Constables participate in a selection process to gain promotion. If they are successful in the selection process, they assume the rank and then participate in a self-paced Diploma of Police Supervision conducted by distance learning. 'Critical incident and emergency management' and 'leadership and management development' are among the elements which must be completed within specified periods.

During an assessment block, officers are exposed to a variety of scenario based exercises and assessments. Their involvement in field assessments may be as either the supervisor, a role play participant or an observer. All program participants are also offered the opportunity to attend and observe assessments prior to their chosen assessment block. Assessments of other areas are conducted in the workplace.

Provided the officer has discharged his or her duties as a Sergeant satisfactorily and completed the mandated aspects of the Diploma, he or she is then confirmed in the rank of Sergeant after one year.

There are large numbers of Senior Constables upgraded, on a temporary basis, to the rank of Sergeant who receive no sanctioned training before assuming their

new duties. The School of Critical Incident Management has introduced a one-day 'Front Line Supervisor Information Seminar' for officers who are upgraded. The course is delivered on an ad hoc basis when there are sufficient numbers of volunteering officers who have been, or are about to be, upgraded.

This is a commendable initiative, which goes some way to addressing the need to develop additional skill sets, particularly relating to command and control techniques, when assuming the duties of a Sergeant. I am of the view that attendance at such course should be mandatory before an officer is promoted or upgraded.

Officers promoted to the rank of Senior Sergeant are required to complete an Advanced Diploma of Police Management. This is also a two-year self-paced distance learning program for which students are required to complete the studies in controlling multi-agency emergency situations and managing operations.

Senior Sergeants promoted to the rank of Inspector are required to complete a Graduate Certificate of Management through the Police Training Academy. In addition, they are also required to complete courses provided in the Advanced Diploma of Police Management unless they have prior learning recognised. The Graduate Certificate is also a two-year self-paced distance learning program.

Clearly, it is not yet possible to evaluate the impact of changes made over the past year to the training of Sergeants, Senior Sergeants and Inspectors. The move to self-paced distance learning in these ranks may have an impact on the extent to which officers can obtain practical experience in command and control techniques. Consideration may need to be given to supplementing it with classroom and scenario training.

I strongly advocate the development of mandatory refresher training for operational Sergeants, Senior Sergeants and Inspectors every three years to ensure that the skills required for the management of critical incidents are adequately maintained.

Recommendations

OST training

23. Quality assurance reviews of OST training be undertaken and that the process include interviews with officers and instructors.
24. The two-day twice-yearly OST training courses be maintained and address operational safety tactics training exclusively and that the days be of eight hours duration.
25. Divisions and Regions deliver other training, for example in First Aid and CPR, during an additional training day.

26. The next two OST training cycles focus on equipping officers with enhanced skills in dealing with people presenting with the symptoms of a mental disorder and that this area be covered regularly in future.
27. Training in tactical communication techniques be reintroduced into the OST training and be integrated with training on dealing with people who have a mental disorder.
28. The use of OC spray and OC foam at the fatal shootings of Mr. Hubbard and Mr. Chapman form the basis of case studies in the next two-day OST training program.
29. The Operational Safety Principle of cordon and containment be taught and practised. This should include development of Emergency Plans, the application of SMEAC (Situation, Mission, Execution, Administration, Communication), communication of the plan, allocation and communication of tasks during critical incidents, the use of radios and the maintenance of communication to all personnel throughout the incident.
30. The firearm-training package be delivered once a year with the alternate six-month OST course including only a qualification shoot.
31. The OST Training Unit maintain a training matrix of all OST subjects so as to monitor how frequently they are being taught.
32. The OST Training Unit obtain and analyse information from the Use of Force Register, Coronial findings, Incident Debriefings and Critical Incident Review Panel reports to identify areas for additional and remedial training and that such information from the preceding six months be made available to OST Instructors at the commencement of every OST cycle to assist them to demonstrate to students the practical relevance of the training they are undertaking.
33. Victoria Police produce testimonials to show the relevance and usefulness of OST training in critical incidents.
34. Victoria Police install closed circuit television for the Academy OST Training facility and scenario village and provide video recording and display at other OST Training facilities across the state.
35. Minimum standards for OST training facilities be documented using the Wangaratta facilities as a benchmark.
36. An audit of all OST training facilities be carried out against the documented standards and to ensure that the better facilities are used to capacity.

37. Scenario training to be more prescriptive, mandated and recorded in every two-day training program.
38. Portable radios be available to personnel during scenario training.
39. A formal scenario training debriefing methodology be developed and implemented at the conclusion of all scenario training.
40. The number of appropriately qualified instructors be increased.

Recruit training

41. Recruits only wear the equipment belt in accordance with the training they are receiving at the time.
42. Instructors, educators and mental health professionals who teach recruits consult and collaborate to ensure that elements of the training are coordinated and complementary.
43. Instructors all become OST qualified.
44. Squads of 24 be regarded as the maximum for effective non-class room based training sessions.

Training for Sergeants, Senior Sergeants and Inspectors

45. The distance-learning concept for current Critical Incident Management Training for officers who have been promoted to the ranks of Sergeant and Senior Sergeant be monitored and consideration given to incorporating structured and hands-on learning experiences that incorporate face-to-face training and scenario training.
46. Successful completion of the one-day Critical Incident Management Training Program be mandatory before duties at or above the rank of Sergeant be commenced, whether the duties be temporary or permanent.
47. Victoria Police deliver the current one-day face-to-face Critical Incident Management Training Program at least twice per annum to enable succession planning.
48. All officers currently performing duties at the rank of Sergeant or above who have not at least completed Critical Incident Management Training be directed to do so before the end of 2006.
49. Critical Incident Management Refresher Training be developed and attendance by operational officers every three years be required.

8. Specialist support for regional areas

Many coroners over a number of years have been critical of police in regional areas for not establishing cordon and containment lines during incidents, where this would have been possible, and not seeking assistance from specialist support units. Fatal shootings by Victoria Police have occurred regularly in regional areas since 1980 (See Appendix Four). I recognise that the resolution of critical incidents in regional areas can be significantly more difficult than in metropolitan areas because the resources often immediately available to the officers is limited. However, it is important that Victoria Police officers in regional areas do not have the impression that no specialist support can or will be made available to them. This perception may have arisen after the leases for fixed wing aeroplanes were not renewed in 1993.

Currently the deployment of specialist personnel (SOG, CIRT, Dogs, Negotiators etc) to assist in the resolution of critical incidents in country areas can be accomplished by the use of the Victoria Police helicopter based at Essendon. This is a shared resource with the Metropolitan Ambulance Service.

The distance the helicopter can travel is determined in large part by its weight. There are also insufficient pilots and flight crew to allow for the availability of a police helicopter on a 24-hour basis. When flying from Melbourne to the majority of regional areas in Victoria, the helicopter can only transport two passengers without needing to stop and refuel. For example, flight times with two passengers using the current police N3 helicopter to Warrnambool, Wodonga, and Bairnsdale would take 60 minutes, Shepparton and Morwell 40 minutes and 115 minutes (which may require an extra 30 minute fuel stop) to Mildura.

Victoria Police officers are also transported to regional airports by fixed wing aircraft hired and flown by pilots from the general aviation industry. Aircraft and pilots are not always available at short notice, particularly outside normal business hours. Considerable delays are involved even if an aircraft is available as it can take over two hours for the aircraft to be ready for take off. The flight time and travel to the regional airport, and then to a critical incident scene must then be added.

I understand that acquisition of a larger helicopter capable of transporting up to 19 passengers anywhere in Victoria is currently under consideration. It will be some time before a dedicated helicopter is available.

In my view, arrangements need to be put in place in the meantime to enable the attendance, on a 24 hour basis, by specialist police services at urgent and critical incidents which occur in regional Victoria. There are a number of ways such an objective could be implemented, such as fixed wing aircraft operators being contracted to provide 24 hour availability, take-off at short notice and with

minimum delay in reaching flight readiness. As well, some specialist police services, such as dogs, could be established outside Melbourne.

Recommendation

50. That arrangements for the 24 hour deployment of specialist services for urgent and critical incidents in regional Victoria be developed.

9. Support and counselling for families of victims

In the course of speaking with families of people who had died as a result of the six police shootings examined by my investigators, the limited, if any, support offered to the families of people who have been fatally shot by Victoria Police emerged as an issue requiring attention.

Police officers and their families are, appropriately, provided support and counselling through their Employee Support Service. The Clinical Services Branch of the Police Organisation Wellbeing Division provides a wide range of confidential counselling and support services through social workers and psychologists. There is also a Chaplaincy and Peer Support Program.

However, several families of victims indicated they had received little or no help from support or counselling services. In the case of Mr. Kennedy, a four-year old child was involved and was present in the room with his two year old brother when his father was shot dead. The four-year old is suffering significant trauma from the event but neither he nor his mother were assisted by police to obtain counselling or other support.

The Department of Human Services advised my investigators that its Family Violence and Sexual Assault Support Service includes a Victims of Crime Service. Its target groups include 'primary victims of other violent crime and related victims of homicide, which occurred in Victoria in the previous 12 months and was reported to police' which the Department believed would cover the primary relatives of a person who was killed by police.

It nevertheless remains that arrangements for accessing service were not made or facilitated in cases examined in my review. Such a service could assist shocked and bereaved family members. I recommend that the Department of Human Services and Victoria Police further pursue this important issue and establish an operational protocol so that family members of people who have died can be offered support.

Recommendation

51. Victoria Police establish with the Department of Human Services a formalised protocol to offer support and counselling to the families of people fatally shot by officers of Victoria Police.

10. Management information

Strategic Risk Register

The Victoria Police has a risk management process designed to monitor risks and coordinate strategies to reduce or obviate the risks. This includes a Victoria Police Strategic Risk Register that records the risks identified at departmental and regional levels. It is a key guiding document for work plans and procedures throughout the organisation.

The current Strategic Risk Register does not list the use of force as one of top ten risks to the Victoria Police. It is therefore not explicitly addressed in management plans. This is of some concern, especially considering that one of the organisational goals is to ensure a safe and secure environment and community in the application of the Operational Safety Principles by officers, in their use of force.

Records on use of force

The Use of Force Register (the Register) was established by Project Beacon in 1995 to facilitate informed and regular review of the use of force by Victoria Police. The responsibility for the Register and its supporting database were subsequently transferred to the then Training Department (now Education Department) upon the conclusion of Project Beacon in 1997 and it has remained there.

The success of Beacon would have been impossible without clear insight into the operational environment and the way officers resolve critical incidents. The database was designed to facilitate analysis of the use of force across the state. It was used extensively to ensure that the revised training programs were relevant and that the tactics being demonstrated were effective. The database was also used to provide advice to the Coroner and to government where required.

Establishment of the Register proved to be a successful strategy, as it was associated with a gradual but steady decrease in the frequency and severity of use of force incidents. This included vehicle pursuits with serious or fatal consequences. A similar trend was observed in complaints made against police in relation to the use of force. This decrease continued until 2000-2001, when the downward trend appeared to plateau and then rise again, particularly in relation to serious injury and fatal vehicle pursuits.

It was during the period in which an increase in the use of force can be identified that regular analysis of the Register ceased, apparently due to a reduction in the staffing levels and training in the area. Presently, the Register can only be interrogated for straightforward, low-level enquiries.

At my request and with the assistance of my investigators, Victoria Police audited six aspects of the Register, including the extent of changes to the Register's format; support, use, and functionality; administration and management; its use in the development of training programs, especially OST training; its use by areas other than the Education Department; and its place within the Victoria Police organisational structure.

This audit built upon an internal audit conducted in 2002. The 2005 audit established, in general terms, that the Register continues to function essentially as it did when commissioned insofar as the operational reporting of use of force incidents (including vehicle pursuits) is concerned. However, ongoing analysis of operational reports, provision of both routine and specific advice, and the inclusion of use of force intelligence in the development of OST training programs and policy are occurring by exception only. Compared to its potential capacity, reporting and analysis of data from the Register is insignificant.

The limited attention to this valuable resource requires urgent attention and I am pleased to note advice from the Assistant Commissioner, Education that additional funding for staff training and software upgrading has been provided since the completion of the 2005 audit. I am aware that a strategy has been developed to progress the matter and look forward to the improved facility the investment will allow.

Occupational Health and Safety Act 2004

One final aspect of contemporary policing that was considered and guided the Register's development in 1995 was the need to closely monitor occupational health and safety issues arising from operational policing incidents. Ten years later, the requirement that organisations take such initiatives has increased markedly. Where formerly for reasons of good practice it was incumbent on Victoria Police to monitor risk and minimise the potential for injury to officers, the *Occupational Health and Safety Act 2004* now demands this. Police at all levels must bear in mind the risks of operational policing and have timely, reliable and credible information available to them about those risks and how best to minimise them. Effective use of the Register is critical to complying with this legislation.

Recommendations

52. The potential failure by Victoria Police officers to observe the 'Safety First Philosophy' and the 'Operational Safety Principles' be identified in

the Victoria Police Risk Management Profile as one of the top ten risks to the organisation. This should ensure appropriate attention and risk management strategies are adopted.

53. Enhancements be made as a matter of urgency to the Use of Force Register to ensure that robust reporting regimes, which the database can provide, are available.
54. The Register be used to inform and assist the Education Department in identifying use of force trends, and the development of strategies and tactics to address them, and that regular reports on use of force trends be provided to operational Department heads and to the heads of ESD and the Corporate Management Review Division.
55. Intelligence gained from the Register be incorporated into all OST training, particularly in the understanding of the Operational Safety Principles, so that the importance and relevance of the training is demonstrated to operational officers.

11. Conclusion

This review has identified a wide range of issues which have played a part in the recent increase in fatal police shootings. It appears that Victoria Police has lost some of the strategic focus on safety and avoiding the use of force which it developed during Project Beacon. For the most part, the policy, practices and procedures have remained unchanged but the requisite ongoing and continuous attention to use of force issues as part of the planning and decision-making of Victoria Police has fallen away. The result is a lack of effective risk management, a culture in which self-assessment, review and improvement are given insufficient attention, and a diminution of essential police training to accommodate other organisational priorities.

It is important that Victoria Police acknowledge the risk posed if use of force issues are not accorded the highest level of priority during its planning and decision-making. The risk is very real, not only to the public but also to its officers and to Victoria Police as an organisation. The consequences for officers who find themselves in a position of needing to use force, particularly lethal force, cannot be underestimated. A fatal police shooting is a tragedy in itself and the impact profound and lifelong, for both police and the families of the victims. Further, the cost to the organisation in terms of staff morale, retention, training and experience is immense. The inappropriate use of force may also bring about a loss of confidence in Victoria Police by the general public, only adding to the difficulty of the functions officers perform.

It will be necessary for the Victoria Police Corporate Committee to regain the kind of focus displayed during Project Beacon and communicate this throughout the organisation. Established practices which are not satisfactory must be addressed and meaningful partnerships with other agencies established.

Once the impact of this renewed emphasis has begun to be felt throughout the ranks of Victoria Police, its leaders will need to ensure that one of the key results is, in fact, justified confidence. This can be brought about by officers knowing that the framework and resources exist to support them in their work. It requires contemporary and thorough policy and training and for senior operational police to show increased initiative and lateral thinking when planning and responding to potentially violent incidents. Particular attention is required in building the skills of officers who undertake general policing duties to deal with people presenting with the symptoms of mental disorder and managing incidents that involve edged weapons.

Officers need to be encouraged to recognise the limitations of their abilities and capacities. To this end, they need to be actively aware of the specialist resources that are available should they require them, and how to manage a situation so those resources can be of most assistance. Senior operational police need to be equipped to command a situation and specialist resources need to be available in a timely fashion.

Victoria Police must emphasise through its internal practices and procedures that officers are accountable for their use of force. This includes thorough incident debriefing and review and reinvigorating the management of and intelligence obtained from records about the use of force. In incidents where the use of force is lethal, such internal mechanisms also need to be supplemented by post-incident drug and alcohol testing and participation in coronial proceedings.

It is my intention to actively review the investigation of all future deaths that are the result of Victoria Police use of force and vehicle pursuits. I also intend to monitor the implementation of measures flowing from the recommendations made in this report.

Recommendations

Guiding philosophy and principles

1. Victoria Police reinforce to officers that:
 - the objectives of Victoria Police are to protect life and property and to help those in need of assistance; and
 - the success of an operation will be primarily judged by the extent to which the use of force is avoided or minimised.

2. Victoria Police continue to adopt the ten Operational Safety Principles currently included in the Victoria Police Manual.

Special Operations Group

3. A Superintendent be placed directly in charge of the SOG to reflect the current responsibilities of the unit.
4. Victoria Police amend VPM Instruction 106-2 – SOG Attendance to include the requirement that the deployment of the SOG is immediately communicated to the Regional Assistant Commissioner. In the case of an incident tasked by the Crime Department, the Assistant Commissioner Crime should also be informed.
5. Victoria Police brings to the attention of all officers, including the SOG, the responsibilities of the Forward Commander.
6. VPM Instruction 104-1 be amended to provide that, in circumstances where it is practical, the Forward Commander should always be an officer senior in rank to the SOG Tactical Commander. The instruction should also specify that the Forward Commander always retains control of the incident.

Equipment and Procedures

7. A portable radio be carried at all times by all operational officers.
8. The use of the Taser X26 by Victoria Police SOG and CIRTs continue.
9. The Taser be carried securely in the front of CIRT vehicles to enable immediate access.
10. A working party be formed as proposed in this report to review the use and deployment of the Taser X26, to consider the Coroner's recommendations and to report to the Chief Commissioner within twelve months.
11. The current policy of Sergeants and above being the only officers permitted to deploy OC foam be discontinued.
12. OC foam be distributed across the state for carriage in police vehicles.
13. Victoria Police promotes to operational units the capability and capacity of Critical Incident Response Teams to attend and assist in resolving critical incidents and to provide timely advice to Forward Commanders across the State during critical incidents.
14. That CIRT staff be provided with additional training in understanding people with a mental disorder to enhance their capabilities to resolve

critical incidents involving people with such a condition and to provide timely and consistent advice to Forward Commanders across the State. The Memphis Model, described briefly on page 38, may provide a useful model for the provision of such training.

Incident debriefing and review: policy and practice

15. It be a requirement that police who have fired shots leading to a member of the public being fatally wounded be routinely tested for the presence of illegal drugs and alcohol as soon as practicable, but within hours, of the incident and in circumstances which ensures the integrity of testing.
16. Victoria Police Manual 104-4 on Incident Debriefing be amended to require that debriefings occur where a person has died or been seriously injured as a consequence of police use of force or vehicle pursuit, that debriefings occur as soon as possible, and in any case within three days of the incident occurring; and the convenor of the debriefing to be either the Operations or Forward Commander and attendees include all, or a representative group of officers and supervisors from, units involved and or reporting emergency services or organisations.
17. All fatal or near fatal incidents as a result of Victoria Police use of force or vehicle pursuit be thoroughly and impartially examined by a Critical Incident Review Panel with the role and responsibilities outlined in this report.
18. The *Coroners Act 1985* be amended so that essential witnesses can be required to give evidence in coronial investigations with proper protection of their right to silence in other jurisdictions.

Addressing situations involving people with a mental disorder

19. Victoria Police develop strategies to redress deficiencies in the understanding by police of mental disorder and how to respond to situations involving people with such a condition, including education and training for all operational officers; investigation of how the concepts underlying the Memphis Model could assist in responding to crisis calls involving complex issues about mental disorder; and co-operative arrangements with other organisations involved in responding to the particular needs of these individuals.
20. The IDLC develop and implement a protocol for the availability and deployment, on a 24 hour basis, of a senior mental health professional to advise, support and, where necessary, attend to assist Victoria Police Forward Commanders to resolve critical incidents involving people with a mental disorder.

21. That the role of the IDLC as the key body to oversee improved co-operative arrangements between Victoria Police and the Department of Human Services be reinforced and that Victoria Police be represented at Commander or Assistant Commissioner level.
22. A Sub-Committee of the IDLC be formed by Victoria Police and the Department of Human Services, Mental Health Branch, comprised of operational officers to immediately focus on practical operational issues of concern, including issues relating to the deployment of CAT Teams.

Education and training in resolving critical incidents

23. Quality assurance reviews of OST training be undertaken and that the process include interviews with officers and instructors.
24. The two-day, twice-yearly, OST training courses be maintained and address operational safety tactics training exclusively and that the days be of eight hours duration.
25. Divisions and Regions deliver other training, for example in First Aid and CPR, during an additional training day.
26. The next two OST training cycles focus on equipping officers with enhanced skills in dealing with people presenting with the symptoms of a mental disorder and that this area be covered regularly in future.
27. Training in tactical communication techniques be reintroduced into the OST training and be integrated with training on dealing with people who have a mental disorder.
28. The use of OC spray and OC foam at the fatal shootings of Mr. Hubbard and Mr. Chapman form the basis of case studies in the next two-day OST training program.
29. The Operational Safety Principle of cordon and containment be taught and practised. This should include development of Emergency Plans, the application of SMEAC (Situation, Mission, Execution, Administration, Communication), communication of the plan, allocation and communication of tasks during critical incidents, the use of radios and the maintenance of communication to all personnel throughout the incident.
30. The firearm-training package be delivered once a year with the alternate six-month OST course including only a qualification shoot.
31. The OST Training Unit maintain a training matrix of all OST subjects so as to monitor how frequently they are being taught.

32. The OST Training Unit obtain and analyse information from the Use of Force Register, Coronial findings, Incident Debriefings and Critical Incident Review Panel reports to identify areas for additional and remedial training and that such information from the preceding six months be made available to OST Instructors at the commencement of every OST cycle to assist them to demonstrate to students the practical relevance of the training they are undertaking.
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34. Victoria Police install closed circuit television for the Academy OST Training facility and scenario village and provide video recording and display at other OST Training facilities across the state.
35. Minimum standards for OST training facilities be documented using the Wangaratta facilities as a benchmark.
36. An audit of all OST training facilities be carried out against the documented standards and to ensure that the better facilities are used to capacity.
37. Scenario training to be more prescriptive, mandated and recorded in every two-day training program.
38. Portable radios be available to personnel during scenario training.
39. A formal scenario training debriefing methodology be developed and implemented at the conclusion of all scenario training.
40. The number of appropriately qualified instructors be increased.
41. Recruits only wear the equipment belt in accordance with the training they are receiving at the time.
42. Instructors, educators and mental health professionals who teach recruits consult and collaborate to ensure that elements of the training are coordinated and complementary.
43. Instructors all become OST qualified.
44. Squads of 24 be regarded as the maximum for effective non-class room based training sessions.
45. The distance-learning concept for current Critical Incident Management Training for officers who have been promoted to the ranks of Sergeant and Senior Sergeant be monitored and consideration given to incorporating

structured and hands-on learning experiences that incorporate face-to-face training and scenario training.

46. Successful completion of the one-day Critical Incident Management Training Program be mandatory before duties at or above the rank of Sergeant be commenced, whether the duties be temporary or permanent.
47. Victoria Police deliver the current one-day face-to-face Critical Incident Management Training Program at least twice per annum to enable succession planning.
48. All officers currently performing duties at the rank of Sergeant or above who have not at least completed Critical Incident Management Training be directed to do so before the end of 2006.
49. Critical Incident Management Refresher Training be developed and attendance by operational officers every three years be required.

Specialist support for regional areas

50. That arrangements for the 24 hour deployment of specialist services for urgent and critical incidents in regional Victoria be developed.

Support and counselling for families of victims

51. Victoria Police establish with the Department of Human Services a formalised protocol to offer support and counselling to the families of people fatally shot by officers of Victoria Police.

Management information

52. The potential failure by Victoria Police officers to observe the 'Safety First Philosophy' and the 'Operational Safety Principles' be identified in the Victoria Police Risk Management Profile as one of the top ten risks to the organisation. This should ensure appropriate attention and risk management strategies are adopted.
53. Enhancements be made as a matter of urgency to the Use of Force Register to ensure that robust reporting regimes, which the database can provide, are available.
54. The Register be used to inform and assist the Education Department in identifying use of force trends, and the development of strategies and tactics to address them, and that regular reports on use of force trends be provided to operational Department heads and to the heads of ESD and the Corporate Management Review Division.

55. Intelligence gained from the Register be incorporated into all OST training, particularly in the understanding of the Operational Safety Principles, so that the importance and relevance of the training is demonstrated to operational officers.

Appendix one: Use of force legislation

Section 462A of the *Crimes Act 1958*:

A person may use such force not disproportionate to the objective as he believes on reasonable grounds to be necessary to prevent the commission, continuance or completion of an indictable offence or to effect or assist in effecting the lawful arrest of a person committing or suspected of committing any offence.

Section 463B of the *Crimes Act 1958* further states:

Every person is justified in using such force as may reasonably be necessary to prevent the commission of suicide or of any act which he believes on reasonable grounds would, if committed, amount to suicide.

Section 10 of the *Mental Health Act 1986* also contains provisions relating to the apprehension of psychiatrically disordered persons in certain circumstances:

- (1) An officer of the police force may apprehend a person who appears to be mentally ill if the officer of the police force has reasonable grounds for believing that—
 - (a) the person has 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.
- (1A) An officer of the police force is not required for the purposes of sub-section (1) to exercise any clinical judgment as to whether a person is mentally ill but may exercise the powers conferred by this section if, having regard to the behaviour and appearance of the person, the person appears to the officer of the police force to be mentally ill.
- (2) For the purpose of apprehending a person under sub-section (1) an officer of the police force may with such assistance as is required—
 - (a) enter any premises; and
 - (b) use such force as may be reasonably necessary.

Appendix two: Police shooting deaths in Australia 1990 to 2004

Year	NSW	Vic.	QLD	WA	SA	Tas.	NT	ACT	Total
1990	1	2					1		4
1991		2	1	1		1			5
1992	2	2							4
1993	1	1				1			3
1994		9	1	1	1				12
1995		3	1					1	5
1996	1						1		2
1997	3	2					1		6
1998	3	3							6
1999			1	1	2		2		6
2000	3	1	1	1					6
2001	1				2				3
2002		1	3				1		5
2003	1		2						3
2004	2	3	1						6
Total	18	29	11	4	5	2	6	1	76

Source: Australian Institute of Criminology National Deaths in Custody Program 1990 – 2004.

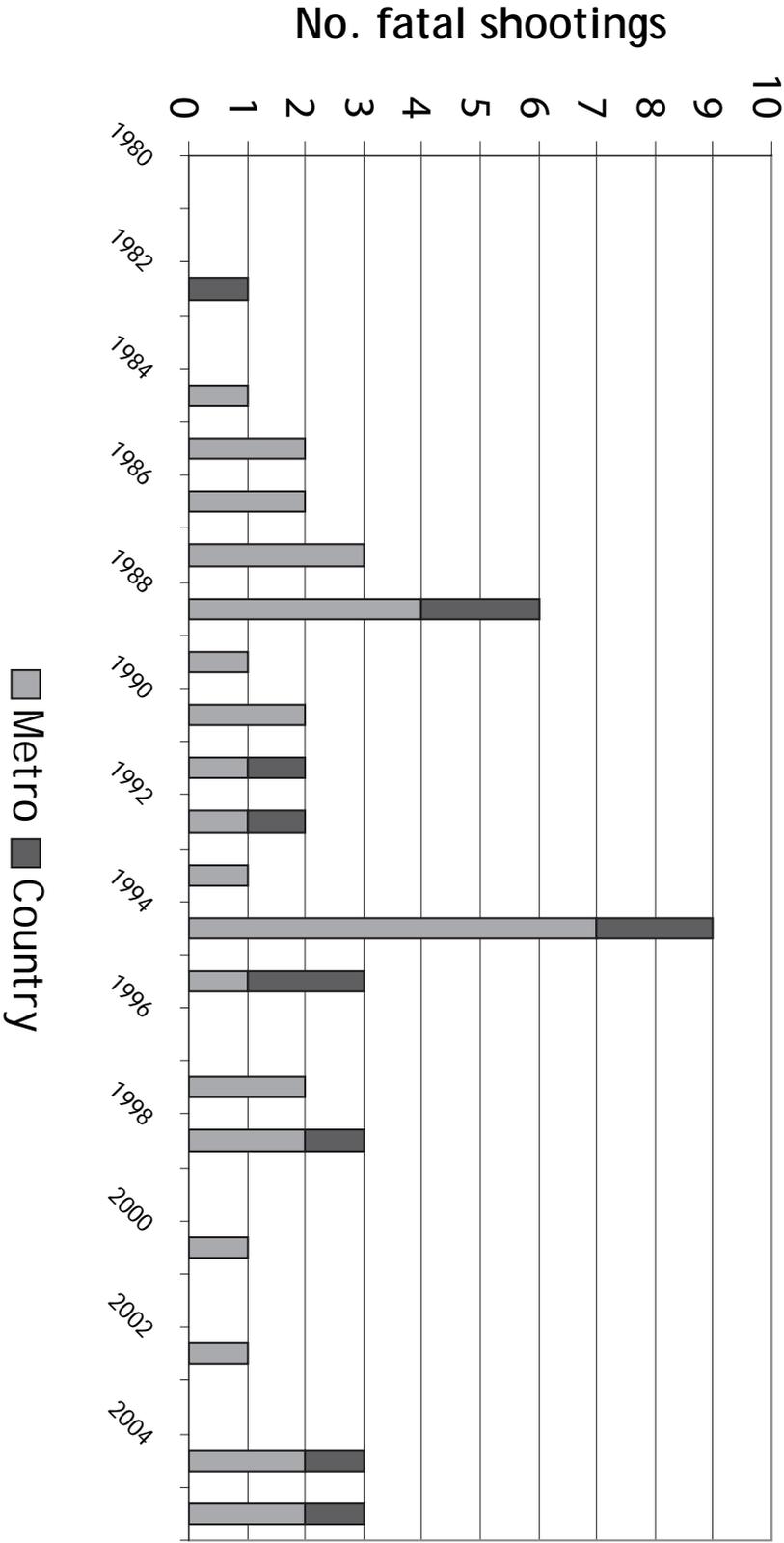
Appendix three: Victoria Police Manual - Carriage of operational safety equipment

Table 101-3, section 5.1 - Carriage of operational safety equipment – general

- Only sworn employees whose duties may bring them into contact with an armed person may carry firearms, as determined by Station Managers, see section 6.2.
- Sworn employees issued with a firearm must carry all items of operational safety equipment applicable to the duties being undertaken.
- Each police officer performing mobile patrol duties (except motor cycles) that may require them to attend at critical incidents must carry a ballistic vest in the motor vehicle
- Where the duties require the carriage of OC spray/foam and/or batons, Station Managers, section or supervising Sergeants may authorise sworn employees to carry OC spray/foam or batons, without firearms.
- For the purposes of this table, any requirement to carry:
 - firearms – includes applicable holster, speed loader and spare rounds of ammunition, unless otherwise specified.
 - batons – includes any applicable baton keeper, unless otherwise specified.
 - OC spray/foam – includes scabbard.

Situation	Must be carried	Must not be carried	Subject to approval or discretionary
Uniform duties <i>(if the duties require carriage of firearms as per section 6.2)</i>	Firearm OC spray/foam Extendable baton Handcuffs Equipment belt	Shoulder holster Long baton Ankle holster	Wearing ballistic vests
CIU, crime squad and RRU duties <i>(if the duties require carriage of firearms as per section 6.2)</i>	Firearm - if exposed, display identification Extendable baton Handcuffs OC spray/foam	Long Baton Equipment belt	Wearing ballistic vests
Other plain clothes duties	As directed by the Station Manager or Operations Commander	As directed by the Station Manager or Operations Commander	As directed by the Operations Commander
Crowd Control Situation / Sporting Event	As directed by the Operations Commander (if the Operations Commander is below Inspector then seek authorisation from the District Inspector or Divisional Manager)	Firearms	Firearms – the Operations Commander may determine that arrest teams are required. The Regional Assistant Commissioner must approve this. Only the arrest teams can carry firearms. Any items approved by the Chief Commissioner or Divisional Manager via OSTT Unit
Other planned operation or incident	As directed by the Operations Commander	As directed by the Operations Commander	
Public meetings or ceremonial occasions	No operational safety equipment is to be carried		

Appendix four: Victoria Police shooting deaths in metropolitan and country areas from 1980 to date





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