

34/10; [2010] VSC 285

SUPREME COURT OF VICTORIA

CAHIR v JAMIESON & ORS

Beach J

18, 25 June 2010

CORONERS – INQUEST – FINDING BY CORONER THAT POLICE OFFICER FAILED TO TAKE REASONABLE CARE FOR HIS OWN HEALTH AND SAFETY – FINDING THAT SUCH OFFICER MAY HAVE COMMITTED AN INDICTABLE OFFENCE – WHETHER FINDINGS BY CORONER WRONG IN LAW – WHETHER FINDINGS SHOULD BE QUASHED: CORONERS ACT 1985, SS19, 21, 59; CORONERS ACT 2008, SS83, 87, SCHEDULE 1; OCCUPATIONAL HEALTH & SAFETY ACT 1985, S25; OCCUPATIONAL HEALTH & SAFETY ACT 2004, S25.

Section 19(3) of the *Coroners Act* 1985 provides:

"A coroner must not include in a finding or comment that a person is or may be guilty of an offence."

J., in her capacity as Coroner, conducted an investigation in the death of Gregory Biggs. As a result of an incident in a public place a police officer Sergeant Cahir ('C'). shot Mr Biggs fatally. In delivering the record of investigation into Mr Biggs' death, J. stated that C. relied upon "bravado and spontaneity". J. also stated she found that C. failed to take reasonable care for his own health and safety and may have committed an indictable offence as defined and intended by s25 of the *Occupational Health and Safety Act* 2004 ('Act'). Upon an application for a declaration that the Coroner's findings were wrong in law—

HELD: Declaration made. The Coroner's finding that C. may have committed an indictable offence as defined and intended by s25 of the Act was wrong in law and constituted an error of law on the face of the record. Further, the fact that s25 of the Act was not in force as at the date of Biggs' death and that C. was not an employee within the meaning of s25 provided additional grounds for the making of the declaration. No further declaration made.

1. Section 21(3) of the *Coroners Act* requires a Coroner who forms an opinion that an indictable offence has been committed to make a report to the DPP. However, the occasion of the report (and the underlying beliefs) have no place in the record of investigation. Neither version of Form 1 of the *Coroners Regulations* 1966 and 2007 permit the recording of the Coroner's belief as to the possible commission of an indictable offence nor the fact of any necessary report to the DPP. Whilst such a statement in the findings or comments is expressly prohibited, any such statement is also impliedly prohibited in the course of discussing the evidence.

Keown v Khan [1998] VSC 297; [1999] 1 VR 69; (1998) 101 A Crim R 503, followed.

2. The function of the Supreme Court in the present case is not to conduct a merits review of the Coroner's decision. Whilst the Coroner made a mistake as to an important matter of fact, it could not be said that it was not open to the Coroner to make the statement that the Police relied too "heavily on bravado and spontaneity". If it was the Supreme Court's role to make findings based on the evidence given before the Coroner, the Court would not have concluded that the evidence justified any statement that might suggest that C. relied upon "bravado" or "bravado and spontaneity". There is much to be said for the proposition that C. was confronted with an extremely dangerous situation on the evening of 22 May 2004 and took steps, the appropriateness of which, with the benefit of hindsight and cool reflection, can be debated. Nevertheless, the view the Coroner came to was one that was open to her and not liable to be attacked on the basis of lack of rationality or reviewable unreasonableness. The fact that a judge would differ from a magistrate [Coroner] on a question of fact does not necessarily show any more than that the view of the judge differs from that of the magistrate [Coroner] on a question of fact.

Ericsson Pty Ltd v Popovski [2000] VSCA 52; (2000) 1 VR 260, applied.

BEACH J:

Introduction

1. On 22 May 2004, Mr Gregory Ram Biggs was shot by a member of Victoria Police, Sergeant Samuel Watson Cahir. Mr Biggs died shortly thereafter.

2. Over seven days between 24 May and 1 June 2007, the first defendant, as Coroner, conducted an investigation into the death of Mr Biggs. The investigation was carried out pursuant to the provisions of the *Coroners Act* 1985 (“the 1985 *Coroners Act*”).

3. On 23 October 2009, the Coroner delivered the record of investigation into the death of Mr Biggs.^[1] In the record of investigation, the Coroner stated:

“But the circumstances of Gregory Biggs’ death is also a poignant example of the tragic consequences when the Police rely too heavily on bravado and spontaneity at the expense of policy and procedure and their actual training in relation to dealing with mental illness and/or drug affected persons. The Police have an obligation to the public to implement strategies for preventing violence not creating it or inflaming an already violent situation.”

4. In the record of investigation, the Coroner also stated:

“I find and believe that Sergeant Cahir failed to take reasonable care for his own health and safety and/or the health and safety of L/S/C Hawkins when he removed himself from the police vehicle and confronted Mr Biggs and as such may have committed an indictable offence as defined and intended by s25 *Occupational Health and Safety Act* 2004.

In the circumstances, pursuant to section 21(3) *Coroners Act* 1985 I am required to report my belief to the Director of Public Prosecutions.” (Emphasis in original).

5. Following the delivery of the record of investigation, Sergeant Cahir instituted three proceedings against the Coroner (first defendant), the Chief Commissioner of Police (second defendant), Leading Senior Constable John Hawkins (third defendant) and Mrs Janet Joan Cooper (the mother of the deceased and fourth defendant). In these three proceedings, Sergeant Cahir sought judicial review pursuant to Order 56 of the *Supreme Court (General Civil Procedure) Rules* 2005; sought orders under the 1985 *Coroners Act* that the findings referred to above are void; and sought to appeal the findings pursuant to s83 of the *Coroners Act* 2008 (“the 2008 *Coroners Act*”).

6. Subsequently, these proceedings were ordered to be tried together. However, at the commencement of the hearing of this proceeding, I gave leave to Sergeant Cahir (with the consent of the defendants) to discontinue the second and third proceedings – leaving on foot the present proceeding for judicial review. In the present proceeding:

(a) the Coroner takes a *Hardiman* approach;^[2]

(b) the Chief Commissioner of Police and Leading Senior Constable Hawkins broadly support the submissions of Sergeant Cahir; and

(c) Mrs Cooper, as mother of the deceased, contends that the Coroner made no error entitling Sergeant Cahir to any relief.

7. For the reasons given below, it will be declared that the Coroner’s finding that Sergeant Cahir may have committed an indictable offence as defined and intended by s25 of the *Occupational Health & Safety Act* 2004 (“the 2004 OH & S Act”) was wrong in law and constituted an error of law on the face of the record. However, no further declaration or order will be made.

A preliminary matter: s59 of the 1985 *Coroners Act*

8. At the time the Coroner delivered the record of investigation in this matter, s59 of the 1985 *Coroners Act* was still in force. Section 59 provided:

“(1) Any person may apply to the Supreme Court for an order that some or all of the findings of an inquest are void.

(2) The Supreme Court may declare that some or all of the findings of the inquest are void and may order the State Coroner—

(a) to hold a new inquest, or direct any coroner, other than the coroner who held the first inquest, to hold a new inquest; or

(b) to re-open (or direct another coroner to re-open) the inquest and to re-examine any finding.

(3) The Supreme Court may only make an order if it is satisfied that—

- (a) it is necessary or desirable because of fraud, consideration of evidence, failure to consider evidence, irregularity of proceedings or insufficiency of inquiry; or
- (b) there is a mistake in the record of the findings; or
- (c) it is desirable because of new facts or evidence; or
- (d) the findings are against the evidence and the weight of the evidence.”

9. The 1985 *Coroners Act* was repealed on 1 November 2009. On that date, the 2008 *Coroners Act* came into force. The transitional provisions in relation to the 2008 *Coroners Act* are contained in Schedule 1 of that Act.^[3] Clause 8 of Schedule 1 of the 2008 *Coroners Act* provides:

“(1) Subject to clause 10, if a hearing of an application to the Supreme Court has begun under section 18, 28, 29, 30, 35, 59 or 59B of the old Act and the application is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the application.

(2) Despite subclause (1), the determination of the application by the Supreme Court under that subclause is deemed to be a determination of the Supreme Court under section 87 of the new Act.”

10. During the course of the hearing, I was told that the reason for discontinuing the proceeding under s59 of the 1985 *Coroners Act* was the repeal of s59 of that Act. It was said (correctly, in my view) that Clause 8 of Schedule 1 of the 2008 *Coroners Act* had no application in this case because no hearing of any application under s59 of the 2005 *Coroners Act* had begun prior to 1 November 2009. However, that is not the end of the matter. The question still arises as to whether s59 continues to have application in respect of records of investigation delivered prior to its repeal.

^[4]

11. As none of the defendants were prepared to submit that the plaintiff had a continuing right under s59 of the 1985 Act^[5] – and that this continuing right could affect the Court’s discretion whether or not to grant judicial review – it is not necessary for me to give any further consideration to this issue. However, it should not be thought that this judgment provides any support for the proposition that an application cannot be made under s59 of the 1985 *Coroners Act* after 1 November 2009 in respect of a record of investigation delivered before that date. For example, in *The Colonial Sugar Refining Company Limited v Irving*,^[6] the writ was issued on October 25 1902. On 25 August 1903, the *Judiciary Act* came into force, removing the ability to appeal from a decision of the State Supreme Court to the Privy Council in matters involving the exercise of Federal jurisdiction. On 4 September 1903, the Supreme Court of Queensland delivered judgment. Thereafter, application was made for leave to appeal to the Privy Council. The Privy Council held that although the right of appeal from the Supreme Court of Queensland had been taken away before the judgment of that Court was given, the provisions of the *Judiciary Act* were not retrospective so as to defeat the appellant’s right of appeal. Unlike *the Colonial Sugar Refining* case, where the right of appeal was removed before the Court at first instance gave judgment, in the present case, the right under s59 was not removed until after the record of investigation was delivered.^[7]

12. However, and in any event, given the way in which the parties have conducted this proceeding, if the plaintiff is otherwise entitled to judicial review, the possible existence of a right under s59 of the 1985 *Coroners Act* will not affect this entitlement.

The provisions of the 1985 *Coroners Act*

13. Section 19 of the 1985 *Coroners Act* sets out the matters which a Coroner investigating a death must, if possible, find. Section 19 also deals with comments that a Coroner may make. Section 19 relevantly provides:

- “(1) A coroner investigating a death must find if possible—
- (a) the identity of the deceased; and
 - (b) how death occurred; and
 - (c) the cause of death; and

(d) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1996.

S19(1)(e) repealed by No. 7/1999 s10(b).

(2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(3) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

S19(4) inserted by No. 25/1995 s10.

(4) ...”

14. Section 20 of the 1985 *Coroners Act* requires a Coroner or the Coroner's clerk to keep a record of each investigation into a death. The record is required to be kept in the prescribed form. Under the *Coroners Regulations* 1996, regulation 8 provided that the record of each investigation of a death must be in Form 1. Similarly, under the *Coroners Regulations* 2007, regulation 8 provided that the prescribed form was in the form of Form 1. Form 1 in each case was contained in the relevant Regulations.

15. Section 21 of the 1985 *Coroners Act* deals with reports that the Coroner may or must make. Relevantly, s21(3) provided:

“A coroner must report to the Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated.”

16. Form 1 (as prescribed by the *Coroners Regulations* 1996 and the *Coroners Regulations* 2007) provided for the recording of the identity of the deceased; whether an inquest was held (and, if so, where and on what date); the time and place of death; the circumstances in which death occurred; whether any person contributed to the cause of death^[8]; and any comments. Neither version of Form 1^[9] provided for the issue of any report that may or must be made by the Coroner.

The grounds for relief

17. The plaintiff advances five grounds upon which judicial review is sought. The grounds advanced are:

“1. The learned Coroner erred in including in her finding or comment a statement (the inclusion of which was and is contrary to s19(3) of the *Coroners Act* 1985 (Vic)) that Sergeant Cahir may have committed an indictable offence. (See the Record of Investigation into Death dated 23 October, 2009 at p17.6.)

2. The learned Coroner erred in determining that Sergeant Cahir ‘may have committed an indictable offence [contrary to] s25 of the *Occupational Health and Safety Act* 2004.’ (See the Record of Investigation into Death dated 23 October, 2009 at p17.6.)

PARTICULARS

(i) Section 25 of the *Occupational Health and Safety Act* 2004 (Vic) was not in operation and effect on 22 May 2004.

3. The learned Coroner erred in failing to consider the (uncontradicted) evidence of Sergeant Cahir (as contained within his statement in the Inquest Brief at pp164-173) concerning his awareness and state of mind prior to alighting from the police car and his purpose in alighting from the police car.

PARTICULARS OF EVIDENCE OF SERGEANT CAHIR

(i) Sergeant Cahir saw Mr Biggs at the pedestrian traffic lights.

(ii) Sergeant Cahir saw that Mr Biggs was attacking the said pedestrian traffic lights with incredible ferocity with an overhead motion and ‘was like a man possessed’.

(iii) Sergeant Cahir noticed heavy vehicular traffic on Lygon Street and pedestrian traffic.

(iv) Sergeant Cahir saw people on the footpath to the north of where Mr Biggs was standing.

(v) Sergeant Cahir believed that Mr Biggs ‘posed a threat to any person who was in the general area’ and ‘presented a threat to anyone that might be around’.

(vi) Sergeant Cahir ‘knew that if [he] didn’t do something then and there [then Mr Biggs] would hurt or kill someone’ and ‘[believed that he] had no option but to get out of the car when [he] did’.

(See the statement made by Sergeant Cahir in the Inquest Brief at pp166.8 & ff.)

4. The learned Coroner erred in failing to find that:

(a) Sergeant Cahir had, immediately prior to alighting from the police car, reasonably believed that

if he did not alight from the police car, then Mr Biggs would (or, in the alternative, could) hurt or kill someone; and
 (b) in alighting from the police car, Sergeant Cahir's purpose was to ensure that no-one would be hurt or killed by Mr Biggs; and
 (c) had Sergeant Cahir not alighted from the police car when he did, then it was reasonably possible that someone would have been hurt or killed by Mr Biggs.

5. The learned Coroner erred in finding that:

- (a) 'the Police [including Sergeant Cahir had] rel[ie]d too heavily on bravado and spontaneity ...'
 - (b) 'the Police [including Sergeant Cahir had] inflam[ed] an already violent situation'; and
 - (c) the Police [including Sergeant Cahir] had created violence, not prevented it.
- (See the Record of Investigation into Death dated 23 October, 2009 at p13.4.)"

18. Grounds one and two are directed to the statements made by the Coroner concerning the possibility that the plaintiff committed an indictable offence under s25 of the 2004 OH & S Act. Ground one makes complaint that s19(3) prohibited the Coroner from making any statement that the plaintiff is or may be guilty of an offence. Ground two relates to the fact that, in any event, even if the Coroner was permitted to make a statement that the plaintiff is or may be guilty of an offence, s25 of the 2004 OH & S Act was not in force on 22 May 2004.^[10]

19. Grounds three to five concern both of the statements made in the record of investigation as extracted in paragraphs [3] and [4] above. In summary, it is said that the statements sought to be impugned were not open on the evidence.^[11]

Ground one: The s19(3) point

20. In *Keown v Khan*,^[12] Callaway JA^[13] said:^[14]

"Section 19(3) does not expressly prohibit a statement that a person is or may be guilty of an offence if that statement appears neither in the findings required by s19(1) nor in any comments under s19(2), but any such statement in the course of discussing the evidence is impliedly prohibited."

21. The fourth defendant seeks to defend the Coroner's statement as to the belief that Sergeant Cahir may have committed an indictable offence on the basis that the Coroner's statement was neither a finding under s19(1), nor a comment under s19(2). Rather, it is said that the statement "was an articulation by her Honour of the fact that she had the necessary basis for a report to the Director of Public Prosecutions under s21(3)".

22. However, as was said by Callaway JA in *Keown v Khan*,^[15] whilst such a statement in the findings or comments is expressly prohibited, any such statement is also impliedly prohibited in the course of discussing the evidence. In *Keown v Khan*, the Court of Appeal noted the difficulty created by Form 1 of separating findings from comments and findings and comments from a discussion of the evidence (or reasons). It is, of course, to be remembered that it is only a decision that is capable of review, not the reasons for decision.

23. The fourth defendant submitted that s21(3) of the 1985 *Coroners Act* permitted the Coroner to state her belief that an indictable offence had been committed and that the matter was accordingly to be reported to the DPP. Undoubtedly, s21(3) requires a Coroner who forms such an opinion to make a report to the DPP. However, the occasion of the report (and the underlying belief) have no place in the record of investigation. Neither version of Form 1^[16] permit the recording of the Coroner's belief as to the possible commission of an indictable offence nor the fact of any necessary report to the DPP. Properly understood, ss19, 20 and 21 of the 1985 Act:

(a) prohibit the Coroner from including in the record of investigation any statement that a person is or may be guilty of an offence; and

(b) require a Coroner who forms the belief that an indictable offence has been committed to report the matter (separately from the record of investigation) to the DPP.

24. It follows that in making the statements referred to in paragraph [4] above, the Coroner made an error of law on the face of the record.^[17] Accordingly, Sergeant Cahir is entitled to a declaration that, in making those statements, the Coroner committed an error of law on the face of the record.

Ground two: the s25 of the 2004 OH & S Act was not in force point

25. Section 25 of the 2004 OH & S Act provides:

“(1) While at work, an employee must—

(a) take reasonable care for his or her own health and safety; and

(b) take reasonable care for the health and safety of persons who may be affected by the employee's acts or omissions at a workplace; and

(c) co-operate with his or her employer with respect to any action taken by the employer to comply with a requirement imposed by or under this Act or the regulations.

Penalty: 1800 penalty units.

(2) While at work, an employee must not intentionally or recklessly interfere with or misuse anything provided at the workplace in the interests of health, safety or welfare.

Penalty: 1800 penalty units.

(3) In determining for the purposes of subsection (1)(a) or (b) whether an employee failed to take reasonable care, regard must be had to what the employee knew about the relevant circumstances.

(4) An offence against subsection (1) or (2) is an indictable offence.

Note However, the offence may be heard and determined summarily (see section 28 of the *Criminal Procedure Act 2009*).”

26. There is no issue between the parties that at the time Mr Biggs was shot by Sergeant Cahir, s25 of the 2004 OH & S Act was not in force. However, the fourth defendant seeks to defend the Coroner's statements set out in paragraph [4] above on the basis that at the time of the shooting, s25 of the *Occupational Health and Safety Act 1985* (“the 1985 OH & S Act”) was in force. Section 25 of the 1985 OH & S Act provided:

“25. (1) An employee while at work shall take the care of which the employee is capable for the employee's own health and safety and for the health and safety of any other person who may be affected by the employee's acts or omissions at the workplace.

(2) An employee shall not—

(a) wilfully or recklessly interfere with or misuse anything provided in the interests of health safety or welfare in pursuance of any provision of this Act or the regulations; or

(b) wilfully place at risk the health or safety of any person at the workplace.”

27. Strictly speaking, having regard to the view I have taken in relation to ground one, it is not necessary to consider ground two. However, the fact that s25 of the 2004 OH & S Act was not in force on 22 May 2004 provides an additional ground for holding that the statements referred to in paragraph [4] above were wrongly made.

28. Further, the Coroner's statements cannot be defended on the basis that even if the 2004 OH & S Act was not in force, her Honour must have believed (had she turned her mind to the issue) that Sergeant Cahir may have committed an offence under s25 of the 1985 OH & S Act.

29. There are many problems with that form of reasoning. It is sufficient to say that no reasonable Coroner could have formed the belief that Sergeant Cahir may have committed an offence under s25 of the 1985 OH & S Act. This is so because, on any view of the evidence, Sergeant Cahir was not an employee within the meaning of s25 of the 1985 OH & S Act.^[18]

30. It follows from what I have said above that there was no basis upon which the Coroner could or should have expressed the view that Sergeant Cahir may have committed an offence under s25 of the 2004 OH & S Act. The Coroner's finding in this respect was wrong in law.

Grounds three to five

31. Grounds three to five seek to attack not only the statement set out in paragraph [4] above, but also the statement set out in paragraph [3] above. I have already concluded that the statement set out in paragraph [4] was wrongly made. I turn now to consider the statement set out in paragraph [3].

32. In summary, by grounds three to five, the plaintiff seeks to establish that the Coroner failed to take into account the uncontradicted evidence of Sergeant Cahir^[19] and to contend that

instead of making the statements set out in paragraph [3] above, the Coroner should have made the findings set out in ground four.^[20]

33. There was a delay in excess of two years between the conclusion of the hearing of the inquest and the delivery of the record of investigation into the death of Mr Biggs. In those circumstances, it is necessary to give close scrutiny to the findings and reasons of the Coroner.^[21]

34. Sergeant Cahir did not give evidence at the inquest. However, a ten page statement made by him on 23 May 2004 was tendered.^[22] The statement provided:

“HAWKINS [the third defendant] and I then travelled north in Lygon Street. As we passed the intersection that I now know to be Park Street, I looked over to my right and saw a man attacking a set of pedestrian traffic lights with what appeared to be metal bars in his hand. He was standing on the footpath closest to the south bound (east side) of Lygon Street, approximately 20 metres north from the intersection of Park Street.

My initial thoughts were that this man was crazy. He was attacking the traffic lights with incredible ferocity with an overhead motion smashing the lights facing the south bound traffic. He was like a man possessed. Jack slowed the car down and I could tell that he was about to do a U-Turn. In the same instant I realised that the man was carrying what appeared to be four swords, two in each hand. It immediately came to my mind that this man was mentally disturbed and was presenting a threat to anyone that might be around. This was based on his actions and weapons. At the time there was heavy vehicular traffic on Lygon Street, there was pedestrian traffic heavier than I would have expected at that time. I remember on Lygon Street as we were driving up, that it was unusual to see so many people out walking dogs and riding bikes at that time. The weather was fairly still, it seemed a nice night for the time of year.

There were people on the footpath north of where the man was standing but where the buildings are. On seeing the man I immediately recognised that this was a very bad situation and I was amazed that we had not received a call about this man. It was clear that he was posing a threat to any person who was in the general area.

As Jack was slowing the car and I realised he was about to do the U-Turn I got out of the car. I realised that if the car completed the U-Turn and I was still sitting in the passenger seat, I would have been placed in immediate danger. The car hadn't completed its U-Turn when I got out.

...

When I got out of the car I had a clear view to the male who had walked a couple of metres south of where he had been hitting the traffic lights. At this stage I was standing in the south bound lanes of Lygon Street. Pretty much from the time I got out of the car, I was yelling to the male, ‘Police don't move, drop the weapons’. This was almost like an automatic response from OSTT training.

Just after I got out [of] the car, I drew my firearm because I was in close proximity to the man. The firearm was in the ready position, pointed downwards not threatening but in a position where it could be quickly deployed if necessitated. Initially I walked towards the man to maintain contact and to prepare to prevent him from having contact with anyone that may have been further along the street. He turned around shortly after I took a few steps. He raised the swords from a position pointing down to a position that was higher and now pointing at me. I remember his eyes were wide open and pronounced and he was like somebody that was possessed. He appeared totally focused on me and was moving towards me.

...

There were a number of things going through my mind during the incident. I could not see that it would be an option letting the man get away from us with the weapons in the state that he presented himself. I knew that if we didn't do something then and there he would hurt or kill someone. I had no option but to get out of the car when I did. The man could not be contained. At no time was there any indication that he was going to be controlled by verbalisation.

...

I fired the shot to protect myself. I was conscious from the very first confrontation when I drew my firearm of the possibility of other persons entering the vicinity of this man.

...

I had never seen the male person before. I have no idea what motivated him to do what he did. I have no doubt that if we hadn't intervened he would have endangered the life of one of the pedestrians in the immediate area or occupants of the cars in Lygon Street.”

35. The paragraphs of Sergeant Cahir's statement extracted above are the basis for the particulars of evidence of Sergeant Cahir relied upon by him in ground three. Further, the plaintiff relied upon additional evidence given to the Coroner that:

- (a) there were at least two people (if not four people) at a nearby tram stop (some 50 to 70 metres away);
- (b) there were three people, including a young child, in the vicinity;
- (c) the surrounding area was residential, and leading through the park to the pedestrian crossing where the events took place was a walking/bicycle path; and
- (d) there was at least one car which contained four people on Lygon Street in the area opposite the lights which were being attacked by Mr Biggs.^[23]

However, there was debate before the Coroner as to whether any of these people (or others who might have happened to pass by) were in such immediate danger to require Sergeant Cahir to take the actions he took. For example, it was clear that at least one of the three people referred to in sub-paragraph (b) above (Amanda Douglas) was not aware of anything significant or untoward occurring until after the shot was fired by Sergeant Cahir. On the other hand, apart from people who might have come on the scene (along the bicycle path or otherwise), it should be noted that if Mr Biggs had wanted to make a move on the people at the nearby tram stop, he could have closed the distance between them in ten to fifteen seconds.

36. In submitting that the Coroner failed to consider the evidence of Sergeant Cahir,^[24] reliance was placed upon the Coroner's description of the events at about the time Sergeant Cahir got out of the police vehicle. The Coroner said:

"Prior to completing the turn, Sergeant Cahir exited the front passenger seat of the police vehicle. He drew his police issued firearm. As he got closer to Mr Biggs, Sergeant Cahir identified the weapons as a (sic) Samurai type swords."

37. The only evidence as to when Sergeant Cahir identified the weapons as Samurai swords came from Sergeant Cahir's tendered statement. In that statement, Sergeant Cahir said that he realised that what Mr Biggs was carrying appeared to be four swords while he was still in the police vehicle – not after he had "exited the front passenger seat". However, it is not possible to know to what extent (if any) this error of fact made by the Coroner influenced (or played a part in) the making of the statement complained of set out in paragraph [3] above.

38. Central to the investigation of the death of Mr Biggs was the issue of the appropriateness of the police response. There was evidence and significant time devoted to the question of whether an approach of containment should have been pursued (that is, a quieter approach with clear instructions delivered in a more normal, everyday voice). Further, there was debate as to whether any and what discussion or planning should have occurred between Sergeant Cahir and Leading Senior Constable Hawkins and whether there should have been a call for back-up immediately.

^[25]

39. It was submitted on behalf of Sergeant Cahir that the Coroner failed to consider the evidence of Sergeant Cahir as contained in his statement.^[26] I reject this submission. The record of investigation discloses that the Coroner gave consideration to Sergeant Cahir's statement. The statement is referred to in footnote 21 of the record of investigation. Further, notwithstanding the error of fact referred to in paragraph [37] above, it is clear that the Coroner relied upon Sergeant Cahir's statement in her description of some of the events that occurred on the evening of 22 May 2004.

40. Contrary to the submissions made on behalf of Sergeant Cahir, the Coroner was not bound to accept everything that Sergeant Cahir said in his statement. The Coroner was bound to investigate the death, weigh the evidence, determine what evidence was to be accepted and what was to be rejected, and then make appropriate findings and comments.

41. If it was my role to make findings based on the evidence given before the Coroner, I do not think I would have made findings suggesting that Sergeant Cahir relied upon "bravado and

spontaneity” (either “at the expense of policy and procedure and ... training” or at all). However, that is not my role. The question is whether it was open to the Coroner to make such a finding and/or use the language she used in her conclusion – if that is what it was. I say “if that is what it was” because there is real doubt as to whether the statement complained of by Sergeant Cahir is merely an expression of the Coroner's reasons for coming to her ultimate findings or whether the statement is a reviewable finding or determination.

42. As I have already said, the function of this Court is not to conduct a merits review of the Coroner's decision. Whilst the Coroner made a mistake as to an important matter of fact,^[27] I cannot say that it was not open to the Coroner to make the statement referred to in paragraph [3] above. If it was my role to make findings based on the evidence given before the Coroner, I do not think I would have concluded that the evidence justified any statement that might suggest that Sergeant Cahir relied upon “bravado” or “bravado and spontaneity”.^[28] There is much to be said for the proposition that Sergeant Cahir was confronted with an extremely dangerous situation on the evening of 22 May 2004 and took steps, the appropriateness of which, with the benefit of hindsight and cool reflection, can be debated. Nevertheless, the view the Coroner came to was one that was open to her and not liable to be attacked on the basis of lack of rationality or reviewable unreasonableness. To borrow from the words of Brooking JA in *Ericsson Pty Ltd v Popovski*:^[29] “the fact that a judge would differ from a magistrate [Coroner] on a question of fact does not necessarily show any more than that the view of the judge differs from that of the magistrate [Coroner] on a question of fact”.

The disposition of this proceeding

43. The plaintiff has persuaded me that the Coroner's statement set out in paragraph [4] above should not have been made. However, no legal effect or consequence attached to this statement. Indeed, I was told in argument that the DPP had advised Sergeant Cahir that the matter had been investigated and no charges would be laid. In the circumstances, *certiorari* does not lie.^[30] However, the plaintiff is entitled to a declaration.

Conclusion

44. For the reasons given above, it will be declared that the Coroner's finding that Sergeant Cahir failed to take reasonable care for his own health and safety and/or the health and safety of Leading Senior Constable Hawkins when he removed himself from the police vehicle and confronted Mr Biggs and, as such, may have committed an indictable offence as defined and intended by s25 *Occupational Health and Safety Act* 2004, was wrong in law and constituted an error of law on the face of the record.

45. I will hear the parties on the precise form of order.

[1] Cf s20 of the 1985 *Coroners Act*.

[2] See *R v The Australian Broadcasting Tribunal & Ors; ex parte Hardiman & Ors* [1980] HCA 13; (1980) 144 CLR 13; 29 ALR 289; (1980) 54 ALJR 314.

[3] See s119 of the 2008 *Coroners Act*.

[4] See generally *Maxwell v Murphy* [1957] HCA 7; (1957) 96 CLR 261 at 267; [1957] ALR 231; (1957) 31 ALJR.

[5] Either because of common law principles or the operation of s14(2) of the *Interpretation of Legislation Act* 1984.

[6] [1906] UKPC 20; [1906] AC 360; 94 LT 387; 75 LJPC 54; 22 TLR 405.

[7] Indeed, in *Colonial Sugar Refining Company*, the actual hearing in the Supreme Court occurred after the commencement of the *Judiciary Act* and the removal of the right of appeal – whereas in the present case the hearing was concluded before s59 was repealed. But cf *Australian Coal and Shale Employees Federation v Aberfield Coal Mining Co Limited* [1942] HCA 23; (1942) 66 CLR 161; [1942] ALR 281 where the relevant regulation (regulation 16AA of the Industrial Peace Regulations), on its terms, took away a right of appeal in relation to awards covered by it that had been given “whether before or after the commencement of [the] regulation”. See further *Esber v The Commonwealth* [1992] HCA 20; (1992) 174 CLR 430; 106 ALR 577; 66 ALJR 373; 15 AAR 249.

[8] But note the repeal of s19(1)(e) of the 1985 Act which dealt with the issue of contribution.

[9] And it is to be noted that the Coroner used Form 1 of the 1996 Regulations in this case (although nothing turns on this).

[10] It did not come into operation until 1 July 2005.

[11] It was also said that they were unreasonable in the sense that no reasonable Coroner could have made them, and that they were irrational and illogical in the sense recently explained by the High Court in *Minister for Immigration and Citizenship v SZMDS* [2010] HCA 16; (2010) 240 CLR 611; (2010) 266 ALR 367; (2010) 84 ALJR 369; (2010) 115 ALD 248.

As to whether a ground of *Wednesbury* unreasonableness is available in relation to factual conclusions or fact finding processes, see *Re Minister for Immigration; ex parte s 20/2002* [2003] HCA 30; (2003) 198 ALR 59 at paragraphs [73]-[74] and [142]-[146]; (2003) 77 ALJR 1165; (2003) 73 ALD 1; (2003) 24 Leg Rep 10, *Director of Animal and Plant Quarantine v Australian Pork Limited* [2005] FCAFC 206; (2005) 146 FCR 368 at paragraphs [64]-[65]; 224 ALR 103; 88 ALD 325; *Australian Retailers Association v Reserve Bank of Australia* [2005] FCA 1707; (2005) 148 FCR 446 at paragraph [562] and *Carcione Nominees Pty Ltd v Planning Commission (WA)* [2005] WASCA 56; (2005) 30 WAR 97; (2005) 140 LGERA 429, 449.

[12] [1998] VSC 297; [1999] 1 VR 69; (1998) 101 A Crim R 503.

[13] With whom Ormiston and Batt JJA agreed.

[14] *Ibid* at 78[21].

[15] *Ibid*.

[16] Form 1 under the 1996 Regulations or Form 1 under the 2007 Regulations.

[17] The record of investigation being incorporated in the record (see s10 of the *Administrative Law Act* 1978).

As to the error made by the Coroner being a jurisdictional error, see *Kirk v Industrial Relations Commission of NSW* [2010] HCA 1; (2010) 84 ALJR 154, [66]-[90]; (2010) 262 ALR 569; (2010) 113 ALD 1; (2010) 190 IR 437.

[18] "Employee" is defined in s4 of the 1985 *OH & S Act* to mean "a person employed under a contract of employment or under a contract of training". However, as has been repeatedly held, a police officer is not an employee of the Crown (see *Enever v R* [1906] HCA 3; (1906) 3 CLR 969; 12 ALR 592; *State of Victoria v Horvath* [2002] VSCA 177; (2002) 6 VR 326, 343 and *Bau v State of Victoria* [2009] VSCA 107, [126]. But cf *Konrad v Victoria Police* (1999) 91 FCR 96 where it was held that the purpose of Division 3 of the *Industrial Relations Act* 1988 (Cth) was to give effect to the convention concerning termination of employment at the initiative of the employer and therefore the word "employee" in Division 3 of the *Industrial Relations Act* was not to be confined to its common law meaning).

Further, there is no equivalent in the 1985 *OH & S Act* of s5(2) of the 2004 *OH & S Act*, which provides:

"For the purposes of this Act and the Regulations—

(a) a member of the police force or member of the Retired Police Reserve of Victoria is to be taken to be employed by the Crown under a contract of service; and

(b) despite any contrary rule of law, the contract of service and the relationship of employer and employee is to be taken to exist between the Crown and each of those members in respect of the performance of the duties and exercise of the powers as such a member (whether arising at common law, under statute, by the instructions of superiors or otherwise)."

[19] The evidence is paraphrased in the particulars under ground three set out in paragraph [17] above.

[20] Extracted in paragraph [17] above.

[21] See *Expectation Pty Ltd v PRD Realty Pty Ltd* [2004] FCAFC 189; (2004) 140 FCR 17, 32 [66] and following (and in particular [71] and [72]); (2004) 209 ALR 568; (2004) 140 FLR 17; *Hadid v Redpath* [2001] NSWCA 416; (2001) 35 MVR 152 and *A Team Diamond Headquarters Pty Ltd v Main Road Property Group Pty Ltd* [2009] VSCA 208, [54]; (2009) 25 VR 189.

[22] There was also a supplementary statement dated 22 May 2007.

[23] See the statements and evidence of Hugh Whitehead, Claire Wood and Will Stoyles and the statements of Amanda Douglas, Milli Vukovic, Christopher Oliver and Josh Roulen.

[24] And also in advancing grounds four and five.

[25] See specifically the evidence of Senior Sergeant Andrew Miles, attached to the Education Department of Victoria Police and who was in charge of the Instructor Development Specialist Courses Unit of the Operations Services Courses Division.

[26] Extracts of which appear in paragraph [34] above.

[27] The time at which Sergeant Cahir identified the weapons as swords.

[28] See the statement made in the Coroners record of investigation extracted at paragraph [3] above.

[29] [2000] VSCA 52; (2000) 1 VR 260, 265 [14].

[30] See *Ainsworth v Criminal Justice Commission* [1992] HCA 10; (1992) 175 CLR 564 at 580-1; (1992) 106 ALR 11; (1992) 66 ALJR 271; 59 A Crim R 255 (Mason CJ and Dawson, Toohey and Gaudron JJ) and *Hot Holdings Pty Ltd v Creasy* [1996] HCA 44; (1996) 185 CLR 149 at 158; (1996) 134 ALR 469; [1996] 3 Leg Rep 2 and following (Brennan CJ and Gaudron and Gummow JJ).

APPEARANCES: For the plaintiff Cahir: Mr OP Holdenson QC with Mr CJ Winneke, counsel. Minter Ellison, solicitors. For the second defendant Chief Commissioner of Police: Ms FM Ellis, counsel. Victorian Government Solicitor's Office. For the third defendant Leading Senior Constable Hawkins: Mr PJ Lawrie, counsel. Russell Kennedy, solicitors. For the fourth defendant Cooper: Victoria Legal Aid.