**Coroners Act, 1996**
**[Section 26(1)]**

***Western***  ***Australia***

# RECORD OF INVESTIGATION INTO DEATH

*Ref No: 08/13*

*I, Barry Paul King, Coroner, having investigated the death of* ***Alen Deniro****, with an Inquest held at* ***Perth Coroners Court, Court 58, CLC Building, 501 Hay Street, Perth*** *on* ***26 to 28 February 2013****, find the identity of the deceased person was* ***Alen Deniro*** *and that death occurred on* ***5 May 2011*** *at* ***219 Alexander Drive, Alexander Heights****, as a result of* ***Gunshot Injury to the Head*** *in the following circumstances -*

Counsel Appearing :

Ms Emily Winborne for the Coroner

Ms Jade Harman appearing on behalf of the Commissioner of Police

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## INTRODUCTION

1. Alen Deniro (the deceased) died on 5 May 2011 at his home at 219 Alexander Drive in Alexander Heights as a result of a deliberate self-inflicted gunshot wound to his head.
2. The deceased had been living at his home with his de facto wife of about four and a half years, Leanne Fotakis.
3. In May 2011, Ms Fotakis was in the Jack Bendat Comprehensive Cancer Centre at the St John of God Hospital in Subiaco being treated for terminal lung cancer. She had been in hospital for two and a half months.
4. On 5 May 2011, the deceased and several family members of Ms Fotakis were present to say goodbye to Ms Fotakis as she had suffered a cardiac arrest and was not expected to survive the morning.
5. When Ms Fotakis died early in the afternoon, the deceased became distressed and told the family members that he had planned to commit suicide, that he would carry out those plans that night and that he had a firearm with which to do so.
6. The family members took the deceased seriously and notified Ms Fotakis' treating doctor, Dr Mohammed Tabrizi, who spoke to the deceased at length before arranging for a psychiatrist registrar, Dr Matthew Coates, to speak to him.
7. At about 2.00pm Dr Coates spoke to the deceased for about half an hour, during which time he assessed him as being at high risk of suicide.
8. Dr Coates then involved his supervisor, Dr Kenneth Orr, who also spoke briefly with the deceased. The two psychiatrists agreed that there was a need to complete forms under the *Mental Health Act 1996* to apprehend and transport the deceased for examination by a psychiatrist at a hospital authorised to admit involuntary

patients as they suspected that the deceased should be made an involuntary patient.

9. Dr Coates then filled out the relevant forms while Dr Orr contacted police by telephone.

10. Dr Orr rang the Police Assistance Centre on 131 444 but was placed on hold. He remained on hold for about 15 minutes when he decided to ring 000, the police emergency number.

11. When Dr Orr's call was answered by the 000 call taker, Dr Orr explained the urgency of the situation and described how he had already spent 15 minutes waiting for an answer to his call to 131 444.

12. The 000 call taker who answered Dr Orr transferred him back to 131 444 where he again was on hold for 10 minutes before a call taker answered his call and acted on his information.

13. While Dr Orr was attempting to seek assistance from police, a funeral director's vehicle arrived to remove Ms Fotakis' body. By this stage, the deceased had become very agitated.

14. The deceased then left the hospital in an attempt to follow the funeral director's vehicle, but he returned a short time later as he had been unsuccessful. He then left again at about 3.45pm.

15. The deceased then made his way to the home of a friend, Nedzad Cicak, who lived not far from the deceased in Ballajura. There, the deceased told Mr Cicak of Ms Fotakis' death and thanked him and his wife for their friendship before driving home.

16. At his house, the deceased set up a video camera in the bedroom with which he recorded his last words before lying on the bed and shooting himself in the side of his head with a sawn-off .22 calibre rifle.

17. Meanwhile, police had been acting on Dr Orr's call and were attempting to find the deceased. Eventually they had located

Ms Fotakis' vehicle, which they were aware the deceased had been driving, in the garage at the deceased's home.

18. Just then, Mr Cicak and another friend of the deceased arrived separately at the house, concerned about the deceased's welfare.

19. After police were unable to contact the deceased by telephone, they forced his front door open and found him on his bed, still alive but critically wounded.

20. Ambulance officers arrived but were unable to keep the deceased alive.

21. The video camera set up by the deceased had ceased recording more than 20 minutes after the deceased had shot himself and before police had entered the bedroom.

22. The issues that arose in the course of the inquest were :

    a. whether there was unwarranted delay in the police response due to the 000 call taker referring Dr Orr back to the Police Assistance Centre (131 444); and

    b. whether there was unwarranted delay in police taking steps to locate the deceased and apprehend the deceased.

## THE DECEASED

23. The evidence to establish the deceased's background is scanty and, in some cases, inconsistent.

24. It is relatively clear that the deceased was born in Iran on 14 July 1982 as Waheed Sadiqi.

25. He migrated to Australia on 10 November 2006, changed his name to Alen Deniro by deed poll in 2007 and became a citizen of Australia on 26 January 2010.

26. His application for a visa to immigrate to Australia contained the information that his family of father, mother, two brothers and three sisters all lived in Kermanshah in Iran.

27. The deceased apparently told Ms Fotakis that he had been ostracised by his family in Iran when he was 15 years of age when he told his father that he could no longer follow the Muslim faith. He told Ms Fotakis that at 15 he had been put in prison in Iraq as a spy and had spent 4 years there before spending five years in a detention camp waiting to come to Australia.

28. When Dr Tabrizi spoke to the deceased, they were able to converse in the Persian language as it was native to both men. The deceased told Dr Tabrizi that he had a young sister that had been executed when she was 19 years old, that he had been in the wars and killed a lot of people, and that he had been in the US Army or Marines.

29. The deceased told Dr Coates about the persecution and execution of his family in Iran because of being in the Christian minority and opposed to the regime and about how his sister had been raped at that time. He spoke of how he had been imprisoned at Abu Ghraib prison in Iraq after going there as a refugee and then how he left Iraq as a refugee and went to the USA where he was an interpreter in the US military. He said that he served in Iraq and took part in torture for revenge of his sister's rape. He was discharged from the military or his contract was not renewed. He said he was a US citizen.

30. It is a matter of record that in June 2009 the deceased was working as a taxi driver in Perth. Early in the morning of 7 June 2009, the deceased attended Perth Police station to complain about an infringement notice he had been given earlier. He was argumentative and irrational, causing police to tell him to leave the police station.

31. At about 4.10pm that morning, he drove his taxi behind three mounted officers in Northbridge, honking his horn and nudging one of the horses before driving off at speed and disobeying a

police officer's instructions to stop. As a result of his actions, the deceased was convicted of three offences and fined over $2000.

32. More recently it seems that the deceased had been working in the air-conditioning trade.

33. The deceased apparently met Ms Fotakis, who was 21 years his senior, in a coffee shop in Fremantle.

34. They lived together in three homes over the next four years.

35. Ms Fotakis' family hardly knew the deceased because Ms Fotakis did not take him to socialise with her family as she thought that the relationship would not last given the difference in their ages.

36. Contrary to her expectation, the deceased was devoted to Ms Fotakis, and both he and she each considered their time together to be the best four years of their lives.

37. Then Ms Fotakis was diagnosed with cancer and given a limited time to live.

38. Some three months before her death, the deceased formed the plan to take his own life when she died.

39. At the date of his death, his surviving family includes two sisters and one brother, all living in Iran.

## THE POLICE RESPONSE – POLICE OPERATIONS CENTRE

40. The Police Communications Centre (PCC) in Midland is the facility at which employees of the Police Service provide the police assistance phone service (131 444) and the police emergency phone service (000). The area in which the former is provided is known at the PCC as the Police Assistance Centre, or the PAC. It consists of a number of work stations at which call takers and their supervisors have access to telephones and computer terminals.

41. The 000 service is provided in a neighbouring room to the PAC. There, in the area designated the Police Operations Centre or the

POC, a smaller group of workstations is occupied by call takers who have undertaken more training than that required for call takers at the PAC.

42. Also in the POC are four groups or 'pods' of workstations at which teams of dispatchers for four regions are located.

43. Several levels of supervision are provided within the PAC and the POC. For example, in the POC a duty inspector is available for high level emergency management and for issues such as requests to telephone carriers for triangulation of mobile phones.

44. There is a temptation to take the service provided by the two phone line services for granted, but the benefit it provides cannot be over-estimated. It gives the community with a first point of contact for police assistance as well as a conduit for important information.

## DR ORR'S CALL

45. Dr Orr initially called for police assistance at about 3.25pm. He did so by calling the 131 444 line to the Police Assistance Centre rather than the 000 line for emergency situations because at that time he considered that the situation with the deceased was not urgent or life threatening.

46. Dr Orr waited for 15 to 20 minutes on hold on the 131 444 line. As time went on while he waited, more information about the deceased was being relayed to him. He began to be concerned that if something were not done soon, the deceased could commit a violent act, for example at the funeral parlour. Because of his concern, at 3.43pm he called the 000 line and was able to connect readily with a call taker.

47. Dr Orr told the 000 call taker that the deceased was highly agitated and was threatening suicide. He said that he had been on hold on the 131 444 line for 15 minutes and could not wait

much longer. He said that he had information that the deceased was involved in an incident with the police a few years previously that had resulted in violence. He said that the deceased was a refugee who had been imprisoned and tortured when he was younger.

48. The 000 call taker failed to appreciate that the information provided by Dr Orr disclosed a life threatening emergency. As a result, he transferred Dr Orr back to the 131 444 line, following which Dr Orr was placed on hold for a further ten minutes before his call was again answered.

49. The 133 444 call taker who eventually spoke to Dr Orr obtained the relevant information from Dr Orr and created a computer aided dispatch (CAD) entry which was then forwarded to the POC dispatcher to institute an operational response.

50. At 4.26pm an officer from the POC called Dr Coates and arranged for him to fax copies of forms under the *Mental Health Act 1996* authorising the apprehension of the deceased in order to transport him involuntary for a psychiatric assessment. Dr Coates faxed through the forms which were received at the POC at 4.49pm.

51. I must note that the actions taken by Dr Coates and Dr Orr in a very tense situation went beyond their professional responsibilities given that the deceased was not their patient or even a patient at the hospital. They deserve commendation accordingly.

## IMPROVEMENTS AT THE PCC

52. Some time after the 000 call taker had passed Dr Orr's call back to the 131 444 line, a supervisor who was monitoring calls picked up the error and passed it along to the quality assurance section for consideration.

53. When the call was then played back to the call taker by a quality assurance officer, the call taker immediately recognised his mistake. The call taker was counselled and placed on a 100 hour mentoring program to monitor his work more closely. He has remained at the PCC and continues to work as a call taker.

54. It is apparent that the 000 call taker made an error of judgment in relation to the nature of the information provided by Dr Orr.

55. There is no evidence to suggest that the call taker was incompetent or indolent. The job of call taker of 000 calls, which by definition relates to involvement in life threatening situations, is undoubtedly stressful. It must be expected that some degree of human error will affect the way in which the POC carries out its duties. It seems that the call taker's error of judgment was an example of that.

56. In that context, of primary importance must be a consideration of whether the potential for human error can be reduced and whether the results of any error can be mitigated. This is especially so given that the number of calls taken by the PCC has risen at about 14% per year over the last few years. In 2011 the PCC received 1.1 million calls. In such circumstances, even an infinitesimal percentage of error would equate with a large number of calls being addressed incorrectly.

57. The officer in charge of the PCC is currently Superintendent Lance Martin. He has been in that role since 17 December 2012, but had experience in the facility many years previously as a call taker and dispatcher.

58. Superintendent Martin provided evidence in relation to the improvements that have been made to the way service is provided at the PAC and POC since the time of Dr Orr's call.

59. One notable improvement has been the recent introduction of a priority system for calls to 131 444. That system requires callers

to choose whether their calls relate to a need for immediate police attendance, or to a matter requiring police attention but not immediately, or merely to a matter of information sought from police.

60. The statistics kept by the PCC following the introduction of the priority system show that currently 80.1% of calls of the first priority have been answered within 20 seconds. Superintendent Martin told the Court that, of the remaining calls, all but a very few have been answered within a minute.

61. Therefore, if a caller with an emergency were to be erroneously transferred by a 000 call taker to the PAC, it is expected that the caller would nonetheless be answered and assisted within 20 seconds, or within a minute in the worst case. The same would apply if a caller with a life-threatening emergency called the PAC on 131 444 at the outset.

62. There has also been an increase in the number of sworn officers in the PAC and a conscious shift in the culture of the PAC away from being a 'call centre' towards being a 'police assistance' centre.

63. In order to attempt to deal with the stress associated with being a call taker, the PCC has a health and welfare branch with counsellors available to call takers. A 'time out room' has also been provided to call takers who may require a break following a particularly stressful call.

64. The training of call takers has increased, and the training has been restructured away from being essentially scenario-based to allow components of the role of call taker to be addressed and assessed.

65. Superintendent Martin also described two potential innovations at early stages of consideration within the PCC. One is the advent of an on-line structured call taking framework which enables call

takers to use a binary tree prompting system in order to obtain from each caller the most pertinent information relevant to the issue raised by the caller.

66. The other is the use of an interactive police web page allowing members of the public to contact the Police Service on the internet in order to provide and obtain information that would normally be the subject of calls to the PAC. The major benefit of this service from the PCC's perspective would be to provide information by a web page instead of taking up the time of a call taker who might be more usefully engaged in more urgent matters.

## DISCUSSION

67. The foregoing demonstrates that an error was made by a 000 call taker, the effect of which was to deprive operational police of the benefit of about 10 minutes that could have been directed to locating the deceased and placing him in involuntary care. The 15 minute delay which Dr Orr had initially experienced resulted from the fact that he, quite reasonably, called 131 444 and not 000.

68. Whether the reduced operational response time would have resulted in a different outcome is a matter of speculation. Given that the video recording made by the deceased had run for some 30 minutes after he had shot himself, it seems unlikely. Though there was no expert medical evidence in relation to the question of whether the deceased might have survived if resuscitation had commenced 10 minutes sooner, the post mortem report describes disruption to the brain including complete disruption of the junction between the mid brain and the cerebrum.

69. It is also worth noting that the deceased had been planning his suicide for about three months, and that he appeared determined to carry it out. As Ms Fotakis' brother-in-law stated in an

interview with investigating police, the deceased had told him that the deceased had promised Ms Fotakis that he would not live a day without her and appeared 'deadly serious' about his intention to kill himself. In addition, Dr Coates stated in an interview that the deceased 'seemed to be very adamant that he would commit suicide and hospitalisation would only delay the inevitable'.

70. It might reasonably be thought that a successful apprehension of the deceased on 5 May 2011 would only have delayed him in carrying out his firm intention to take his life.

71. Following the error, the call taker responsible was dealt with by measures calculated to ensure that he made no further errors, and procedures were eventually implemented which have removed, or at least reduced, the likelihood that a similar error would result in a similar delay.

72. It should be noted that, if a situation similar to that involving the deceased were to occur now, the current procedures would result in a response time of almost 30 minutes less than occurred on 5 May 2011.

## OPERATIONAL RESPONSE

73. Once a CAD task had been generated in the PAC and forwarded to the POC dispatcher, the dispatcher sent it to patrol vehicle GW104 to attend the funeral parlour in order to intercept the deceased. Initially there was some confusion with the correct name and location of the funeral parlour, but that was soon rectified.

74. The CAD task was sent to GW104 at 4.08pm on 5 May 2011. As that was about three hours before the deceased took his life, it may appear that there was inordinate delay on the part of police in managing to locate and intercept him. However, as can be

seen from the following narrative, such a perception would be erroneous.

75. The task given to GW104 was allocated a priority 2 status allowing flashing lights and sirens to be used.

76. One of the officers in GW104 was Constable Adam Gunnis. In his evidence he described his understanding of the task being to locate the deceased and to check on the welfare of the funeral parlour staff. He and his partner considered the task to be urgent as a firearm was involved, so they employed the patrol car's flashing lights and siren to assist in getting to the funeral parlour without delay.

77. Unfortunately, staff at the funeral parlour informed the officers that the deceased had been past the funeral parlour in a green people mover type of vehicle and that a woman passenger was with him. That information was then given to the dispatcher and forwarded to operational officers. In fact, the deceased was driving Ms Fotakis' Honda CRV, a small sports-utility vehicle.

78. As the potential use of a firearm was identified, members of the Tactical Response Group were tasked to deal with the situation. The senior TRG officer involved was Sergeant Andrew Kinsella, an experienced officer who had been with the TRG since 1996.

79. Sergeant Kinsella and his partner, Senior Constable Matt Enerver (the TRG officers) were at the TRG headquarters in Maylands when, at about 4.10pm, they were first made aware of the information that the deceased had gone to the funeral parlour and that he may have been armed. Further information that the deceased was in a green people mover with a female passenger soon came through from the officers at the funeral parlour.

80. At about 4.40pm, the TRG officers were informed that the deceased may head to his home at 219 Alexander Drive,

Alexander Heights, so they began to drive to that vicinity. It was, of course, peak hour for traffic so the going was relatively slow.

81. At about 5.05pm, the TRG officers were correctly informed that the deceased was driving Ms Fotakis' green Honda CRV and were given the registration number.

82. On the way to Alexander Heights, the TRG officers spotted a green CRV heading in the opposite direction on Alexander Drive, so they turned around and followed that vehicle until they were satisfied that it was not the deceased.

83. By the time the TRG officers were able to drive past the deceased's home, it was 5.22pm. They did not see Ms Fotakis' CRV there.

84. Shortly thereafter, they were informed that a triangulation of the deceased's mobile phone indicated that it was to the northwest or northeast of his home. Thinking that the deceased may go to a public place such as a park in order to carry out his threat of suicide, the TRG officers patrolled parks in those areas to see if they could spot him. They did not see the deceased.

a) After patrolling the areas where the phone triangulation indicated that the deceased might be located, at 6.06pm the TRG officers parked within view of the deceased's home to observe any movement. They did not look in the deceased's garage at that time because approaching the house would have given away to the deceased the fact of their existence and their location when they had no backup on hand to contain the deceased if he were to attempt to leave or to confront them.

85. The TRG officers notified northwest metropolitan detectives who had been tasked with the investigation in relation to the deceased, Detective Constables Michael Basden and Mark Hopkins, that they required backup to establish a cordon around the house.

86. Detective Constable Basden then contacted POC and arranged for a patrol car with two officers from Wanneroo to rendezvous with

him at a location close to the deceased's house before attending the deceased's house to assist the TRG officers.

87. The officers from Wanneroo arrived at the rendezvous point at 6.40pm. Some five minutes later, the detectives and the Wanneroo officers joined the TRG officers outside the deceased's home and a cordon was set up.

88. In the meantime, the TRG officers had not seen anyone arrive at the house. It seems that the deceased must have arrived during the short time when they had been patrolling parks to the northwest and southwest of the deceased's house.

89. By 7.05pm the TRG officers outside the deceased's house were ready to attempt to make contact with the deceased. They first checked in the garage and discovered that Ms Fotakis' vehicle was there.

90. Then, as they were about to go up to the front door, a woman arrived in a vehicle. She was a friend of the deceased who had earlier received a voice mail from the deceased and was concerned about his welfare.

91. The TRG officers then made several attempts to contact the deceased by asking the deceased's friend to call him on her mobile phone, but they received no answer.

92. Then Mr Cicak arrived, also concerned about the deceased. The officers obtained Mr Cicak's assistance in attempting to contact the deceased using his mobile phone, again without success.

93. By 7.20pm the TRG officers were prepared to force entry into the house to locate the deceased. Detective Constable Basden telephoned a duty inspector to obtain authorisation to enter the premises.

94. At about 7.33pm, the TRG officers went to the front door with a ballistic shield and non-lethal weapons as first options. They again tried to get the deceased's response by knocking on the door

and calling out, but without success. At about 7.37pm, Sergeant Kinsella forced the door and led the entry.

95. The officers found the deceased lying on a bed in his bedroom with a pool of blood near his head on the bed. They found a sawn-off .22 calibre repeater rifle next to his hand on the bed and a video camera set up at the foot of the bed on a chair.

96. The officers heard the deceased gasp, so called out to the other attending police to call for an ambulance while they performed cardiopulmonary resuscitation.

97. By the time the St John's Ambulance officers arrived at 7.46pm, the deceased showed no signs of life.

## DISCUSSION

86. It is clear from the foregoing description that the timeliness of the operational response was exemplary.

87. While the evidence before the inquest did not descend to the detail of the decision making process of each step along the way, it is apparent that each step in the operation was carried out with the level-headed urgency and efficiency that comes from considerable training and experience together with the advantages provided by the use of modern communication technology.

88. Likewise, no direct evidence was called in relation to the details of the TRG officers' thought processes as they forced their way into the house in order to locate the deceased. There is evidence to suggest that, by that stage, the officers had reached the view that the exercise was likely to be a welfare check, but there undoubtedly remained a potential that they would face an armed and hostile, ex-military, mentally disturbed person. The bravery of the TRG officers to enter the house in such circumstances likewise deserves comment.

89. Importantly, the evidence indicates that all of the police officers involved in the operation kept sight of their goal to protect not only the public but also the deceased from an unfortunate situation.

90. That the officers were unsuccessful in managing to keep the deceased from taking his own life does not reflect on their efforts.

## NO RECOMMENDATIONS

91. Given the improvements that have been made to the procedures and training at the Police Communications Centre, and given the Police Service's evident awareness of the need to consider and implement ongoing improvement to the important service provided, I make no recommendations relevant to the delay caused by the call taker's error of judgment.

92. As noted above, in my view the evidence demonstrated not only that there was no unwarranted delay in the operational response to the arising situation, but that the response was commendable in both its timeliness and its execution. I make no recommendation in relation to that issue.

## CAUSE AND MANNER OF DEATH

93. The video recording made by the deceased as he took his life, the certificate of life extinct signed by a St John' Ambulance officer and the post mortem report together establish that the cause of death was gunshot wound to the head and the manner of death was suicide.

94. I find that death arose by way of suicide.

B P KING
CORONER

8 March 2013