



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004422

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of Justin James Filardo

Delivered On: 14 April 2026

Delivered At: Coroners Court of Victoria
65 Kavanagh Street, Southbank, Victoria

Hearing Dates: 14 April 2026

Findings of: Coroner David Ryan

Counsel Assisting the Coroner: Ms Jess Syrjanen, Senior Coroner's Solicitor
Coroners Court of Victoria

Chief Commissioner of Police: Ms Katherine Goldberg, Special Counsel
Hall & Wilcox

Keywords: Fatal police shooting; family violence; schizophrenia

INTRODUCTION

1. On 30 July 2025, Justin James Filardo (**Justin**) was 45 years old when he was fatally shot by uniform Victoria Police members at his home in Yarra Junction, Victoria.

BACKGROUND

2. Justin was the fourth child born to parents Salvatore and Dale Filardo. His siblings were Jason, Michael, Bianca and Cristina. Jason tragically passed away when he was only two weeks old and Cristina sadly passed on Boxing Day in 2022.¹ Growing up, Justin excelled at swimming and gymnastics and enjoyed playing the cello. Dale described him as “*cheeky and always up to mischief with his brother*”.²
3. When Justin was 15 or 16 years old, he left his high school (Essendon Grammar School). Shortly before leaving, Dale observed a change in Justin. He started behaving “*out of character*” and he was required to attend the Children’s Court for minor offending.³
4. In 1997, when Justin was about 17 or 18 years old, he went on holiday with Bianca and their father. Bianca observed that Justin exhibited some unusual behaviours during the trip and stated that he “*had been acting weird*”.⁴ Dale advised Bianca that she would speak to Justin about his behaviour. Dale recalled sitting on the couch with Justin later, watching television, and noted that Justin told her to be quiet, when she had not said anything. She also noted Justin was sweating and agitated.⁵
5. Dale called a friend who lived nearby for advice as she was unsure what to do. Her friend advised her to contact their mutual friend, who was a psychiatric nurse. Dale spoke to the mutual friend, which resulted in the attendance of the Crisis Assessment and Treatment Team (**CATT**) and police officers. Justin was reportedly calm and compliant and agreed to be transported to hospital.⁶

¹ Coronial Brief (**CB**), Statement of Dale Filardo, 91.

² Ibid, 92.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid, 93.

6. Justin was admitted to the (then-named) Early Psychosis Prevention and Intervention Centre (**EPPIC**) in Parkville. Justin experienced multiple inpatient hospital admissions between 1997 and 1998 and was also managed under a Community Treatment Order (**CTO**) made under the *Mental Health Act 1986*.⁷ Justin originally received a diagnosis of bipolar disorder (single manic episode).⁸
7. From 1998 to 2004, Dale recalled that Justin worked, assisting his father to undertake renovations at their home in Ascot Vale and at a restaurant in Carlton. In 2010, Justin and Dale moved to Yarra Junction together. Dale recalled that Justin appeared the happiest during this period of his life. He was able to independently travel to see his general practitioner (**GP**) and was enrolled in business and computer courses.⁹
8. From 2000 to 2012, Justin did not receive any public mental health treatment and was managed privately by psychiatrist, Dr John Cox, at the Albert Road Clinic. He was commenced on clozapine in January 2001.¹⁰
9. In July 2012, Justin did not attend Dr Cox for regular appointments and consequently was non-compliant with his medications. His behaviour escalated at home and Dale called the CATT for assistance.¹¹ Justin presented with florid psychotic symptoms including persecutory and grandiose delusions. He was hospitalised for about two weeks at Eastern Health's Maroondah Inpatient Unit. Clinicians re-titrated his clozapine dose and briefly prescribed olanzapine.¹² His diagnosis was also revised to schizophrenia.
10. After his discharge, Justin was monitored in the community via a CTO and received case management from the Yarra Ranges Continuing Care Team. Justin's treating team gradually increased his clozapine dose to 325mg nightly by November 2012. He was discharged from his CTO in July 2013 and remained engaged with services until December 2014.¹³

⁷ CB, Joint statement of Dr Dhyanthi Devasagayam and Alan Bates, 236.

⁸ Ibid.

⁹ CB, Statement of Dale Filardo, 93.

¹⁰ CB, Joint statement of Dr Dhyanthi Devasagayam and Alan Bates, 236.

¹¹ CB, Statement of Dale Filardo, 93, 94.

¹² CB, Joint statement of Dr Dhyanthi Devasagayam and Alan Bates, 236, 237.

¹³ Ibid.

11. In December 2014, Justin transitioned to Eastern Health’s Clozapine GP Shared Care Program (**EHSCP**). Eastern Health has explained that the EHSCP is designed for patients with stable mental health and minimal case management needs. Under this model, Justin was reviewed by his GP every 28 days, and by an Eastern Health psychiatrist once every six months.¹⁴ These six-monthly reviews continued until the time of Justin’s death.

THE CORONIAL INVESTIGATION

12. Justin’s death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. Justin’s death was also reportable under section 4(2)(c) of the Act as immediately before his death he was considered to be a “*person placed in custody or care*”. The definition of “*person placed in custody or care*” in section 3(1) of the Act includes a person who a police officer is attempting to take into custody or who is dying from injuries sustained when a police officer attempted to take the person into custody. Section 52(2)(b) of the Act requires that an inquest be held into Justin’s death. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 14 April 2026.
13. At the hearing, a summary of the evidence was provided to the Court by Senior Coroner’s Solicitor, Ms Jess Syrjanen. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the brief, I was satisfied that there were no significant factual disputes or controversies which remained unresolved in order for me to make the findings required under section 67 of the Act. The Chief Commissioner of Police and the Justin’s family were given an opportunity to make submissions in relation to the evidence.
14. The Coroners Court of Victoria (**the Court**) is an inquisitorial court.¹⁵ The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if

¹⁴ Ibid.

¹⁵ Section 89(4) of the Act.

possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

15. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
16. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.
17. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.
18. Coroners are empowered to:
 - a) report to the Attorney-General on a death;¹⁶
 - b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;¹⁷ and
 - c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.¹⁸
19. These powers are the vehicles by which the prevention role may be advanced.
20. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of

¹⁶ Section 72(1) of the Act.

¹⁷ Section 67(2) of the Act.

¹⁸ Section 72(2) of the Act.

an offence.¹⁹ It is also not the role of the coroner to lay or apportion blame, but to establish the facts.²⁰

21. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.²¹
22. A directions hearing was held on 26 August 2025 at which it was confirmed that Victoria Police had assigned Detective Senior Sergeant Paul Scarlett (**D/S/Sgt Scarlett**) to be the Coronial Investigator for the investigation of Justin's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. The brief also included relevant footage from Body Worn Camera (**BWC**) of police members.
23. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

24. In the weeks prior to Justin's death, his family observed a change in his demeanour.²² Dale spoke to her son, Michael, and observed that Justin appeared to be unable to focus, was a “*bit standoffish*” and was not communicating as he normally did.²³ Dale observed that this behaviour lasted for about one week, then “*things returned to normal*”.²⁴
25. During the week leading up to the fatal incident, Dale observed that Justin was not following his usual routine. She noted he was not eating, his sleeping patterns were erratic, he was not showering or shaving, and he spent all his time in his bedroom. Dale considered that Justin

¹⁹ Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.

²⁰ *Keown v Khan* (1999) 1 VR 69.

²¹ (1938) 60 CLR 336.

²² In July 2025, Bianca was also living in the same house with Dale and Justin, and Michael was living on the property with his daughter in a separate unit.

²³ CB, Statement of Dale Filardo, 94.

²⁴ *Ibid.*

was “*sliding into psychosis*” and noted that she had observed similar behaviour in the past when he experienced an acute mental health crisis.²⁵

26. On the morning of 30 July 2025, Justin exited his bedroom and “*declared he was back*”.²⁶ Dale was relieved when he made this announcement as she had been concerned about his wellbeing. Bianca was working from home in her bedroom, upstairs.²⁷
27. Dale was out of the house for most of the day running errands. She returned home at about 3.00pm and recalled that “*everything was normal*”. Dale spoke to Bianca, who advised that she had apologised to Justin for recent arguments between them. Bianca asked Justin if he hated her and he said “*No*”, however when Bianca asked Justin if he loved her, he also replied “*No*”.²⁸
28. At some point after arriving home, Dale checked on Justin in his room as he had not emerged for some time. She asked him if he wanted a drink and observed that he had a “*strange demeanour like he had been a couple of days prior*”.²⁹ Dale observed that Justin struggled to respond but eventually advised that he wanted orange juice. Dale advised that she did not have any orange juice and offered apple juice instead. Justin replied “*Yes*”.³⁰
29. Dale recalled that she walked to the kitchen to get a glass of apple juice for Justin and returned to his room to deliver it to him. Justin pushed past Dale, walked into the kitchen and threw the juice into the sink. Dale sat on the couch, just as Bianca walked in. Dale witnessed Justin touch Bianca on the upper arm in an affectionate way. Dale felt this was a reassuring gesture and assumed it was the result of the conversation they had earlier that day. Bianca and Justin then both left the kitchen.³¹
30. About five minutes later, Dale heard Bianca screaming from her bedroom. She did not hear any words or arguing, only screaming. Dale ran to the bottom of the stairs and thought about

²⁵ Ibid, 95.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid, 96.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

climbing the stairs up to Bianca's bedroom. Dale could not hear Justin, but she could hear "thumping". She was unsure of the source of the thumping but heard two or three thumps in a matter of seconds.³²

31. Dale grabbed her phone and fled to the front of the property to call emergency services. The call was placed at 5.32pm.³³ Dale advised the operator that her "*son who has schizophrenia has just attacked my daughter*".³⁴ When asked, Dale advised the operator that she believed her son was experiencing a psychotic episode and it sounded like he was "*throwing her around*".³⁵ When asked if he had any weapons, Dale initially said no, then recalled that "*he had like an old fashioned sword under his bed*".³⁶ When the operator asked Dale about Justin's demeanour, she explained that he was not communicating like he normally does and was asking "*really strange question[s]*".³⁷
32. At 5.34pm, Warburton 304 (**EWR302**) comprising Senior Constable Jason Lodel (**SC Lodel**) and Leading Senior Constable Ben Pardo (**LSC Pardo**) was assigned to respond to the event. Millgrove 6535 (**MV6535**), an Advanced Life Support ambulance unit, was also assigned to the event about 20 seconds later.³⁸
33. When EWR302 were assigned to the event, they had just completed a job at Grand Panorama Court, Launching Place.³⁹ LSC Pardo was driving and SC Lodel was his offside. En route to the event, SC Lodel looked up the address on LEAP⁴⁰ and noted there was no history of family violence at that address. The members also discussed their approach and plan for the job. They agreed to speak to the complainant (Dale) to establish who was inside the address. They planned to move all people out of the house, if possible, then deal with Justin directly. If it

³² Ibid, 96.

³³ CB Exhibit 81, Triple Zero Victoria Event Chronology, 318.

³⁴ CB, Exhibit 80, Triple Zero call transcript, 308.

³⁵ Ibid, 311.

³⁶ Ibid.

³⁷ Ibid, 312.

³⁸ CB Exhibit 81, Triple Zero Victoria Event Chronology, 319.

³⁹ CB, First statement of SC Jason Lodel dated 31 July 2025, 120.

⁴⁰ Law Enforcement Assistance Program.

was not safe or possible to approach Justin directly, they planned to wait outside for backup.⁴¹ LSC Pardo noted that the next available police unit (Mooroolbark 302) was not close by.

34. At 5.41pm, SC Lodel called Dale while enroute to the event.⁴² When they arrived at the property on Warburton Highway, they were greeted by Justin's brother, Michael. Dale joined the group shortly afterwards. Dale appeared visibly shaken and told LSC Pardo that she was unsure whether her daughter was "*alive or dead*".⁴³ Dale explained that Justin had schizophrenia and that he had been unwell for the previous few days. She noted that she did not observe the argument, but she heard Bianca screaming and heard the "*thumping*".⁴⁴ She also noted that Justin had a sword under his bed, however, was unsure whether he was using it or had it in his possession at the time.
35. Michael explained to police how to access the property and led the members up the driveway. At the front of the property, there is a long driveway on the left-hand side, and a small unit at the front where Michael lives with his family. Behind the unit, there is a single car port and a brick structure on the right-hand side. At the end of the driveway, on the left-hand side, there is another wooden structure, with a swimming pool to the right. At the very back of the property is the main house. There is access to the main house via a small service road at the very top of the property. The main house is a two-storey structure. Bianca's bedroom and bathroom are the only rooms on the second storey.
36. The members entered the house at 5.45pm and called out to both Justin and Bianca. They did not hear a response, however as they approached the staircase, they heard a noise from upstairs.⁴⁵ LSC Pardo climbed the stairs first, closely followed by SC Lodel. LSC Pardo had a can of oleoresin capsicum (**OC**) in his right hand, while SC Lodel was holding his taser in his right hand.⁴⁶

⁴¹ CB, First statement of LSC Ben Pardo dated 31 July 2025, 112.

⁴² CB, Exhibit 22, BWC of SC Jason Lodel, 2:11.

⁴³ Ibid, 3:24.

⁴⁴ Ibid, 4:24.

⁴⁵ Ibid, 6:55.

⁴⁶ Ibid.

37. At the top of the stairs was an open door. LSC Pardo walked through the doorway, into Bianca's bedroom at 5.46.03pm. SC Lodel followed seconds later.⁴⁷
38. Inside the bedroom, there was a chair immediately to the left of LSC Pardo, which was covered with items. Directly in front of LSC Pardo, was Bianca's bed. The bed head was positioned against the left-hand wall of the room. Justin was standing up on the other side of the bed, partially leaning over the bed. Bianca was lying on the bed and had a significant injury to her left arm, which appeared to be twisted behind her back. Justin's hands were around Bianca's neck.⁴⁸
39. At the foot of the bed, on the floor, there were blood-stained items of clothing and blood stains on the carpet. In his statement to the Court, LSC Pardo recalled that Justin had his hands on Bianca's neck and it appeared as though he was trying to stop her from breathing.⁴⁹ SC Lodel recalled that Justin appeared to be "*gritting his teeth [and SC Lodel] believed [Justin] was squeezing her neck/throat a [sic] hard as he could*".⁵⁰ SC Lodel stated that he believed Justin was trying to kill Bianca.
40. LSC Pardo immediately told Justin, "*okay mate back away right now*" and pointed at the floor at the foot of the bed. Both members then shouted, "*get down*" and "*get down on the floor*". Justin did not respond to their directions. SC Lodel aimed his taser at Justin and discharged it twice. The taser appeared to make contact with Justin, as he briefly removed one of his hands from Bianca's neck to touch his upper left arm, however then returned to assaulting her.⁵¹ When SC Lodel's taser did not subdue Justin, he dropped it to the floor, removed his firearm from his holster, and pointed it at Justin.⁵² While pointing his firearm at Justin, SC Lodel directed him to "*let it go*" several times, however Justin did not comply. LSC Pardo also withdrew his taser and discharged his taser once, although it did not appear to have any effect on Justin.⁵³

⁴⁷ Ibid, 7:01.

⁴⁸ Ibid, 7:02.

⁴⁹ CB, First statement of LSC Ben Pardo dated 31 July 2025, 114.

⁵⁰ CB, First statement of SC Jason Lodel dated 31 July 2025, 123.

⁵¹ CB, Exhibit 22, BWC of SC Jason Lodel, 7:12.

⁵² CB, Exhibit 21, BWC of LSC Ben Pardo, 9:07.

⁵³ Ibid.

41. SC Lodel first discharged his firearm at 5.45.23pm. After firing the first round, he yelled “*let it go*” again, however Justin did not comply.⁵⁴ SC Lodel discharged further shots; after the third shot, Justin yelled “*ahh nup*” but did not remove his hands from Bianca’s neck and continued to hold onto her neck for the first seven shots. Between the eighth and ninth shots, Justin fell onto his side on the bed and became unresponsive. In total, SC Lodel discharged ten bullets; the last bullet was fired at 5.46.35pm.⁵⁵
42. SC Lodel then secured his firearm, immediately rushed over to the bed and placed pressure on Bianca’s significant arm wound. Bianca was conscious and breathing and moaned when SC Lodel first approached her. Bianca was able to provide her first name and surname to police. SC Lodel remained at Bianca’s side until paramedics arrived, continued putting pressure on her arm and provided reassurance to her.⁵⁶
43. LSC Pardo made a broadcast on the police radio at 5.46.48pm to advise there was a single female with significant arm injuries, however she was conscious and breathing, and that the male had been shot by police.⁵⁷
44. While awaiting paramedics and additional police, LSC Pardo exited the main house and met Michael outside. Michael had heard the gunshots and asked what had happened. LSC Pardo instructed Michael to remain at the bottom of the property (on Warburton Highway). LSC Pardo began to clear a path for paramedics and additional police members who were due to attend shortly.
45. Mooroolbark 202 (**EMB202**), which comprised Senior Constables Breanna Fowler (**SC Fowler**) and Sharlee Gray (**SC Gray**), arrived at the front of the property at 5.54pm.⁵⁸ The pair spoke to Michael, who explained how to enter the property via Adams Lane, at the rear. SC Fowler walked around to the rear of the property, to block it off with police tape, while SC Gray walked up the driveway to meet LSC Pardo.⁵⁹

⁵⁴ Ibid, 9:13.

⁵⁵ CB, Exhibit 22, BWC of SC Jason Lodel, 7:32.

⁵⁶ Ibid.

⁵⁷ CB, Exhibit 21, BWC of LSC Ben Pardo, 9:38.

⁵⁸ CB, Exhibit 26, BWC of SC Breanna Fowler, 1:01.

⁵⁹ CB, Exhibit 24, BWC of SC Sharlee Gray, 2:37.

46. SC Gray entered Bianca's bedroom at 5.58pm and checked on SC Lodel, who was still applying pressure to Bianca's arm. SC Gray checked Justin and confirmed he was not breathing and did not have a pulse.⁶⁰
47. As SC Fowler was walking along Little Yarra Road, to enter Adams Lane, she encountered the first paramedic unit, MV6535. SC Fowler entered the ambulance, and they drove to the top of the Filardo's home, on Adams Lane.⁶¹
48. Paramedics arrived in Bianca's bedroom at 6.00pm, applied pressure to Bianca's arm, taking over from SC Lodel. Paramedics observed that Bianca had suffered an incomplete amputation of her left arm, with her humerus protruding out of the upper arm. Paramedics applied a tourniquet and administered analgesia. The first paramedic unit was joined by a Mobile Intensive Care Ambulance (MICA) at 6.27pm.⁶² After treating and stabilising Bianca, paramedics pronounced Justin deceased at 6.40pm.⁶³ Bianca was later airlifted to the Royal Melbourne Hospital for further treatment and surgery.

IDENTITY OF THE DECEASED

49. On 4 August 2025, Deputy State Coroner Paresa Spanos made a formal determination identifying the deceased as Justin James Filardo, born 31 July 1979, via fingerprint identification.
50. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

51. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (VIFM) performed an autopsy on 31 July 2025 and provided a written report of her findings dated 20 November 2025.

⁶⁰ Ibid, 5:45.

⁶¹ CB, Exhibit 26, BWC of SC Breanna Fowler, 4:20.

⁶² CB, Exhibit 29, Patient Care Record of Bianca Filardo, 297.

⁶³ CB, Exhibit 27, Patient Care Record of Justin Filardo, 284.

52. The post-mortem examination revealed ten gunshot wounds with a total of nine projectiles retrieved and handed to the Victoria Police ballistics expert.⁶⁴
53. There were two gunshot wounds to the left scalp, one of which entered the skull causing a non-survivable injury to the brain. The other grazed the left scalp, travelled tangential to the head (not entering the skull) and entered the left upper back.⁶⁵
54. There was a cluster of six gunshot wounds to the left upper anterior chest and left shoulder region which resulted in fatal injuries to the heart, aorta and lungs.
55. There were two gunshot wounds to the left upper arm.
56. At the time of the autopsy, Victoria Police detectives advised Dr Zhou that the uniform members present deployed their tasers prior to discharging their service firearm. Upon examination, Dr Zhou observed two taser darts attached to the skin of the right upper anterior chest. One had a cylindrical appearance while the other appeared flatter and button shaped. The two darts were located about 3.5cm apart.⁶⁶
57. There was no evidence of significant natural disease.
58. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.⁶⁷
59. Dr Zhou provided an opinion that the medical cause of death was *1(a) Gunshot wounds to the head and left shoulder.*
60. I accept Dr Zhou's opinion.

FURTHER INVESTIGATIONS

61. As Justin's death occurred as the result of the use of police force, the Homicide Squad conducted a comprehensive investigation. This is standard procedure for fatal incidents

⁶⁴ Medical Examiner's Report, 4.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Toxicology Report, 1.

involving police use of force. The Coronial Investigator obtained statements from all members involved and gathered a range of collateral medical information about Justin's mental health.

Police investigation at the scene and after the incident

62. Sergeant Scott Ellis (**Sgt Ellis**), of the Major Crime Scene Unit, attended the scene for the purposes of collecting evidence. From Bianca's bedroom, Sgt Ellis collected a black-handled 'Procooker' knife and a brown-handled knife in a closet. The brown-handled knife was sheathed.⁶⁸ Sgt Ellis also seized an iPhone, MacBook and two iPads from Bianca's room.
63. From the kitchen, Sgt Ellis located three kitchen knives in a bag and a butcher's knife set, both on top of the refrigerator. In Justin's bedroom, Sgt Ellis located a large sword which was snapped at the handle. The blade was still in its sheath. Amongst some loose items in Justin's room, Sgt Ellis located a black-handled 'Tramontina' knife.⁶⁹
64. Of note, none of the bladed weapons recovered from the home had any traces of blood on them. The only blood observed at the scene was in Bianca's bedroom upstairs (both on the floor at the foot of the bed and on the bed).
65. The court contacted D/S/Sgt Scarlett to seek his opinion regarding the likely cause of Bianca's injuries in the absence of blood on any of the bladed weapons within the house. D/S/Sgt Scarlett noted that Bianca understandably has a limited recollection of the events, and Dale did not witness the assault itself. Bianca's initial recollection was that the assault commenced downstairs near her mother's ensuite door.
66. Based on the location of blood within Bianca's room and the absence of blood anywhere else in the house, D/S/Sgt Scarlett opined that the most serious phase of the assault likely occurred within Bianca's bedroom.
67. Given Bianca's limited recollection of the incident, I am unable to conclude with certainty where the assault commenced, or the weapon(s) used. In all the circumstances, I am satisfied

⁶⁸ CB, Statement of Sgt Scott Ellis, 172.

⁶⁹ Ibid, 173.

that I do not need to resolve this issue, as I am satisfied that the assault was perpetrated by Justin and there is no evidence of third-party intervention.

Mental health treatment

Eastern Health

68. As noted above, Justin received six-monthly reviews by an Eastern Health psychiatrist, as part of their EHSCP. Justin's last review by Eastern Health occurred on 5 March 2025. Consultant Psychiatrist Dr Dhyanthi Devasagayam (**Dr Devasagayam**) and Registered Nurse Alan Bates (**RN Bates**) attended Justin's home for a face-to-face review. Justin reported that he felt well and was compliant with his clozapine treatment regime.⁷⁰ Justin spoke about a recent holiday to Queensland and described some of his activities while there.
69. Justin denied experiencing any side effects of clozapine including chest pain, pyrexia or difficulty breathing. He reported being able to assist his mother with chores around the house and confirmed he was attending monthly appointments with his GP.⁷¹
70. Dr Devasagayam and RN Bates recorded that Justin's mood was level, his speech was coherent, his concentration was fair, and his insight was intact (he was aware of the need for ongoing compliance). Justin was otherwise alert, awake and cooperative with no evidence of hallucinations, delusions or suicidal/homicidal ideas or plans.⁷²
71. The agreed plan made by Dr Devasagayam and RN Bates was to continue clozapine and regular GP reviews. They documented that Justin was willing to have a repeat echocardiogram, as his last echocardiogram occurred in May 2022. They also discussed lifestyle changes for weight loss and to improve Justin's social interaction, however he was resistive to those suggestions.⁷³

⁷⁰ Eastern Health records for Justin Filardo, 44.

⁷¹ Ibid, 45.

⁷² Ibid.

⁷³ Ibid, 46.

Yarra Junction Medical Centre - GP

72. Justin's most recent appointment with his GP, Dr Gamini Colombage (**Dr Colombage**) was on 4 July 2025. Justin presented for review of his blood test results and repeat clozapine prescriptions. Dr Colombage noted that Justin presented at his usual baseline mental and physical state. He did not disclose any thoughts, intentions or plans to harm himself or others. Dr Colombage noted that there were no clinical signs to suggest Justin was at risk to himself or others.⁷⁴

Non-compliance with medication

73. Dr Colombage and Eastern Health clinicians were unaware of Justin's non-compliance with medications in the days prior to the fatal incident. From the available evidence, it is unclear when Justin ceased taking his medication.

74. At my direction, the Court obtained an expert opinion from Professor Olaf Drummer (**Prof Drummer**), a forensic pharmacologist and toxicologist, employed in a part-time capacity by VIFM. Prof Drummer was asked to interpret Justin's post-mortem toxicology results and provide advice about the likely period of non-compliance.

75. Prof Drummer explained that clozapine is an atypical antipsychotic drug with complex actions, acting as a blocking drug on serotonin and dopamine receptors. He noted that clozapine is readily absorbed when taken orally, with maximum blood concentrations usually achieved within a few hours of consumption.⁷⁵ The elimination half-life of clozapine is about six to 12 hours. This means that once the drug is absorbed, it will be removed by the body such that the concentration halves every six to 12 hours.⁷⁶

76. Prof Drummer explained that there is variation in the elimination rate from one person to another, and loss of drug in tissues can be somewhat slower, particularly in poorly perfused tissues. Prof Drummer noted evidence which suggests within one to two weeks of cessation

⁷⁴ CB, Statement of Dr Gamini Colombage, 245.

⁷⁵ Statement of Prof Olaf Drummer, 2.

⁷⁶ Ibid, 3.

of clozapine, a number of withdrawal symptoms appear. This includes withdrawal-associated psychosis, cholinergic rebound,⁷⁷ catatonia, and serotonergic discontinuation symptoms.⁷⁸

77. It is unclear why Justin self-ceased his clozapine tablets or precisely when he last took a tablet. According to Dale, Justin's behaviour in the week of the fatal incident was unusual (week commencing 28 July 2025). In my view, it is likely that Justin ceased his clozapine tablets one to two weeks prior to the fatal incident, but after his last appointment with Dr Colombage on 4 July 2025, where no symptoms of schizophrenia, psychosis or mood disturbances were observed.

Cause of injury to Bianca's arm

78. At my direction, the Court obtained an expert opinion from Forensic Physician, Dr Maaike Moller (**Dr Moller**), of VIFM. The purpose of the report was to attempt to identify the mechanism of the injuries sustained by Bianca.

79. Dr Moller reviewed Bianca's medical records following the incident. She noted the radiological findings on imaging of the left upper arm, including a laceration of the distal humeral anterior, muscle separation adjacent to the humerus, dislocation of the elbow joint and traction injury to the nerves.

80. Dr Moller concluded that a plausible explanation for the injury to the arm would be at least one application of sharp force trauma in the horizontal plane to cause the skin defect, with a hyperextension force to cause the dislocation and nerve traction injuries. Other applications of both sharp or blunt force could not be excluded.⁷⁹

81. In the circumstances, I am unable to determine exactly how Justin inflicted the injury to Bianca's arm. It is likely that it occurred from a combination of a sharp object and blunt force. I am unable to determine what sharp object was used.

⁷⁷ Symptoms may include nausea, vomiting, sweating, agitation, confusion, tremors, anxiety, psychosis, and delirium, amongst others.

⁷⁸ Statement of Prof Olaf Drummer, 3.

⁷⁹ Ibid, 5.

Investigation of use of lethal force by police

Testing of firearm involved

82. Acting Sergeant Christian Tomming (**A/Sgt Tomming**), a firearm and toolmark examiner, attended the scene and investigated the use of firearms by the attending members. A/Sgt Tomming recovered:

- a) Ten fired cartridge cases
- b) Four fired taser ‘barbs’
- c) Various fired bullet fragments
- d) Various fired taser components⁸⁰

83. A/Sgt Tomming seized the firearms and tasers involved in the incident, for further examination and testing.

84. Upon a review of SC Lodel’s firearm, A/Sgt Tomming was able to load test bullets into the weapon, and it fired as expected. He conducted a series of tests to determine if the firearm could be discharged by any other means (e.g., dropping the firearm). The test results were normal, and the weapon did not accidentally discharge.⁸¹ All safety features (magazine safety, striker safety, trigger safety and out of battery safety) were tested and found to be functioning normally.⁸²

Testing of tasers involved

85. D/S/Sgt Scarlett enlisted the assistance of New South Wales Police Force (**NSWPF**) Senior Technical Officer Christian Halbmeier (**STO Halbmeier**) to review the two tasers deployed by LSC Pardo and SC Lodel in this incident. STO Halbmeier noted that SC Lodel’s taser was discharged twice while LSC Pardo’s taser was discharged once.⁸³

⁸⁰ CB, Statement of A/Sgt Christian Tomming, 175-178.

⁸¹ Ibid, 179.

⁸² Ibid.

⁸³ CB, First statement of STO Christian Halbmeier dated 23 October 2025, 222, 229.

86. At my direction, D/S/Sgt Scarlett obtained a supplementary statement from STO Halbmeier, with respect to the effectiveness of the two taser devices used. STO Halbmeier had regard to the technical data downloaded from the two tasers, in combination with viewing the BWC footage of both LSC Pardo and SC Lodel.
87. STO Halbmeier noted that the first discharge of the taser “*appear[ed] to have little to no effect on [Justin]*”. He noted that SC Lodel discharged his taser again a few seconds later, which also had limited effect on Justin.⁸⁴ STO Halbmeier opined that the aiming point for both cartridges appeared to have sufficient probe spread, given the nature of the violent event that was occurring.⁸⁵
88. STO Halbmeier noted that when LSC Pardo discharged his taser, Justin appeared to let out a scream, however, did not appear to react in any other appreciable manner.⁸⁶
89. The two tasers were otherwise found to be in normal working order and functioning as expected.

Decision to engage lethal force

90. According to the *Victoria Police Manual – Operational safety and the use of force*, members are instructed that the use of operational safety equipment (**OSE**) must be in accordance with specific legal requirements. Victoria Police uses the safety tool ‘SAFE TACTICS’ to support decision-making when using OSE. There are various reporting requirements for members to complete after using or threatening to use an OSE.⁸⁷
91. In the present case, the members approached the scene with the knowledge that they may have to use OSE. LSC Pardo had his OC spray in his hand, while SC Lodel had his taser drawn. Before using any force, the members clearly directed Justin to get on the floor and let go of his sister. When Justin did not comply, the members escalated to the use of a taser.

⁸⁴ Second statement of STO Christian Halbmeier dated 2 February 2026, 3-4.

⁸⁵ Ibid.

⁸⁶ Ibid, 5.

⁸⁷ Victoria Police Manual – Operational Safety and the Use of Force (as at 29 April 2025).

92. I note that OC spray was an option that was not deployed on this occasion. Given the perilous scene confronted by the police members, the clear and ongoing threat to Bianca's life which required an immediate and urgent response and the ineffectiveness of the tasers, I am satisfied that it was reasonable for OC not to have been deployed in this case. Further, the deployment of OC spray would likely have caused significant further pain and distress to Bianca given the acute and open nature of the wound to her arm.
93. I further note that the members could have physically engaged Justin directly. However, I am satisfied that this would have represented an impractical and potentially dangerous option for the members given that from their perspective he was possibly armed. Further, noting his response to the deployment of the tasers, it may have taken some time to overpower and restrain Justin in circumstances where it was clear that Bianca had a life-threatening injury which required urgent treatment.
94. Although only three of the four possible taser rounds were deployed (between the two members), it is clear from a review of the BWC footage that these did not have an appreciable impact on Justin, as he continued to assault his sister. Further, the first seven bullets did not have an appreciable effect on Justin, and it was not until between the eighth and ninth bullets that Justin ceased his assault and fell to the side. In all of the circumstances, I am satisfied that it was appropriate and proportionate for SC Lodel to discharge his firearm to subdue Justin, particularly where less than lethal options were ineffective, impractical or unsafe. In my view, the use of lethal force was also justified given the significant and imminent risk to Bianca's life.

FINDINGS AND CONCLUSION

95. Pursuant to section 67(1) of the Act, I make the following findings:
- a) the identity of the deceased was Justin James Filardo, born 31 July 1979;
 - b) the death occurred on 30 July 2025 at 4 Adams Lane, Yarra Junction Victoria 3797, from gunshot wounds to the head and left shoulder; and
 - c) the death occurred in the circumstances described above.

96. Having considered all of the circumstances, I am satisfied that the use of lethal force by the police officers was appropriate and proportionate. I note that the members were confronted with a shocking scene when they arrived in Bianca's bedroom. Urgent action was required and events unfolded rapidly as they responded to Justin's ongoing assault of his sister. When he did not comply with their directions, the members appropriately attempted to subdue Justin with a less than lethal option. When that option did not successfully subdue Justin and address the ongoing threat he presented, I am satisfied that the only reasonable option was to engage him with the use of lethal force.
97. I commend that actions of LSC Pardo and SC Lodel who were required to respond to a horrifying scenario. I have no doubt that the incident has had a significant effect on them. It is likely that their actions saved Bianca's life. In particular, SC Lodel's rapid transition from deploying force to administering first aid and providing comfort to Bianca was remarkable. Tragically, it has also resulted in Justin losing his life. However, I am satisfied that Justin's death could not have been avoided given the serious and ongoing threat to Bianca and the ineffectiveness of non-lethal options.
98. Finally, I note that prior to this incident, Justin's mental health appeared to have been relatively stable for many years. I am satisfied that the treatment provided by his GP and Eastern Health was reasonable and appropriate. For reasons that may never be known, Justin ceased taking his medication in the weeks before the incident, which led to a deterioration in his mental state with the development of psychotic symptoms. I convey my sincere condolences to Justin's family for their loss. The circumstances of his death have had a devastating impact upon them. It must be acknowledged and remembered that Justin suffered from a significant mental illness and was very unwell at the time of the incident.

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

Michael Filardo, Senior Next of Kin

Chief Commissioner of Police (C/- Hall & Wilcox)

Eastern Health

Inspector Stuart Yin

Sergeant Andrina Anderson, Professional Standards Command Oversight Investigator

Detective Senior Sergeant Paul Scarlett, Coronial Investigator

Signature:



Coroner David Ryan

Date: 14 April 2026



NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
