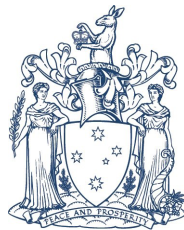

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 0399

FINDING INTO DEATH AFTER INQUEST OF BENJAMIN PETER MADEX

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	Jacqui Hawkins, Deputy State Coroner
Delivered on:	22 August 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank, Victoria, 3006
Counsel Assisting:	Ms Megan Fitzgerald of counsel, instructed by Samantha Brown, Principal In-House Solicitor and Ms George Carrington, Coroner's Solicitor, Coroners Court of Victoria
Chief Commissioner of Police:	Mr Andrew Imrie of counsel, instructed by Dora Cosentino, Minter Ellison
Sgt Murray Brown and Leading Senior Constable Kellow	Ms Rachel Ellyard of counsel, instructed by Katherine Goldberg, Norton Rose Fulbright
Monash Health	Mr Dugald McWilliams of counsel, instructed by Sophie Pennington and Claire Fairley, HWL Ebsworth

Catchwords: MENTAL HEALTH ACT 2014 (VIC), COMMUNITY TREATMENT ORDER, CLINICAL FORENSIC RISK ASSESSMENTS, VOLUNTARY TREATMENT, FORWARD COMMAND, POLICE PURSUIT, EXTENDED FOLLOW, HOSTILE VEHICLE, POLICE SHOOTING, REASONABLE FORCE

BACKGROUND

1. Benjamin (Ben) Peter Madex was 31 years old when he died on 21 January 2021 after being shot by police in Drouin. He is survived by his mother, Loreen Mitchell and his younger brother, Stephen, and two older half-sisters.

2. Ben grew up in and around the Latrobe Valley. His parents, Loreen Mitchell and Peter Madex separated when Ben was about four years old. Loreen describes Peter as having been violent towards her during the relationship and having substance abuse and mental health issues. Peter took his own life when Ben was about five years old.

3. From a young age, Ben struggled with behavioural issues and likely mental health issues. His issues with anger and violence resulted in expulsions from both primary and secondary schools, as well as interactions with the police and the requirement for foster and residential care arrangements from his early teens. Ben began drinking alcohol in his early teens and soon moved onto 'party drugs' and cannabis. Later, his drug use involved heroin, methamphetamine (or ice), as well as prescription medications. Ben's drug use appears to have been a catalyst for worsening mental health and escalating criminal offending.

4. Ben first appeared before a court in relation to criminal offending when he was only 14. The offending continued throughout his teens. He served his first term of imprisonment in 2009, aged about 19. As a result of armed robberies on pharmacies and other violent offending, Ben spent about eight years of his adult life in prison. His final release from prison occurred in September 2020.

5. Ben was hospitalised for mental health crises in 2015 and again in 2016. He was diagnosed with schizophrenia in early adulthood.

CORONIAL INVESTIGATION

Jurisdiction

6. Ben's death constituted a *'reportable death'* pursuant to section 4(2) of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and immediately before death he was a person placed in custody or care. The definition of a "person placed in custody or care" relevantly at subsection 3(j) 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.

7. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

8. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9. 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.

10. 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.

11. Coroners are empowered to:

    (a) report to the Attorney-General on a death;

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; 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.

12. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or

[1] Section 89(4) *Coroners Act 2008.*

may be, guilty of an offence.[2] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3]

Standard of Proof

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[4] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[5]

14. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

15. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[7] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[8]

Sources of evidence

16. This Finding draws on the totality of the material obtained in the coronial investigation of Ben's passing. That is, the court file, the Coronial Brief and any further material obtained by the Coroners Court, together with the transcript of the evidence adduced at Inquest and the submissions hearing.

17. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the

[2] Section 69(1). 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.
[3] *Keown v Khan* (1999) 1 VR 69.
[4] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[5] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[6] (1938) 60 CLR 336.
[7] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

interests of narrative clarity. The absence of reference to any particular aspect of the evidence should not lead to the inference that it has not been considered.

CIRCUMSTANCES OF BEN MADEX'S DEATH

Background

18. Ben was released from prison on 3 September 2020. This was during a Covid-19 lockdown in Melbourne. He was staying with his friend, John Persoons.[9]

19. On 7 September 2020 Ben was admitted for mental health care at Casey Hospital, following self-harm by cutting his throat, with suicidal intent. He was initially placed on an Assessment Order,[10] and later, a Compulsory Treatment Order[11] and remained an inpatient until he was discharged on 18 September 2020.

20. Between 18 and 25 September 2020 Ben's mental health was managed in the community by the Crisis Assessment and Treatment Team (**CAT Team**) pursuant to a Community Treatment Order. On 25 September 2020 Ben's mental state again declined and he returned to Casey Hospital where he was admitted on an Inpatient Temporary Treatment Order.[12]

21. Ben's treating health practitioners at Monash Health sought to have Ben remain subject to compulsory treatment for a period of 26 weeks, to stabilise his condition. However, on 1 October 2020 the Mental Health Tribunal revoked the treatment order on the basis that it was "not satisfied that a Treatment Order is the only way to ensure you will get the treatment you need – criteria (d)".[13] That is, the Mental Health Tribunal was not satisfied that Ben's condition and circumstances met the criterion set out in section 5(d) of the *Mental Health Act 2014* (Vic), being that "there is no less restrictive means reasonably available to enable the person to receive the immediate treatment" they need.

22. Following the determination of the Mental Health Tribunal, Ben became a voluntary patient and was discharged from Casey Hospital on 2 October 2020 to the care of the CAT Team. On 13 October 2020 he was assessed by psychiatric nurse, Margaret Bepete and transferred to the Cranbourne Continuing Care Team (**CCT**).

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[9] Exhibit 1, Coronial Brief, pp141-5, 146-52
[10] Exhibit 2, Monash Health Records, p 27.
[11] Exhibit 2, Monash Health Records, pp 26, 29.
[12] Exhibit 2, Monash Health Records, p 10.
[13] Exhibit 2, Monash Health Records, p 11.

23. On 19 October 2020 Calvin Jutasi, a psychiatric nurse and forensic specialist at Monash Health, performed a forensic assessment of Ben. On 22 October 2020 he produced a report based on this assessment.[14] In his report, Mr Jutasi recorded that Ben had justified his past violent behaviour, without expressing remorse or empathy towards his victims; that he stated that violence was necessary, and he was justified in carrying weapons; and that he has had financial difficulties since leaving prison and had thoughts to reoffend in order to return to prison. He noted persecutory ideation regarding Victoria Police and an intention to continue using illicit substances.

24. In summarising the risk Ben posed, Mr Jutasi stated:

> …Mr Madex is judged to present as High risk of interpersonal violence towards others…harm that could result from interpersonal violence is likely to be high and would likely include use of a sharp weapon or object… [15]

25. He also noted:

> He has a history of violence towards police. He has reported negative outcomes when he had had contact with police members and has no regard for them. Mr Madex is likely going to violently attack any police members that he has contact with and will most likely use a sharp weapon or object. Professionals having direct contact with Mr Madex are also at risk of being physically harmed. He has previously made threats towards professionals working with him when his needs are not met. These professionals include mental health clinical staff on both inpatient and community settings, correctional workers and GPs.[16]

26. Among this risk management recommendations, Mr Jutasi stated:

> It is best that there is a <u>low threshold</u> for inpatient admission if he has impaired or deterioration in his mental state, including high risk of interpersonal violence. Treating teams to also consider the duty to warn when they have any concerns regarding the safety of others, particularly if he is targeting specific individuals.[17]

27. As a result of Mr Jutasi's assessment, risk management practices were implemented by Monash Health staff, including that home visits were not to occur and all consultations were to take place with two security staff present. This could not be accommodated at Ben's local health service site, so he was required to travel to Casey Hospital for appointments. While efforts were made to facilitate this, including the provision of cab charges by Monash Health and offers to pay for transport by Ms Mitchell, Ben failed to

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[14] Exhibit 2, Monash Health Records, pp 196-206.
[15] Exhibit 2, Monash Health Records, p 202.
[16] Exhibit 2, Monash Health Records, p 203.
[17] Exhibit 2, Monash Health Records, p 205.

engage in ongoing voluntary community mental health care. On 23 November 2020, he was discharged from Cranbourne CCT to the care of his general practitioner, Dr Ken Bowes.[18]

28. Ben presented again at Casey Hospital on 19 December 2020, with increased paranoia. He was made subject to an assessment order.[19] At the time of presentation Ben disclosed that he was carrying a knife. Hospital staff searched Ben and his belongings and confiscated a knife.

29. On the morning of 20 December 2020 Ben was assessed by a registrar, along with consultant psychiatrist, Dr Ajay Vijayakrishnan. Dr Vijayakrishnan formed the view that Ben did not meet the criteria for compulsory treatment set out in section 5 of the *Mental Health Act 2014* and revoked the assessment order. Ben agreed to be admitted as a voluntary inpatient.

30. Later that day, an incident occurred in which Ben became agitated and aggressive when a female patient he was reportedly being overly friendly with was transferred to a different ward. A code grey was called. During the incident, Ben was again found to be in possession of a knife. At this time, Dr Vijayakrishnan decided to discharge Ben from the hospital. Dr Vijayakrishnan states that the decision was made on the basis of balancing the risks of Ben remaining as an inpatient versus being discharged. Dr Vijayakrishnan considered that Ben was a voluntary patient and his treatment needs could be met in the community.[20] No ongoing treatment arrangements were put in place by Monash Health (save for phone contact on 25 December 2020).[21] It does not appear that Ben's general practitioner was provided with a discharge summary or any advice regarding the ongoing management of his mental health at this time.

31. Over the month or so prior to his death it appears that Ben's paranoia increased, and he was struggling with the pressures of living in the community. His mother and friends all reported escalating paranoia, carrying knives in the belief that people were out to get him, and believing people were talking about him behind his back.[22]

[18] Exhibit 2, Monash Health Records, p 96.
[19] Exhibit 2, Monash Health Records, p 8.
[20] Exhibit 1, Coronial Brief, p 577.
[21] Exhibit 2, Monash Health Records, p 600.
[22] Exhibit 1, Coronial Brief, pp 133-140, 141-5, 156-8, 153-5.

32. Ben fell out with his friend John Persoons and was told to move out. However, they stayed in contact. Ben then spent some time living with another friend, Shelly Wilmink, but Ben's drug use, paranoia and carrying knives meant that this became unsustainable, so Shelly helped him to move into a boarding house.[23]

33. Text messages Ben sent to his mother between 13 December 2020 and his death provide insight into his paranoid state of mind and difficulties coping.

34. Ben had reportedly been dealing drugs in the lead up to his death and became indebted to drug dealers.[24] This appeared to increase his fears, whether real or paranoid.

35. Over 19 and 20 January 2021 Ben became paranoid that his friends had been calling him a paedophile. He made visits to Shelly Wilmink, John Persoons and his mum where he relayed these paranoid thoughts and made various fatalistic statements.[25]

Events of 21 January 2021

36. In the days leading up to his death, it is unknown how, but Ben came to be in possession of a Ford Territory. At about 7.00am on the morning of 21 January 2021 Ben crashed the Ford Territory, flipping it onto its side in a ditch on the side of Boolara-Mirboo North Road. A local dairy farmer, Fiona Baker came to Ben's aid. At his request, she drove Ben to a service station in Mirboo North. Ben appeared unharmed from the accident. Ms Baker observed that Ben was polite, said that he had been in Melbourne the night before, and smelled of alcohol.[26] Ms Baker took a photograph of Ben standing in front of the upturned Ford Territory.[27]

37. Ben purchased a cigarette lighter at the service station, then appears to have walked across to Baromi Park, which is adjacent to the service station.

Car theft and driving incident

38. At approximately 7.35am Anthony Brusamarello parked his Audi in the carpark of Baromi Park to await the arrival of his boss. Moments later, Ben approached Mr Brusamarello's car and produced a large knife.[28] According to Mr Brusamarello, Ben

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[23] Exhibit 1, Coronial Brief, p 156.
[24] Exhibit 1, Coronial Brief, pp 143-4.
[25] Exhibit 1, Coronial Brief, pp 157, 144, 131, 139.
[26] Exhibit 1, Coronial Brief, pp 170-1.
[27] Exhibit 1, Coronial Brief, p 17.
[28] Exhibit 1, Coronial Brief, p 174.

calmly told him that he was taking his car, allowed Mr Brusamarello to keep his iPad and phone, and then apologised as he stole the Audi.[29] Mr Brusamarello immediately reported the incident to police.

39. At 7.42am the job was dispatched to police. Over the course of about an hour and a quarter, Ben drove at dangerously high speeds and extremely erratically while police attempted to locate and arrest him.

40. At about 8.00am Darren Millsom observed the Audi drive at a speed estimated to be about 80kmph through a roadworks roadblock. The Audi almost hit a road worker, mounted the footpath to avoid a bobcat, then accelerated again, narrowly missing the bobcat as it passed a roadworker.[30]

41. One of the road workers, Lochie Faust, says "as he got really close to me, I moved off the road and he swerved towards me causing me to then have to take a massive leap off the road."[31]

42. Another witness, Roma Hall described being dangerously overtaken before seeing the Audi overtake a truck across double lines and then pass through a roundabout at around 8.10-8.15am. She commented, "I thought someone was going to get killed…how he made it in front of the truck and through the roundabout I do not know…".[32]

43. Witness Shelley Hankinson described,

> the car was flying. He came up behind me in the right hand lane and then pulled into the left hand lane after he overtook the car behind us. He then passed me and the ute on the inside lane and then pulled out in front of the ute and then went straight over into the shoulder on the right hand side, kind of creating a third lane… rocks were showering everywhere…[33]

44. Wayne Comer called triple zero after he observed the Audi dangerously overtaking other vehicles and clipping the side of his own, by travelling outside of the marked lanes.[34]

45. Shortly after Mr Comer reported his observations to police, he saw Sergeant (**Sgt**) Murray Brown and Leading Senior Constable (**LSC**) Jodi Kellow parked on Princes

[29] Exhibit 1, Coronial Brief, pp 428-41.
[30] Exhibit 1, Coronial Brief, pp 195-7.
[31] Exhibit 1, Coronial Brief, pp 198-200.
[32] Exhibit 1, Coronial Brief, pp 201-2.
[33] Exhibit 1, Coronial Brief, pp 214-5.
[34] Exhibit 1, Coronial Brief, pp 203-6, 442-7.

Highway in a police vehicle and made a report directly to them, before driving on. Moments later, the Audi passed Sgt Brown and LSC Kellow's vehicle at high speed.

46. Sgt Brown stated that the Audi was going at a fast rate of speed. "By the time I had our car in drive and was on the freeway the Audi was out of sight…"[35] Sgt Brown continued to follow the vehicle for some time, driving at high speed, before catching up to the Audi when it encountered traffic. When Sgt Brown got within about 50m of the Audi, he attempted to intercept it by activating his emergency lights and siren. Within seconds, as the Audi accelerated, he decided to terminate the pursuit.

47. LSC Kellow gave similar evidence about following the Audi and the brief pursuit.[36]

48. Shortly after, Sgt Brown and LSC Kellow observed the Audi turn into a dead-end road in an apparent attempt to avoid traffic caused by road works. Sgt Brown drove after the Audi and attempted to block it in. The Audi drove over an embankment to avoid the police vehicle and turned back onto Princes Way.

49. LSC Kellow had been communicating their observations and actions to D24 via police radio.

50. Officer 1 and Officer 2 were in an unmarked police SUV near the dead-end road. Monitoring police communications, they began to drive towards the expected location of the Audi, with emergency lights on. They came up behind a white Holden Commodore (Commodore) in the east-bound lane. Moments later, they observed the Audi driving west bound on the wrong side of the road. Thinking a collision was imminent, Officer 2 slowed down and avoided the collision between the Audi and the Commodore.[37]

51. Daryl Casey, the driver of the Commodore described the events this way:

> I looked in my mirror and noticed a black SUV Police vehicle with its blue and red lights flashing. I thought they were trying to pull me over. I very briefly looked down and flicked my left indicator on. I would have looked down only a second. When I looked [up], there was a car coming straight at me. I didn't get a chance to do anything and next thing I knew there was the bang of the airbag going off and dust in my eyes…[38]

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[35] Exhibit 1, Coronial Brief, pp 279-88.
[36] Exhibit 1, Coronial Brief, pp 289-302.
[37] Exhibit 1, Coronial Brief, pp 314-21, 303-13.
[38] Exhibit 1, Coronial Brief, pp 223-5.

The shooting incident

52. Officer 2[39] stopped the SUV and Officer 1 got out and approached Ben. A moment later, Officer 2 came to the scene as well.

53. Officer 1 described coming upon the collision and observing the Audi driver alight from the vehicle while it was still moving and facing the Commodore. He stated:

> …I followed the offender towards the white commodore and I shouted "Stop Police, Stop Police"… He looked like he was heading towards the commodore with intent. After yelling out, a few moments later the offender stopped and turned around and looked directly at me. I saw that he was holding a large 20-30 centimetre bladed hunting knife in his left fist with the blade pointing directly at me. I can't recall exactly what he was saying, but he sounded aggressive and was saying something to me. As soon as he turned around he was fixated on me.
>
> At this time the male was about six to eight metres away from me. I started to back away. I shouted a number of times "Drop the knife, drop the knife!" The male continued to walk directly at me at a fast pace. I continued to yell "Drop the knife!" I was aware that behind me was a steel road barrier and I was getting close to it. The male kept closing distance so I continued to yell at him "Drop the knife!" Once he got to maybe five to six metres away, I removed my firearm from the holster. I immediately raised and pointed my firearm at the male and shouted "Police don't move, drop the knife!" He continued to walk at me. He got within three to four metres of me. At this point I feared for my life. I was in fear that I would be seriously injured or killed if he was to get any closer. I aimed my firearm at the male's centre of mass and I fired one shot. He continued to move forward so I quickly fired a second shot.

54. Mr Casey described what he saw of the shooting:

> I was in shock to begin with…
>
> …I saw a male…He was running down the hill back towards the silver Audi and the black police car. I was watching from a distance, he had something in his right hand…
>
> I heard people yelling, I'm pretty sure the words were "drop to the ground." They yelled that at least twice. The male was still moving towards.
>
> I then heard 2 very loud bangs almost one after the other. I knew the sounds immediately were gun shots…[40]

55. Mick Henry also witnessed the incident:

> The male ran to one of the cars that were stopped and it looked like he was going to get into the driver's side of the car. He stopped for a few seconds and turned

[39] Officer 1 and Officer 2 are pseudonyms as per Order dated 15 May 2023.
[40] Exhibit 1, Coronial Brief, pp 223-5.

> around and looked at the police members. One of the police had his gun drawn and the other didn't.
>
> The male ran diagonally straight at the closest police officer and I heard 2 shots "bang, bang"…The police officer that was being run at was running backwards to make distance…[41]

56. Ian Robinson, who was in his car near the collision, observed that Ben approached his car with "…an angry expression on his face. I observed the male was carrying a knife in his right hand…I believed the male's intention was to steal my car and possibly stab me… I accelerated away hard and the male did not get a chance to open my door, but it was close…"[42]

57. As soon as they had determined there was no ongoing risk of violence from Ben, Officer 1 and Officer 2 rendered first aid. Sgt Brown and LSC Kellow arrived at the scene moments after the shooting. They assisted in the provision of first aid and management of the scene.

58. Ambulance Victoria arrived approximately 10 minutes later. Despite continued efforts, Ben passed away shortly after.

IDENTITY OF THE DECEASED

59. On 23 January 2021, Benjamin Peter Madex was formally identified by a fingerprint analysis and comparison. Ben's identity was not in dispute and required no further investigation.

CAUSE OF DEATH

60. On 22 January 2021, Dr Melanie Archer, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy on Ben's body. Dr Archer reviewed the Victoria Police Report of Death, the section 27 immediate request for autopsy, the post mortem CT scan and the ambulance records.

61. Among Dr Archer's anatomical findings were gunshot wounds to the chest and the pelvis. Although there was a superficial incised wound to the left hand, potentially sustained during Ben's handling of the knife, and abrasions and bruising mainly to the

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[41] Exhibit 1, Coronial Brief, pp 230-2.
[42] Exhibit 1, Coronial Brief, pp 237-40.

limbs, there was no evidence of further significant trauma at autopsy or on the post mortem CT scan.[43]

62. Post mortem toxicological analysis suggested recent use of heroin, methamphetamine, diazepam, cannabis and aripiprazole (an anti-psychotic). No alcohol was detected.

63. Dr Archer provided an opinion that the medical cause of death was 1a) Gunshot wounds to the chest and pelvis. I accept Dr Archer's opinion.

CORONIAL INQUEST

64. A coronial inquest is mandatory in respect of Ben's death pursuant to s52(2)(b) Coroners Act where the deceased was, immediately before death, a person placed in custody or care.

65. The coronial inquest commenced on 15 May 2023 and was heard over for four days, with a submissions hearing on 22 May 2023.

Witnesses

66. Thirteen witnesses were called to give *viva voce* evidence at the Inquest, including:

    a) Ms Loreen Mitchell

    b) Ms Margaret Bepete, Registered Psychiatric Nurse, Monash Health

    c) Mr Calvin Jutasi, Forensic specialist and registered nurse, Monash Health

    d) Dr Ajay Vijayakrishnan, Consultant Psychiatrist, formerly Monash Health

    e) Dr George Antony, Interim Service Director, Mental Health Program, Monash Health

    f) Acting Sergeant Wade McNeill, Victoria Police

    g) Sergeant Murray Brown, Victoria Police

    h) Leading Senior Constable Jodi Kellow, Victoria Police

    i) Mr Terry Werner, civilian witness

    j) Mr Brock Neve, civilian witness

    k) Police Officer 2, Victoria Police

    l) Inspector Andrew McKee, Victoria Police

[43] Dr Archer had noted Ben's involvement in two motor vehicle collisions just prior to his death.

m) Inspector Richard Watkins, Victoria Police

Scope of Inquest

67. The following issues were examined at the Inquest:

1. The circumstances leading up to the death of Mr Madex, including:

a) The appropriateness of Mr Madex's mental health care, treatment and management in the months prior to his death.

b) The appropriateness of the Victoria Police response to alleged illegal activities by Mr Madex on 21 January 2021 including:

i. Its response to Mr Madex's alleged theft of a vehicle and the manner that vehicle was driven;

ii. The brief vehicular pursuit, termination of the pursuit and the 'extended follow'; and

iii. Whether the shooting of Mr Madex was justified and a reasonable use of force.

2. Any prevention opportunities.

The appropriateness of Mr Madex's mental health care, treatment and management in the months prior to his death.

68. Throughout his life, Ben had multiple admissions to hospital for his mental health as either an involuntary or voluntary patient.

69. Less than four months passed between Ben's release from prison on 3 September 2020 and his death on 21 January 2021. During that time he presented to the emergency department and was admitted to Monash Health's Casey Hospital on three separate occasions for mental health care and other medical needs, including addiction medicine and physical healthcare. I determined the management of Ben's mental health care, and treatment was a relevant consideration in understanding the circumstances leading up to his death.

70. Four witnesses from Monash Health gave concurrent evidence at the Inquest: Calvin Jutasi, Margaret Bepete, Dr George Antony, Dr Ajay Vijayakrishnan.

Ben's admissions to hospital from September to December 2020

71. Four days after Ben was released from prison, he presented to Casey Hospital on 7 September 2020. Ben was admitted as an inpatient for 11 days. During his admission he was assessed and placed on a Compulsory Treatment Order (**CTO**).

72. Criteria for an involuntary admission to a mental health facility is outlined in section 5 of the *Mental Health Act* 2014 (Vic). (**MHA**) In evidence, Dr Antony explained the four criteria that must be met which includes "a disorder of memory, thought, mood, perception", secondly, that "they need treatment to prevent serious deterioration, as risk to themselves or others. Third, that treatment can be provided as a compulsory patient; and fourth, that there's no less restrictive means of delivering that treatment".[44] If the patient meets all four criteria, the patient can receive compulsory treatment.

73. When a patient is first admitted, Dr Antony stated the "assessment order is the first step of initiating compulsory treatment."[45] Assessment must take place within 24 hours by a delegated authorised psychiatrist.[46] Ben was subject to an assessment order on 7 September 2020, with a temporary treatment order being made the next day, which is the second step.[47]

74. Dr Antony commented that as the patient recovers "their care can be provided in a less restricted manner but still as a compulsory patient, at which point its required that you will vary the order".[48]

75. Treating clinicians must consider many factors when assessing whether a patient requires or remains as an involuntary admission. Dr Vijayakrishnan commented that forcing treatment upon a person using power to provide compulsory treatment under the MHA may be counterproductive in circumstances where most patients will require long term management.[49] He said "most of the problems we treat are not something that we can just do something and that's it, it's finished. We need people to have a relationship, not just with ourselves, the treating professionals, but also the medication and the treatments per se, so that they can continue to access it".[50]

[44] Transcript of evidence, p 33.
[45] Transcript of evidence, p 34.
[46] Transcript of evidence, p 34.
[47] Transcript of evidence, p 34.
[48] Transcript of evidence, p 36.
[49] Transcript of evidence, p 59.
[50] Transcript of evidence, p 86.

76. At discharge on 18 September 2020, Ben's order was varied to a CTO in the community.[51] His treatment was then transferred to the CAT Team, with an intention to transfer his ongoing management to the CCT.[52] Ms Bepete explained that CAT Team involvement is usually short term, post discharge, to assist with stabilisation until the CCT is able to take over.[53]

77. Ben's mental health rapidly declined, and he presented to Casey Hospital ED again on 25 September 2020, only a week later. Ben reported that he "was feeling very unsafe in the community and wanted further help in the hospital."[54] This demonstrates that at times Ben had good insight into his mental ill-health. It also indicates that when he returned to a community setting and resumed illicit drug use, his mental health could rapidly decline. Dr Vijayakrishnan said that "there is a strong indication that his illness was worsened or, in fact, precipitated at each time by use of substances".[55]

78. Dr Antony noted that because he was on a community treatment order, the only way to facilitate an admission was to vary it back into an inpatient temporary treatment order which is what happened on the day.[56] The plan was to stabilise him and transition him to a long-acting form of medication.[57]

79. During this second admission his treating team sought to have him remain on a CTO for the maximum duration of 26 weeks to stabilise his condition. However, on 1 October 2020, the Mental Health Tribunal revoked his CTO to a voluntary patient because treatment could be provided in a less restrictive manner.[58] No reasons were provided for the revocation of the order, but it is inferred is that the Tribunal formed the view that Ben would cooperate with receiving voluntary care in the community.

Discharge from hospital and difficulty with community engagement

80. Ben was discharged on 2 October 2020. Ms Bepete explained that during the discharge process she would sit with a client and discuss shared care options with a GP or private

[51] Transcript of evidence, p 36.
[52] Transcript of evidence, p 36.
[53] Transcript of evidence, p 37.
[54] Transcript of evidence, p 39.
[55] Transcript of evidence, p 60.
[56] Transcript of evidence, p 39.
[57] Transcript of evidence, p 44.
[58] Exhibit 2, Monash Health medical records, p 11.

psychiatrist.[59] She believed that "Ben was engaging with the GP, who was prescribing a couple of medications".[60]

81. Ben attended some appointments in the following weeks however according to the medical records was often irritable and difficult to engage. He began to disengage and refuse his antipsychotic injection by late October and early November 2020. He had been risk assessed to require two security personnel at all appointments, which reduced flexibility of treatment and Ben had limited capacity and motivation to engage in his own care, particularly when he was using illicit drugs, which exacerbated his mental health issues.

82. The evidence demonstrates that Ben's mental health care was difficult to manage in the community. Attempts were made to facilitate Ben's continued voluntary attendance at appointments, such as providing him with taxi vouchers, however according to his housemate he would give these vouchers to his friends instead. Ben also refused assistance from his mother. Ms Mitchell commented that "any time we tried to get him help, he would just work his way around it".[61]

83. Counsel Assisting submitted that

> Ben was highly institutionalised, having spent most of his adult life in prison, and was clearly struggling with life outside prison. His accommodation was unstable and social supports were minimal. His capacity to seek or utilise help from social supports was always going to be limited.[62]

84. Prior to disengaging, Ben did not satisfy the criteria to be treated as a compulsory patient under the MHA as he continued to engage as a voluntary patient and did not present with acute psychotic symptoms. Monash Health staff were unable to change Ben's status under the MHA after he disengaged as this required further assessment which could not occur unless he presented to hospital.

85. Despite his engagement, Ms Bepete liaised with Ben's GP and his post-release case manager from Ravenhall, who both reported no current concerns for his mental state. Ms Bepete also attempted to contact Ben's housemate, however received no answer and

[59] Transcript of evidence, p 49.
[60] Transcript of evidence, p 49.
[61] Transcript of evidence, p 24.
[62] Transcript of evidence, p 322.

messages were not returned. The evidence demonstrates that she continued to call Ben and even offered at one stage for him to call an ambulance and come to the hospital.[63]

86. The panellists were asked whether it would have been appropriate to seek police assistance to bring Ben into hospital for his injections. Dr Antony explained that given Ben's forensic history and attitude towards police "sending the police out might have made it more challenging to engage him, so the threshold for that would have been higher".[64] Mr Jutasi added "the patient has to be willing to engage despite the high risk, towards others, [though] with limited participation in their own treatment [to] try and assertively treat could be deemed intrusive".[65] He conceded that this tension is difficult to address.[66]

87. A person is not considered to have a mental illness solely because they have previously been treated for a mental illness;[67] therefore, Ben's past acute psychotic symptoms alone were not sufficient justification to make him subject to compulsory inpatient treatment again. A person's engagement in illegal conduct,[68] antisocial behaviour,[69] or consumption of drugs or alcohol[70] do not constitute a mental illness. As such, it would not have been reasonable to treat Ben under the MHA solely due to risks associated with criminal, antisocial, and substance affected behaviour in the absence of current acute symptoms of mental illness.

88. Other than ceasing engagement, no further information had been provided to Monash Health to indicate that Ben's immediate welfare was at risk due to mental ill-health. Therefore, requesting police to conduct a welfare check when Ben disengaged was not warranted.

Ben was assessed as a high risk of violence

89. On 19 October 2020, Forensic Clinical Specialist Calvin Jutasi performed a violence risk assessment and concluded Ben was "a high risk of interpersonal violence towards others in the medium to long term".[71] Mr Jutasi documented in the medical record that

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[63] Transcript of evidence, p 51.
[64] Transcript of evidence, p 55.
[65] Transcript of evidence, p 56.
[66] Transcript of evidence, p 56.
[67] Section 4(2)(o) *Mental Health Act 2014* (Vic).
[68] Section 4(2)(i) *Mental Health Act 2014* (Vic).
[69] Section 4(2)(j) *Mental Health Act 2014* (Vic).
[70] Section 4(2)(l) *Mental Health Act 2014* (Vic).
[71] Exhibit 1, Coronial Brief, p 566.

due to Ben's serious violent offending history and unpredictability, he should only be seen at the clinic with two security staff present and clinicians should not do home visits.[72] Notably, Mr Jutasi reported:

> he has a history of violence towards police. He has negative outcomes when he has had contact with police members and has no regard for them. Mr Madex is likely going to attack any police member he has contact with and will most likely use a sharp weapon or object.[73]

90. An ongoing risk of harm to others was recognised and this risk continued in the absence of acute symptoms of mental illness and appeared to pre-date the onset of mental illness. Ben held pro-criminal attitudes that were not based on delusions or hallucinations, including that violence is necessary when someone does something wrong to you, that carrying weapons is justified and that he would most likely reoffend. Ben's risk of harming others was recognised to increase when he was experiencing symptoms of psychosis including paranoia and auditory hallucinations. However, it was also recognised that Ben was at risk of harming others for reasons other than psychiatric symptoms, including to obtain financial gain and when his needs were not met.[74]

Admission and discharge from Casey Hospital 19-20 December 2020

91. Ben returned to the ED on 19 December 2020 primarily due to suicidal ideation and a reported attempt to overdose on heroin and methamphetamine. He reported some paranoia that people were talking about him, however had good insight into this and it did not appear to be of delusional intensity. It was noted that no overt delusional themes were expressed.[75]

92. On presentation to the ED, Ben volunteered that he had a knife in his possession and handed it over on request as well as agreeing to a bag search. He was initially admitted on an assessment order. It was noted that he was overly familiar with a female co-patient, requesting to share a room with her and requiring firm behavioural limits be set. It was also noted that he was irritable and agitated when his needs were not met. He did not express overt delusional beliefs, present with thought disorder, or report or respond to auditory hallucinations.

[72] Exhibit 2, Monash Health medical records, p 204.
[73] Exhibit 2, Monash Health medical records, p 203.
[74] Exhibit 2, Monash Health medical records, pp 199-203.
[75] Exhibit 2, Monash Health medical records, p 7.

93. When reviewed by Dr Vijayakrishnan on 20 December 2020, Ben did not satisfy the MHA criteria for compulsory inpatient treatment but he remained a voluntary patient. Dr Vijaykrishnan explained that Ben wasn't showing signs of distress or mental illness. Ben described the events that brought him into hospital the day before and he was willing to engage in treatment. This meant that he did not meet the fourth criteria, which states that if there is any possibility of providing the treatment in a less restrictive manner, then treating practitioners are bound to follow the least restrictive route.[76]

94. Shortly before 8.45pm on 20 December 2020 the co-patient with whom Ben was overly familiar was moved to another ward. This upset him and he became aggressive. He required restraint and during this process, a knife fell from his person. In consultation with Dr Vijayakrishnan, it was decided to discharge Ben as his presentation remained the same as when reviewed that morning (with the exception of increased agitation). It was determined that his ongoing admission posed a risk of harm to others on the ward.

95. Dr Vijayakrishnan explained that the decision to discharge was a very complex and difficult decision. He had to weigh up whether it was reasonable to subject Ben to even more restrictive treatments such as seclusion or intensive care, or alternatively discharge him.[77] Dr Vijayakrishnan said the bar is set high when considering implementing very restrictive practices. So it was in that light that the decision was made to discharge him. I accept that these are difficult decisions.

96. Counsel for Monash Health submitted that when considering the appropriate treatment for Ben and how he was managed, the health service not only has obligations to the patients it treats. There is also a duty of care to its workers, other inpatients, and other people attending these facilities. Therefore, extra care had to be taken when dealing with Ben. And in all the circumstances it managed that appropriately.[78]

97. The decision to discharge Ben appeared appropriate. Ben's agitation did not appear to be secondary to psychosis or suicidality. There were no overt psychotic symptoms noted during his admission. Ben's behaviour appeared to be in response to not having his perceived needs met which was a recognised precipitant to his violent behaviours and not directly related to any psychiatric symptoms.

[76] Transcript of evidence. p 62.
[77] Transcript of evidence. p 65.
[78] Transcript of evidence. p 366.

98. Counsel Assisting suggested that the assessment as to whether the criteria for compulsory treatment are met is a subjective one: "it's based on the expertise and experience of the psychiatrist making the decision".[79] The fact that during Ben's prior admission the treating psychiatrist assessed the criteria as met but then the Mental Health Tribunal did not, demonstrate that reasonable minds can differ.[80]

99. Counsel Assisting submitted that the assessment that the criteria was not met on this occasion was appropriate for the following reasons:

    a) Ben had voluntarily presented to the ED the day before;

    b) Ben showed himself willing to remain as an inpatient without an order on 20 December 2020 after the order had been revoked; and

    c) Ben demonstrated that he was willing to take the prescribed medication.[81]

100. It was submitted that these matters all support the view that treatment could be provided at that time in a less restrictive fashion.[82] Further, that the treatment during this admission was at all times appropriate and met a reasonable standard of care.[83]

101. Counsel Assisting and Counsel for Monash Health submitted that Ben's mental health care and management by Monash Health was reasonable and appropriate in the circumstances.[84] I accept this submission.

Police Psychiatry Liaison Meeting 11 November 2020

102. On 11 November 2020, a Police Psychiatry Liaison meeting was held between members of Victoria Police and Monash Health mental health clinicians. The minutes record that Mr Jutasi discussed Ben and reported:

> Client B.M (M) 31yo. Residing in Cranbourne was living in Bairnsdale. Extensive forensic history including incarceration. Has h/o schizophrenia. H/o carrying weapons. Very hostile toward Vic Pol. Belinda [Stone] to liaise with local uniform to ensure good communication of potential.[85]

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[79] Transcript of evidence. p 322.
[80] Transcript of evidence. p 322.
[81] Transcript of evidence. p 323.
[82] Transcript of evidence. p 323.
[83] Transcript of evidence. p 320.
[84] Transcript of evidence. pp 313, 363.
[85] Exhibit 1, Coronial Brief, p 571.

103. Mr Jutasi's evidence was that the purpose of the meeting was to discuss clients that have frequent contact with police, concerns for their mental health, and at risk patients. His understanding was that the information is recorded on the police data base.[86] Mr Jutasi did not have a great recollection of that particular meeting and was reliant on the minutes.[87] He indicated that the note in the minutes was a summary of what was discussed and explained that "there would have been more detailed discussions, a conversation about Ben at the time".[88] It was Mr Jutasi's understanding that Ms Stone, the police representative, was going to notify other uniformed members about Ben living in Cranbourne.[89]

104. The police representative, Ms Stone was unavailable to provide a statement about whether she had completed the action items resulting from the meeting. Instead, Inspector (**Insp**) Andrew McKee from Dandenong Police Complex provided a statement to address these issues. As he did not attend the meeting, he too was reliant on the minutes, and had checked for any emails, circulars or information that may have been shared at the time. Insp McKee found no evidence that Ms Stone had added a warning on LEAP or sent an email or issued a circular.

105. Insp McKee agreed that from the little information he had about the meeting, the information that Ms Stone was provided about Ben could have been entered onto Victoria Police's LEAP database.[90] Further, he said "there's value in updating warning flags, there's value in providing contemporary … information that adds to the safety of any response around a person, police member or elements of the community."[91] However, the evidence revealed that Ben already had two safety warnings flags on LEAP, last updated in 2016; for weapons, drug association and use of force.[92] Insp McKee explained that "…the risks in relation to Ben are apparent from a policing perspective and in relation to how we correspond with him, with existing flags. But there are benefits to the contemporary nature of that information".[93]

106. Counsel for the Chief Commissioner of Police submitted that the communication from Mr Jutasi to the police in the meeting were clearly to make police aware of Ben's risk if

[86] Transcript of evidence, p 73.
[87] Transcript of evidence, p 87.
[88] Transcript of evidence, p 88.
[89] Transcript of evidence, pp 106, 109.
[90] Transcript of evidence, p 265.
[91] Transcript of evidence, p 268.
[92] Transcript of evidence, p 284.
[93] Transcript of evidence, p 287.

they came into contact with him.[94] However, the flow of that information was immaterial in the circumstances of Ben's case because:

a) police did not identify Ben on the day of the incident, so it would not have impacted police's engagement with Ben;

b) Ben hadn't come into contact with police at any stage between the date of the meeting and the day of his death;

c) it would have been dangerous and counterproductive for police to try to proactively engage with Ben;

d) Ben's risk to police was more than adequately covered by what was already on his LEAP profile;

e) There was not a lot of new information in what Mr Jutasi communicated to police that was not already known by police.[95]

107. In the circumstances, I am unable to determine whether Ms Stone passed on this information to her colleagues, but there was no email, circular or information recorded on LEAP to support a conclusion that she did. However, even if the information had been conveyed to police or entered onto the LEAP database, it would not have made any difference to the circumstances that unfolded on 21 January 2021, because police did not know who Ben was prior to the shooting.

108. There is no causal connection to Ben's death, therefore I make no criticism of this aspect of the police's management of Ben's risk and warning flags.

109. I was provided an email on 18 May 2023 by lawyers for Monash Health which confirmed that these meetings still regularly take place. These meetings are a good source of information and intelligence for Victoria Police as to potential risks posed by patients of the mental health system.

Changes that have occurred at Monash Health since incident

110. Monash Health undertook a clinical incident review on 21 April 2021 and identified four key learnings and have enhanced clinical practice such that:

[94] Transcript of evidence, p 350.
[95] Transcript of evidence, pp 350-3.

a) Alerts are now utilised on the Electronic Medical Records (**EMR**) to notify if there is a forensic report.

b) A process to monitor that GP details are captured at the point of admission and discharge.

c) Procedures relating to the searching of patients for dangerous items has been reviewed.

d) Staff were reminded to call a Code Black when a patient shows signs of aggression.[96]

Potential prevention opportunities

Alternative housing options

111. During their concurrent evidence, panellists were asked if Ben's circumstances had highlighted any potential prevention opportunities. Dr Antony commented the mental health system manages high risk mental health patients in a place like Thomas Embling and all other adults in mainstream mental health services.

112. There are three housing options through which longer-term mental health support may be provided: Secure Extended Care Unit (**SECU**), Continuing Care Unit (**CCU**) and Prevention and Assisted Recovery Centres (**PARCS**)[97] ranging from secure inpatient units to community-based care. Dr Antony gave evidence that "they all require willingness to participate in the program and a willingness to abstain from substance use because of the shared space that they are in, and other consumers".[98]

113. According to Dr Antony, Ben's case revealed that there is gap for accommodating and managing patients like him. He stated "there is nothing in between … geared towards consumers who have a high risk of interpersonal violence and severe mental illness".[99] He further stated "we have limited options when the risk is to others".[100]

114. Dr Antony indicated that "there are some plans to look at SECU at a medium forensic level unit, Thomas Embling being the high, SECU being the medium and then low

[96] Exhibit 1, Coronial Brief, pp 627-8.
[97] Transcript of evidence, p 57.
[98] Transcript of evidence, p 58.
[99] Transcript of evidence, p 91.
[100] Transcript of evidence, p 91.

being the mainstream adult mental health services".[101] He said "making SECU services medium secure forensic units would be ... an answer but it's not yet been operationalised".[102] Dr Vijayakrisnan said that "it's a small number of people who transition requiring that intensity,"[103] but they are high risk.[104] Mr Jutasi said "that's where the significant gap is. It can also cater for people who are in the community but are high risk, still in the community but it's a specific unit that addresses the needs of people with forensic or ongoing contact with the criminal justice system".[105]

115. The Royal Commission into Victoria's Mental Health System (**Royal Commission**) recommended the creation of medium secure units, but no timeline has been given for delivery.[106] Dr Vijayakrishnan said there are plans to expand Thomas Embling to include medium risk patients, but he considered a tertiary hospital would be a better option but would need to be properly resourced.[107]

116. The Royal Commission also recommended[108] that by the end of 2026, a portion of the additional 107 beds to be provided at Thomas Embling Hospital be allocated for people "living with mental illness whose treatment, care, and support requirements cannot be safely and appropriately met in acute inpatient settings or through the forensic community model".[109]

117. Counsel Assisting submitted that the recommendation of the Royal Commission ought to be given some priority. Further, the creation of such a unit has good potential to mitigate the low incidence but high risk posed by people such as Ben who have severe mental illness and pose a high risk of violence to others.[110]

118. It was submitted by Counsel for Monash Hospital that "if there was [such] a facility available for Ben then that might have been a better way for him in a controlled environment to start to embrace the treatment, embrace the medication, set on a

[101] Transcript of evidence, p 92.
[102] Transcript of evidence, p 92.
[103] Transcript of evidence, p 92.
[104] Transcript of evidence, p 93.
[105] Transcript of evidence, p 94.
[106] Transcript of evidence, p 93.
[107] Transcript of evidence, p 93.
[108] Recommendation 38, Royal Commission into Victoria's Mental Health System.
[109] Recommendation 38, Royal Commission into Victoria's Mental Health System.
[110] Transcript of evidence, p 328.

different and better path that hopefully may well have avoided the tragic circumstances that ultimately befell him".[111]

119. I agree that the implementation of this recommendation should be prioritised.

Transfer of mental health information

120. When asked to consider whether there were any other opportunities for prevention or improvement, Mr Jutasi discussed the transfer of information from mainstream prison to tertiary mental health. "When someone has a mental illness that information is missing and it's difficult to get that information from mainstream prison, unless someone is sort of in a forensic setting".[112] He commented that

> they require the patient's consent to provide any medical documents or information that would have been provided during their stay in prison. So, unless the person's willing to sign a consent form and release that information, then it's not provided to us. So, you don't know what treatment they would've had in prison, especially someone who's been in prison for a long time, an extended period of time… whereas there could've [been] continuity of care.[113]

121. Mr Jutasi said they can access information from Corrections Victoria, but not in a timely manner.[114]

Conclusions about Ben's medical treatment, care and management of his mental health issues

122. Ben was a complex and challenging patient. He had mental health issues, significant forensic history, posed a risk to others, and struggled to engage with community services as a voluntary patient. The evidence revealed that Ben's mental health fluctuated. When he used drugs or alcohol it would often precipitate an episode of mental ill health.

123. I accept that the decision to require a person to receive treatment as an involuntary patient is difficult. I further accept that Ben did not meet the criteria for an involuntary treatment order during his last admission in December 2020.

124. I find that Ben's medical management and discharge from Monash Health in December 2020 was reasonable and appropriate in the circumstances.

[111] Transcript of evidence, p 364.
[112] Transcript of evidence, p 96.
[113] Transcript of evidence, p 96.

125. I commend Monash Health for the proactive incident review of the circumstances around Ben's three admissions to Casey Hospital prior to his death and the changes they made subsequently.

126. I am mindful that there is a significant gap in providing mental health treatment to a high-risk patient, who does not require an involuntary admission but finds voluntary engagement with treatment in the community challenging, particularly if there is concurrent use of illicit drugs and alcohol.

127. I endorse the Royal Commission's recommendation that medium secure residential facilities are established to assist and support people like Ben.

128. The time between Ben's release from prison to his first admission to hospital due to a deterioration in his mental health was four days. This case has highlighted the importance of timely transfer of a former prisoner's mental health information by Corrections Victoria to tertiary mental health facilities upon release. While I acknowledge that Corrections Victoria was not an interested party in this Inquest, and that the patient's consent is needed, continuity of mental health management would be enhanced by transfer of critical information about custodial mental healthcare to community clinicians as part of the (discharge) planning for a prisoner's release.

129. Accordingly, I endorse the Royal Commission's Recommendation 37 which states that the Victorian Government should "establish a program for people in prison living with mental illness who require ongoing intensive treatment, care, and support to transition the delivery of supports from correctional settings to the mainstream mental health and wellbeing system upon their release".[115]

Victoria Police response to Mr Madex's alleged aggravated carjacking[116]

130. Ben was shot by police on 21 January 2021. The events on the day leading up to his death are causally relevant to the circumstances of his death, commencing with police involvement from notification of the carjacking to the shooting.

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[114] Transcript of evidence, p 97.
[115] Recommendation 37(3), Royal Commission into Victoria's Mental Health System.
[116] The *Crimes Act* 1958 suggests that the conduct in which Ben allegedly engaged may have been characterised as an aggravated carjacking: s79.

Forward command

131. Following the aggravated carjacking in Mirboo North, Acting Sgt McNeill nominated himself as Forward Commander for the incident. He was a passenger and the patrol supervisor in a vehicle, call sign Morwell 251, which driving in the local area.

132. Discussions took place about who should be Forward Commander between A/Sgt McNeill and other sergeants including Wonthaggi 251, and Neerim South 251 (Sgt Brown and LSC Kellow) who were based in three different Police Service Areas (PSA). As the Audi had not been sighted by units other in any other PSA, it was agreed that Morwell 251 should perform the role of Forward Commander.[117]

133. The Forward Commander's role is to provide directions over police communications and ensure that members are aware of who is in control of the incident, it's objectives and associated risks, and to direct operational members responding to the incident.[118]

134. The police response to Ben's actions on 21 January 2021 was considered by Victoria Police's Operational Safety Committee following an Operational Safety Critical Incident Review (**OSCIR**). The OSCIR considered A/Sgt McNeill's on-air directions had room for improvement.[119] In response, A/Sgt McNeill admitted that he had listened to and reflected upon his on air communications and conceded they could have been a little clearer with more detail,[120] but he considered that the police members involved knew what they were trying to achieve.[121] The evidence was that members were aware A/Sgt McNeill was in control of the incident.[122]

135. As an Acting Sergeant at the time, A/Sgt McNeill had not completed the sergeant training.[123] Prior to this incident, A/Sgt McNeill's knowledge of a sergeant's role in a critical incident had been learned on the job. He explained "I'd try and listen in and try and take in, … what other members were doing at incidents, like critical incidents or something like that as well, … try and get an idea of …what's required, ... just in case anything does happen".[124]

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[117] Transcript of evidence, p 150.
[118] Transcript of evidence, p 130.
[119] Exhibit 1, Coronial Brief, Additional material, p 101.
[120] Transcript of evidence, p 145.
[121] Transcript of evidence, p 131.
[122] Transcript of evidence, p 185.
[123] Transcript of evidence, p 132.
[124] Transcript of evidence, p 134.

136. A/Sgt McNeill said he did not believe he needed to speak to a supervisor such as Sale 265 (a senior sergeant), because he knew that the 265 was monitoring the radio and would contact him if needed, and he had been discussing the incident with the other two sergeants on the phone.[125] He said he relied on his knowledge and updates from other members to advise their positions when managing the incident.[126]

137. A/Sgt McNeill explained the plan was to stop the Audi, by using vehicle immobilisation devices such as stop sticks so police could safely effect an arrest.[127] The ability to safely engage stop sticks, might have been enhanced by the involvement of the Airwing, but no resources were available at the time.[128] Police had few options for stopping the Audi that would have complied with policy.[129]

138. Counsel Assisting submitted that whilst there could have been clearer on-air direction, there is no basis for criticism of A/Sgt McNeill, who was an acting sergeant with minimal experience and managing a very high risk and complex incident.[130]

139. It was submitted by Counsel for the Chief Commissioner of Police (**CCP**) that there were some opportunities for improvement in on-air directions and greater supervision.[131] It was further argued that the issues identified in the OSCIR were not prevention opportunities, but areas for continuous improvement.[132] Counsel for CCP submitted that A/Sgt McNeill candidly accepted that his on-air directions could have been better. However, there was nothing to suggest that he didn't have good command and control, and in fact, his plan was the right one[133].

140. Counsel for the CCP advised that Victoria Police is taking steps to address the knowledge gap in senior constables who upgrade to acting sergeant positions through the Observer Training Program. In addition to participants observing qualified sergeant perform their role, over four days they receive instruction on command and control, on-air briefings and performance of the specific functions of Pursuit Controller, and

[125] Transcript of evidence, p 140.
[126] Transcript of evidence, p 134.
[127] Transcript of evidence, p 134.
[128] Transcript of evidence, p 137.
[129] Transcript of evidence, p 155.
[130] Transcript of evidence, p 332.
[131] Transcript of evidence, p 344.
[132] Transcript of evidence, p 344.
[133] Transcript of evidence, p 345.

Forward Commander. The program is an interim measure while a more substantial program goes through its pilot phase and is assessed and evaluated.[134]

141. Since this incident, A/Sgt McNeill has completed the Observer Training Program. [135]

142. It was refreshing to hear A/Sgt McNeill concede there was room for improvement of his on-air directions. This kind of self-reflection speaks volumes for this police member and demonstrates that he is committed to improvement which will certainly serve him well in the future.

143. Despite, these minor imperfections, the evidence clearly demonstrated that responding members were aware of and understood A/Sgt McNeill's plan to stop the Audi and effect an arrest. It was also apparent that without any vehicle interdiction devices and the Air Wing, there were no other resolution strategies reasonably available.

144. I find that A/Sgt McNeill's actions as Forward Commander were reasonable and proved to be effective in the circumstances.

The brief vehicular pursuit, termination of the pursuit and the 'extended follow'

145. Sgt Brown and LSC Kellow were operating under call sign Neerim South 251 and were performing patrol duties on 21 January 2021. Sgt Brown was driving the police vehicle, and LSC Kellow was the front seat observer. Neerim South 251 were aware of A/Sgt McNeill's plan and had been communicating with other units via phone.[136] They understood "the whole objective was to stop the car".[137]

146. According to Sgt Brown, Ben had "two weapons that day: one was the knife, one was the car".[138]

147. After Neerim South 251 had heard the Audi had clipped another vehicle, that was driven by Wayne Comer, on the Princes Freeway near Morwell, LSC Kellow contacted the driver to obtain further information. Mr Comer advised that the Audi had overtaken him at high speed and collided with a centre barrier, before cutting back in front of him and clipped his bulbar.[139] Once they had ascertained what had happened, and recognised

[134] Transcript of evidence, pp 347-8.
[135] Transcript of evidence, p 143.
[136] Transcript of evidence, p 154.
[137] Transcript of evidence, p 154.
[138] Transcript of evidence, p 154.
[139] Exhibit 1, Coronial brief, p 294.

his driving behaviour had become reckless, it added urgency to the effort "to …stop that car".[140]

148. At about 8.40am, the Audi passed Neerim South 251 "at a very fast rate of speed"[141] and they thought it was going to run into the back of a trailer.[142] They immediately decided to follow the Audi.[143]

149. From the moment Neerim South 251 first saw the Audi drive past the exit Robin Hood exit (a distance of approximately 16.8km), LSC Kellow's evidence was they "weren't doing anything other than observing".[144] Sgt Brown continued to drive and LSC Kellow transmitted observations and updates on the radio.[145]

150. Sgt Brown's evidence was that their 'extended follow' did not constitute as a pursuit because they "didn't have the blue/red lights going, no siren, and at no time did we give a direction for him to pull over. He was so far ahead of us he wouldn't have seen us anyway if we had those on, so there was no opportunity to try and direct him to pull over anyway."[146] However, he agreed it was urgent duty driving.[147] His rationale for the urgent duty driving was to monitor the Audi. Sgt Brown believed that if the driver of the Audi saw them, they may have taken evasive action, which could endanger other drivers and make the situation worse. Sgt Brown considered that by hanging back and monitoring the Audi, he would be able to then tell the divisional van crew when to deploy.[148]

151. During this time, according to Sgt Brown they were conducting continuous risk assessments "weighing up the amount of traffic, … the weather and every other component...".[149] A/Sgt McNeill had no issue with Neerim South 251 conducting an extended follow at speed.[150]

[140] Transcript of evidence, p 155.
[141] Exhibit 1, Coronial Brief, p 295.
[142] Transcript of evidence, p 156.
[143] Transcript of evidence, p 156.
[144] Transcript of evidence, p 189.
[145] Transcript of evidence, p 189.
[146] Transcript of evidence, p 157.
[147] Transcript of evidence, p 157.
[148] Transcript of evidence, p 157.

Short pursuit

152. By the time Neerim South 251 reached the Robin Hood exit, Ben was driving erratically and dramatically turned left from the far-right lane, causing the Audi's rear wheels to lock before it turned into the exit. Neerim South 251 gained on the Audi.[151] However, upon activating the lights and siren at the top of the ramp, to the Audi took off at speed on the wrong side of the road.[152] LSC Kellow explained that if they try to intercept and the driver doesn't pull over, that is an evasion. At that stage, Sgt Brown said they "were in pursuit".[153] As soon as the Audi went onto the wrong side of the road, Sgt Brown said he wasn't going to continue with the pursuit, because the danger to the public increased dramatically.[154] The pursuit was terminated.[155]

153. The pursuit was very short, in the order of six to twelve seconds.[156] The timing meant that LSC Kellow said she wouldn't call it a pursuit because "we attempted to intercept, he didn't stop, so we pulled over".[157] Consistent with Sgt Brown, LSC Kellow said they "didn't want to push him, … to do anything… that would put the public at risk in that area, so we stopped."[158]

Attempt to block in the Audi

154. The Audi turned into Amberley Way Drouin, which is a no through road. Knowing it was a dead end, Sgt Brown said to LSC Kellow "he's got no way out except the way he came in, I'm going to block him in"[159] and she agreed. Sgt Brown and LSC Kellow believed they were in a good position to block the Audi in and perhaps stop the vehicle from exiting the street.[160] Sgt Brown believed at the time they could stop the Audi from coming out, which would resolve the situation.

155. Sgt Brown stated he conducted a risk assessment. He noted the street was semi-rural, with a dead end. There were houses on the left and an embankment on the right. There

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149 Transcript of evidence, p 158.
150 Transcript of evidence, pp 138-9.
151 Transcript of evidence, p 158.
152 Transcript of evidence, pp 158-9.
153 Transcript of evidence, p 159.
154 Transcript of evidence, p 160.
155 Transcript of evidence, p 159.
156 Transcript of evidence, p 161.
157 Transcript of evidence, p 193.
158 Transcript of evidence, p 199.
159 Transcript of evidence, p 201.
160 Transcript of evidence, pp 165, 201.

were no pedestrians or other cars. Therefore, he entered the street with the intention of "blocking him in so he couldn't get out".[161]

156. This manoeuvre is not permitted under the Pursuits Policy. However, Sgt Brown considered, with the benefit of hindsight, the Hostile Vehicle Policy permitted it. The Hostile Vehicle Policy states that if "there's a high risk to the public… you can use strategies such as … ramming the car with a police car, blocking them in and other strategies as well".[162] However at the time, he admitted he hadn't considered this policy. He stated he just wanted to stop the Audi because he honestly believed it was "going to kill someone".[163] Sgt Brown's evidence was that they had to take action to stop him.[164] He said "policy or no policy, I would never forgive myself"[165] "if we had done nothing and he collided with a car, ran over a pedestrian: I'd never forgive myself. So we had to try and stop him, stop the car."[166] LSC Kellow agreed.[167]

157. The Hostile Vehicle Policy states: "A hostile vehicle threat occurs where the driver of a vehicle uses it to access or encroach upon an area where the circumstances indicate an intention or recklessness to cause really serious injury and/or death"[168] There is no doubt Ben's driving was sufficiently dangerous to cause serious injury. This policy was implemented for such situations.

158. Whilst Sgt Brown and LSC Kellow did not reference the Hostile Vehicle Policy as a reason for their decision to attempt to block the Audi in, I find their actions were permitted and appropriate in the circumstances.

159. Counsel Assisting submitted that the attempt to intercept and the subsequent short pursuit was reasonable and appropriate, and accorded with policies.[169] It was submitted that the attempt to block the Audi in to the dead-end road was a little more complicated as it technically breached the Pursuit Policy which states that "the use of static or mobile police vehicles to physically box in or stop the pursuit vehicle is not permitted".[170] In contrast, the Hostile Vehicle Policy, which came into operation in

[161] Transcript of evidence, p 165.
[162] Transcript of evidence, p 177.
[163] Transcript of evidence, pp 166, 177.
[164] Transcript of evidence, p 173.
[165] Transcript of evidence, p 166.
[166] Transcript of evidence, p 176.
[167] Transcript of evidence, p 109.
[168] Ex 7, VPM - Hostile Vehicle Policy, p 2.
[169] Transcript of evidence, p 333.
[170] Transcript of evidence, p 333.

October 2019, permits "such force not disproportionate to the objective as [the member] believes on reasonable grounds to be necessary to prevent the commission, continuance or completion of an indictable offence or to effect or assist in effecting the lawful arrest of a person committing or suspected of committing an offence".[171]

160. Counsel for the CCP agreed with this submission,[172] adding that Sgt Brown's risk assessment was impressive, both in its thoroughness and defensibility in this forum.[173] The risk assessment was also relevant to "the decision to conduct urgent duty driving using a silent approach, the decision to intercept and then the decision to re-engage with Ben down the service road…as the road block was technically outside the pursuit policy that was in place".[174]

161. It was further submitted by Counsel for CCP that "police members are able to use their local knowledge and their experience to make assessments of appropriate actions rather than being constrained by overly prescriptive policies that can't necessarily fit all situations".[175]

162. Counsel for Sgt Brown and LSC Kellow submitted that her clients were witnesses of truth. Both were "experienced police officers who were acting conscientiously and with care on the day in question, including engaging in ongoing risk assessments as their role in the response to Ben changed over the day".[176] She further submitted that "sitting over and above all those policies is the fundamental duty of police members to act to protect the public, supported where possible by policy, but not prevented by policy from doing what in their sound and careful judgment seemed appropriate and that's what they did on this occasion".[177]

163. I find that the actions of Sgt Brown and LSC Kellow, particularly the extended follow, short pursuit and attempt to block in, were appropriate and justifiable in the circumstances. It is clear Sgt Brown is an experienced police officer and demonstrated sound professional judgment, strong practical knowledge and risk assessment skills in determining these actions.

[171] Transcript of evidence, p 334.
[172] Transcript of evidence, p 340.
[173] Transcript of evidence, p 340.
[174] Transcript of evidence, p 341.
[175] Transcript of evidence, p 342.
[176] Transcript of evidence, p 361.
[177] Transcript of evidence, p 363.

164. The actions of Sgt Brown and LSC Kellow were proportionate to the risks and justified in the circumstances. I commend their bravery and commitment to protecting members of the community from Ben's dangerous driving. Unfortunately, they were unable to stop the Audi and effect an arrest.

Whether the shooting of Ben was justified and a reasonable use of force

165. Police Officers 1 and 2, operating under call sign Baw Baw 488, were a Family Violence Investigation Unit and had been listening to the radio transmissions about an erratic driver. They thought if an unmarked car could follow from a distance, without alerting the driver, eventually he would stop and they would be able to arrange a cordon and safely make an arrest.

166. When they heard that Neerim South 251 was in pursuit, Baw Baw 488 was in close proximity and, exiting the Princes Freeway. They observed the Audi "on the wrong side of the road coming around the bend on double lines, overtaking four or five cars".[178] Baw Baw 488 slowed their SUV anticipating a collision between a the Commodore in front of them and the Audi.

167. After the collision, the Audi came to a complete stop in front of the police SUV.[179] Ben got out of the Audi and ran towards the Commodore.

168. Civilian witnesses Terry Werner and Brock Neve both described Ben to have a vacant look in his eyes. Mr Werner described him as having his eyes wide open, with no expression on his face.[180] He was armed with a knife and was walking towards the police with purpose and "showing no signs of stopping".[181] Mr Neve stated "we made eye contact and …It's like he sort of stared straight through me".[182] Then he turned his attention to the police and "he was on a mission".[183] He was aggressive.[184]

169. Officer 1 was excused from giving evidence on medical grounds. He made a contemporaneous statement at the time of the incident. He stated he alighted from the police SUV, shouting: "Stop police, Stop Police".[185] Ben then quickly turned around

[178] Transcript of evidence, p 243.
[179] Exhibit 1, Coronial Brief, p 308.
[180] Transcript of evidence, p 224.
[181] Transcript of evidence, p 222.
[182] Transcript of evidence, pp 229-30.
[183] Transcript of evidence, p 230.
[184] Transcript of evidence, p 230.
[185] Exhibit 1, Coronial Brief, p 318.

and re-directed his attention to Officer 1. Officer 1 stated that Ben was holding a large 20-30 centimetre bladed hunting knife in his left fist with the blade pointing directly at him.[186] Ben appeared to be "fixated" on him.[187]

170. Officer 1 shouted to Ben to "drop the knife" a few times. According to Officer 1, once Ben got to within five or six metres of him, he removed his firearm from the holster and pointed it at Ben. He then shouted, "Police don't move, drop the knife".[188] While Ben continued to approach, Officer 1 walked backwards trying to create distance between them but was hemmed in by a roadside barrier. Ben advanced towards Officer 1 in an aggressive manner. Fearing for his life, Officer 1 aimed the firearm at Ben's body and fired one shot. Ben advanced toward him, causing Officer 1 to fire his firearm again.[189]

171. Officer 1 explained in his statement that he shot Ben because he had no doubt that if he hadn't shot him, he would have been seriously injured or killed.[190] He said that the baton or OC spray would not have had an effect on Ben. Officer 1 had no path of retreat and Ben wasn't responding to his verbal commands.[191]

172. Officer 2's evidence was that Officer 1's actions were justified. Indeed, he explained if "he's got a knife in his hands, [...] our training says that whenever there's a knife or a weapon… life-threatening … to go for your firearm first".[192]

173. After Officer 1 discharged his firearm, both members immediately administered first aid to Ben.

174. Mr Werner characterised Ben's actions as "almost suicide-by-cop".[193]

175. The OSCIR found that there were limited radio calls by Baw Baw 488 just prior to the incident explaining their plan or role.[194] In response, Officer 2 stated that as their unit was not directly involved in the incident earlier, and there were lots of other units on air, they tried to keep on air communications specific to information that could assist.[195] In

[186] Exhibit 1, Coronial Brief, p 318.
[187] Exhibit 1, Coronial Brief, p 318.
[188] Exhibit 1, Coronial Brief, p 318.
[189] Exhibit 1, Coronial Brief, p 318.
[190] Exhibit 1, Coronial Brief, p 320.
[191] Exhibit 1, Coronial Brief, p 320.
[192] Transcript of evidence, p 247.
[193] Transcript of evidence, p 224.
[194] Exhibit 1, Coronial Brief, Additional Material, p 102.
[195] Transcript of evidence, p 241.

oral evidence Superintendent Richard Watkins observed that "it's very difficult to put yourself into a position of the police member involved".[196]

176. Counsel Assisting submitted that the lack of communications on the police radio by Baw Baw 488 was readily explicable.[197] Officer 2 stated he felt that it was not appropriate to clog up the radio transmissions prior to having actually observed the Audi vehicle. I accept this as a reasonable explanation for Baw Baw 488's limited communications on police radio.

177. Counsel Assisting further submitted that Victoria Police's response to the aggravated carjacking and subsequent dangerous driving was appropriate in all the circumstances.[198] Police faced a very difficult and challenging incident to manage. They had no way of identifying the driver and utilising intelligence they held in respect of him. Ben engaged in extremely high risk driving which simultaneously increased the need to stop him but also heightened the risk of engagement with him, as it might exacerbate his driving behaviour.[199]

178. Finally, Counsel Assisting submitted that the shooting of Ben by Officer 1 was reasonable and justified.[200] Counsel for the CCP agreed.

179. It was submitted by Counsel for CCP that when Officer 1 was confronted with that situation, he did not hesitate. He moved towards the threat which is a testament to his courage and training, and because of the threat to the public. He added standing back, assessing and attempting to contain Ben so that a more peaceful option could be adopted was simply not an option available to the officers in this case.[201]

180. Counsel for CCP further submitted that Officer 1 used his training and accumulated knowledge. He gave Ben every opportunity by way of commands to drop the knife, and to retreat to avoid the use of force, but unfortunately that was not an outcome that occurred in this case.[202]

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[196] Transcript of evidence, p 306.
[197] Transcript of evidence, p 336.
[198] Transcript of evidence, p 331.
[199] Transcript of evidence, p 332.
[200] Transcript of evidence, p 336.
[201] Transcript of evidence, p 339.
[202] Transcript of evidence, p 339.

181. Counsel for CCP urged me to consider the authority of *Walker v Hamm,*[203] which essentially states that a police officer's conduct has to be assessed having regard to the emergency of the situation. I note Officer 2 said in his statement the baton or OC spray would not have had an effect on Ben.[204]

182. Counsel Assisting submitted that whilst we will never know what motivated Ben to act as he did, several factors provide some insight:

a) he had increased paranoia and fatalism in the days prior to the incident;

b) his behaviour during the incident was unpredictable, dangerous and put people at high risk;

c) he is described by several civilian witnesses as having had a vacant expression, wide eyes, erratic movements, and showing aggression in his final moments; and

d) his comments to Mr Jutasi during the review conducted in October 2020 suggest that he was considering harming himself or others in order to return to prison.[205]

183. In final submissions, Counsel for CCP submitted that "all the police members involved acted appropriately, reasonable and substantially in accordance with policy and best policing practice in their interactions with Ben and in the actions they took in connection with his death and the events leading up to it".[206]

184. Further, he added:

> It's particularly noteworthy in this case that the thought processes and actions of police exemplified the accumulated knowledge of this jurisdiction and the recommendations that have been made as a result of it. It was, in my submission quite striking as a result of the decision-making and the actions particularly in relation to Ben's driving and the police response to it that gave effect to the recommendations and the investigations that this jurisdiction has conducted over the past two decades or so.[207]

185. Counsel for CCP submitted "tragically, despite that, there are still times when members of the public will die at the hands of police. The goal should, of course, be for that never to happen, but the nature of human vicissitude is that it's inevitable from time to

[203] *Walker v Hamm* [2008] VSC 596 (Smith J) at [55].
[204] Transcript of evidence, p 340.
[205] Transcript of evidence, p 337.
[206] Transcript of evidence, p 337.
[207] Transcript of evidence, pp 337-8.

time".[208] It was submitted that no adverse finding or comment is open on the evidence regarding any individual police officer's conduct or the organisation more broadly.[209]

186. Once the Audi crashed into the Commodore, the incident unfolded quickly and dynamically. The members of Baw Baw 488 were soon confronted by a person armed with a knife who had engaged in conduct showing little regard for his own or others' safety. Officer 1's actions were instinctive and informed by his training. I find his actions to protect the public and ultimately to defend himself, despite Ben's aggressive demeanour, to be courageous.

187. Whilst the outcome was tragic, I find Officer 1 used reasonable force that was proportionate to the high risk he faced and was entirely justifiable in the circumstances.

FINDINGS

188. Having investigated the death of Benjamin Peter Madex, I make the following findings and conclusions, pursuant to section 67(1) of the *Coroners Act 2008*:

a) that the identity of the deceased was Benjamin Peter Madex, born 14 June 1989; and

b) that he died on 21 January 2021, at the intersection of Princes Way and Arnup Crescent, Drouin, Victoria, 3818 from 1a) Gunshot wounds to the chest and pelvis; and

c) the death occurred in the circumstances set out above.

189. In the months prior to Ben's death, he had presented to Monash Health's Casey Hospital on three separate occasions for various mental health and other medical issues. Ben's last discharge from hospital was on 20 December 2020, which was only one month prior to his death.

190. This inquest examined Ben's various interactions, attendances, admissions, and engagement with Monash Health in the months leading up to his death. Having reviewed all of these circumstances I am satisfied that Monash Health's medical care, treatment, and management of Ben were reasonable and appropriate. The evidence demonstrated that Ben had good insight into his mental health issues at times. His

[208] Transcript of evidence, p 338.

mental health improved when he was engaged with treatment and not using drugs. However, when Ben was discharged from hospital and started using illicit drugs, his mental health and behaviour would rapidly deteriorate.

191. The events of 21 January 2021 were precipitated by an increased use of illicit drugs. This led to a decline in his mental health, including increased paranoia. It is likely that Ben's drug use and unstable mental health contributed to the decisions he made on 21 January 2021. Given his behaviour on that day, and his past forensic risk assessments, it was unlikely that he would stop at the direction of police.

192. I find that once Ben sped past members of Neerim South 251, they conducted a silent and extended follow. This included driving at speed in an attempt to catch up to Ben. When there was an opportunity to intercept, Neerim South 251 activated their lights and siren, however rather than stopping, Ben accelerated and drove on the wrong side of the road. The pursuit was immediately terminated. I find the extended follow (which involved urgent duty driving) and a very short pursuit was appropriate in the circumstances.

193. The decision by Sgt Brown to attempt to block the Audi in a no through road, whilst not permitted by the Pursuits Policy, was permitted by the Hostile Vehicle Policy. I find the manoeuvre to be reasonable in the circumstances; unfortunately, it was unsuccessful. As an experienced officer, Sgt Brown demonstrated sound professional judgment, strong practical knowledge and the necessary risk assessment skills.

194. Once the Audi crashed into the Commodore, the incident unfolded quickly and dynamically. The members of Baw Baw 488 were soon confronted by a person armed with a knife who had engaged in conduct showing little regard for his own or others' safety.

195. I find Officer 1 gave Ben every opportunity by way of commands to drop the knife and retreat to avoid the use of force, prior to him firing two shots, causing fatal wounds to Ben. He did so in self-defence. I find that Officer 1's discharge of his firearm was an exercise of reasonable force that was proportionate to the high risk he faced. His actions were justified, instinctive and informed by his training. I find Officer 1's actions to protect the public and ultimately to defend himself, despite Ben's aggressive demeanour, to be courageous.

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[209] Transcript of evidence, p 338.

196. I find that the police response to events involving Ben on 21 January 2021 was reasonable, proportionate, and appropriate in the circumstances.

197. Policing can be challenging at times and it is clear that the circumstances of Ben's death have had a significant emotional impact on the police members involved.

198. I convey my sincere sympathy to Ben's mother, Loreen Mitchell. The strength, compassion, and empathy displayed by Ms Mitchell during the conduct of this Inquest was remarkable and unlike anything I have ever seen. Despite the loss of her son, she was able to meaningfully convey empathy and compassion towards the witnesses in this inquest, particularly the police involved.

199. I order that this finding be published on the internet in accordance with section 73(1) *Coroners Act 2008* and the rules.

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

Ms Loreen Mitchell

Monash Health

Sgt Murray Brown, Victoria Police

LSC Jodie Kellow, Victoria Police

Detective Senior Sergeant Kylie Holloway, Professional Standards Command

Mr Shane Patton APM, Chief Commissioner of Police

Detective Sergeant Jason Poulton, Coroner's Investigator, Homicide Squad.

Signature:

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JACQUI HAWKINS
DEPUTY STATE CORONER
Date: 22 August 2023