IN THE CORONERS COURT
OF VICTORIA
AT BENDIGO

Court Reference: COR 2013 1986

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Darren Robert Baxter

Delivered On:	28 November 2013
Delivered At:	Bendigo Coroners Court via video link from Melbourne Coroners Court
Hearing Dates:	21 November 2013
Findings of:	Jacinta Heffey, Coroner
Representation:	Nil-Senior Next of kin in person
Counsel Assisting the Coroner:	Helen Donovan, Coroners Solicitor

I, JACINTA HEFFEY, Coroner having investigated the death of DARREN ROBERT BAXTER
AND having held an inquest in relation to this death on 21 November 2013
at the Bendigo Coroners Court
find that the identity of the deceased was DARREN ROBERT CLIVE BAXTER
born on 25 March 1967
and that his death occurred on 7 May 2013
at the Echuca Hospital
from:

1(a) COMPLICATIONS OF SELF-INFLICTED INCISED INJURIES TO THE NECK

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. On 21 November 2013 a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Darren Robert Baxter (Darren). The inquest was mandatory due to the fact that immediately before his death he was a person placed in custody or care as defined in section 3 of the Act.

2. Immediately prior to Darren's death Victoria Police members were attempting to apprehend him pursuant to section 10 of the *Mental Health Act 1986* (Vic).

3. The coroner's investigator, Detective Senior Sergeant Shane O'Connell, gave sworn evidence of his investigation into the death of Darren and questions were asked of him by Counsel assisting on behalf of Diane Vella, Darren's partner.

BACKGROUND

4. Darren was an indigenous man born on 25 March 1967 and was 46 years of age at the time of his death. Darren had three full sisters, Anita, Lynette, and Deborah (deceased), and a half sister, Vicki, to his mother. Darren also had five half siblings to his father: Robert, Brett, Tracey, Tania and Leonard.

5. At the time of his death, Darren had been in a defacto relationship with Diane Vella (Diane) for approximately 16 years and they resided at unit 3/1 Broderick Court, Echuca with their two sons, Bailey, aged 12 years, and Kobi, aged 8 years. Darren also owned a house in Mathoura, New South Wales.

6. Darren had been receiving medical treatment for depression since September 2012. In April 2013, his medication had changed from Fluoxetine to Mirtazapine, dispensed weekly. He took his last dose of Mirtazepine on the 2nd May, 2013.

7. On the 29 December 2008, whilst Darren was residing in Mathoura, New South Wales with Diane and their two children, he had for no apparent reason armed himself with a meat clever and threatened to kill himself. After the meat clever was removed from Darren by two friends, he then armed himself with a 'barbie mate' barbecue tool and used it to cut his own neck, causing a laceration. Darren then calmed down, before smashing a coffee cup and using it to stab himself twice in the neck.

8. As a result of this incident, Darren was conveyed to the Deniliquin Hospital, where he was treated for his injuries, which were determined as non-life threatening.

9. After treatment for these injuries, Darren was transferred to Nolan House, the psychiatric inpatient unit of the Albury Base Hospital, New South Wales. After he was discharged, he was referred to the Mental Health Drug and Alcohol Service in Deniliquin where he received further treatment.

THE CORONIAL INVESTIGATION

10. The Coroners Act 2008 sets out the role of coronial system in Victoria. This role is to independently investigate certain deaths to establish, if possible, the identity of the deceased, the cause of the death (interpreted as the medical cause of death) and the circumstances in which the death occurred.

11. A coroner's role is also to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice.[1]

12. Detective Senior Sergeant Shane O'Connell from the Homicide Squad was the coroner's investigator assisting me and he prepared the coronial brief and assisted with my investigation.

WAS DARREN IN CUSTODY AT THE TIME OF HIS DEATH

13. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death occurred when the deceased was in custody immediately before his death. In determining whether Darren Baxter was in custody at the time of his death

[1] Coroners Act 2008 (Vic), Preamble and s 1.

regard must be had to section 3 of the Act, which provides that a person whom the police are attempting to take into custody is to be regarded as "a person placed in custody". [2]

14. Section 10(1)(a) of the *Mental Health Act 1986* provides that a member of the police force may take into custody a person who appears to be mentally ill if the member has reasonable grounds for believing that the person has recently attempted suicide or attempted to cause serious bodily harm to himself or to some other person.

15. I find that the members of the police force in this matter were attempting to take Darren into custody for the purposes of the *Mental Health Act* 1986 and therefore his death requires an inquest.

IDENTITY OF THE DECEASED

16. Darren was visually identified as Darren Robert Baxter, born on 25 March 1967 by Joseph Day (Day) in Echuca on Tuesday 7 May 2013. Mr Day had known Darren for a period of 46 years and was his cousin.[3]

MEDICAL CAUSE OF DEATH: FORENSIC PATHOLOGIST EXAMINATION

17. On Wednesday 8 May 2013, Dr Michael Burke, forensic pathologist with the Victorian Institute of Forensic Medicine (VIFM) conducted a post mortem examination of Darren at the Coronial Services Centre, Southbank, Melbourne.

18. Dr Burke concluded the cause of death to be "complications of self inflicted incised injuries to the neck".[4]

TOXICOLOGY EVIDENCE

19. At the time of the post mortem examination blood and urine samples were taken from Darren and analysed by Voula Staikos, senior toxicologist, VIFM,[5] which identified the presence of amphetamine, methylamphetamine and cannabis, along with fluoxetine.

20. Alcohol was not detected in the blood and urine samples.

CIRCUMSTANCES OF DEATH

Friday 3 May to Tuesday 7 May 2013

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[2] Coroners Act 2008 (Vic), s 3.

[3] Inquest Brief, page 10.

[4] Inquest Brief, page 20.

[5] Inquest Brief, page 228.

21. During the afternoon of Friday 3 May 2013, Darren received a phone call from his brother, Brett Packer (Brett). Brett asked Darren to go with him to Mildura, as he wanted to purchase a new car. Brett attended at Darren's address later that day and picked him up. After leaving Darren's home address, they drove to a bottle shop in Echuca and purchased six bottles of beer for Darren to drink in the car. Brett and Darren then drove from Echuca to Robinvale, arriving at 10.30 pm. They attended the residential premises of Ursula Urquhart (Ursula), where they met up with their brother, Robert Ritchie (Robert). Ursula is the ex wife of Robert. They stayed the night at this house.

22. The following morning, Saturday 4 May 2013, Darren, Brett and Robert drove from Robinvale to Mildura, where Brett purchased a new car. They remained together for the whole day, returning to Ursula's house in Robinvale at 4.00 pm. During the course of the evening and night, Darren socialised with other persons present and consumed alcohol and illicit drugs including cannabis and amphetamines. This continued through Sunday and Monday.

<u>The day of the death – Tuesday 7 May 2013</u>

23. On Tuesday 7 May 2013, Darren, Brett and Robert left Ursula's premises in Robinvale and drove back to Echuca, arriving at Darren's premises at unit 3/1 Broderick Court, Echuca at about 3 pm.

24. Upon arrival home, Darren sat in the kitchen area and had a conversation with Diane, Brett and Robert. During the conversation, Darren smoked cannabis using a bong pipe. A short time later, Brett and Robert left the premises.

25. After Brett and Robert left, Darren became very angry and aggressive. Diane telephoned Robert and asked him to return to the house. During the telephone call, Robert was able to hear Darren yelling and screaming in the background.

26. Brett and Robert returned to unit 3/1 Broderick Court, Echuca and observed Darren in the kitchen area yelling and screaming. Darren had armed himself with a jump starter pack and a wheel brace and was hitting himself repeatedly to the head. Daren also picked up a kitchen knife and said that he was going to kill himself.

27. Diane left the premises, while Brett and Robert attempted to stop Darren from further hurting himself. Darren also repeatedly hit himself in the head with a mash hammer and used the knife to stab himself in the neck.

28. He did not respond to their pleas to stop, other than to yell at them to get out of the house. He further yelled at them "I'm going to kill myself, I want you to go."

29. Brett and Robert eventually left the house, via the front door, and Darren followed them out, whilst continuing to hit himself with the mash hammer. He then returned inside the premises.

Emergency Services Notification and Attendance

30. After leaving the house, Robert contacted "000". Diane also spoke with the "000" operator and requested members of the police force and Ambulance Victoria (AV) attendance.

31. Emergency Services Telecommunications Authority (ESTA) records indicate that Victoria Police was notified at 4.53 pm and AV was notified at 4.55 pm.

32. Leading Senior Constable (LSC) Wayne Sperling, LSC Allan Foskett and LSC Ian Quanchi were the first members of the police force in attendance at the scene, arriving at 4.57 pm. On arrival they spoke with the occupants, predominantly Diane, and were advised that Darren was inside the premises, had been hitting himself with an iron bar and was possibly armed with a shovel. The attending members of the police force were also advised that Darren had been consuming alcohol and illicit drugs over the previous days.

33. LSC Sperling took charge of the incident and led LSC Foskett and LSC Quanchi to the front of the premises As they approached they could hear loud thud type noises, followed by groaning from a male. They also observed blood on the ground outside the front of the premises. LSC Sperling called out to Darren on a number of occasions, asking him to come to the front door. Darren did not reply. He then tried the front door of the premises and it appeared locked. LSC Sperling moved to a position where he could see a male, whom he believed to be Darren, in the kitchen of the premises, through a window. Darren, he saw, was armed with a shovel. LSC Sperling further observed Darren hit himself twice in the head with the shovel. He observed that his face was covered in blood. LSC Sperling requested Darren to drop the shovel, but he did not respond.

34. LSC Sperling returned to the front of the premises and told LSC Foskett and LSC Quanchi of his observations. The loud thud and groaning noises continued from inside the house. LSC Sperling and LSC Foskett continued to request Darren to come to the front door. Darren replied with the words "come in" or "coming", but continued to hit himself with the shovel.

35. LSC Sperling formed the view that Darren was not coming outside, so made a decision that they would enter the premises. LSC Sperling was equipped with an oleoresin capsicum (OC) foam canister and he instructed LSC Quanchi to draw his firearm. LSC Quanchi unclipped his forearm holster, but did not draw his firearm. The front doors were left ajar to allow for egress from the premises should it be required.

36. LSC Sperling, LSC Foskett and LSC Quanchi entered the premises and observed Darren in the kitchen area armed with a shovel. He was observed to have sustained severe facial and head injuries and had blood all over his face and chest area.

37. LSC Sperling requested Darren to drop the shovel. Darren did not verbally respond, but again hit himself in the head with the shovel.

38. LSC Sperling formed a view that Darren was not going to comply with his requests so he deployed the OC foam canister at him, striking him in the face and chest region. The OC foam did not have the effect of disarming Darren and he appeared to be getting more aggressive. LSC Sperling continued to request him to drop the shovel, at which he was observed to turn the blade and to strike himself twice to the head with the edge of the blade.

39. LSC Sperling had concerns that Darren would continue in this vein, so he removed his OC spray canister from his equipment vest and deployed OC spray toward him. The OC spray also did not have the desired effect of disarming Darren and he continued to hit himself in the head with the blade of the shovel.

40. LSC Sperling directed LSC Foskett and LSC Quanchi to leave the premises because he saw no other option, based on a risk assessment he had made of the situation. All three members of the police force then left the premises, via the front door.

41. LSC Sperling moved to the front right fence line area and again continued yelling out to Darren, directing him to drop the shovel and come outside. Darren did not respond. LSC Foskett and LSC Quanchi remained at the front of the premises.

42. At 5.03 pm, an update was recorded on the ESTA chronology, provided by LSC Sperling, which states "*male hit himself in head with shovel.*"

43. Three minutes later, at 5.06 pm an update was recorded on the ESTA chronology, which stated "*male still in kitchen with shovel...has been sprayed with OC and foam...nil affect* [sic]."[6]

44. Acting Sergeant (A/Sgt) Simon Pearson arrived at the scene and took charge, at 5.06 pm. On arrival, A/Sgt Pearson received a briefing from LSC Foskett and LSC Quanchi, who he observed were at the front of the premises. A/Sgt Pearson further observed LSC Sperling at the front right area of the premises, at the fence.

45. Inspector Wayne Barclay, had become aware of the incident at 5.05 pm and was dispatched to attend the scene at 5.07 pm.

46. At 5.08 pm an update was recorded on the ESTA chronology, from LSC Sperling, which stated "*Male still going off...hitting himself in head...armed in shed.*"[7]

47. A/Sgt. Pearson commenced a planned response to the situation and directed LSC Quanchi to the left side of the premises, whilst LSC Foskett remained at the front and LSC Sperling remained at the right side, effectively establishing a cordon around the premises. A/Sgt. Pearson requested further police units to attend to assist and they were dispatched at 5.09 pm.

48. At 5.11 pm an update was recorded on the ESTA chronology from A/Sgt. Pearson, which stated: "*Aggressive violent male has injured himself...speaking with male.*"[8]

49. At 5.12 pm an update was recorded on the ESTA chronology, which states "*perimeter surrounded...nil member going into flat.*"[9]

50. At 5.13 pm an update was recorded on the ESTA chronology, which identifies a request from A/Sgt. Pearson for the Crisis Assessment Team (CAT) to be notified to attend.

51. At 5.18 pm an update was recorded on the ESTA chronology, from A/Sgt. Pearson, which states "*male still in premises...still communicating...having some issues with bystanders.*"[10]

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[6] Inquest Brief, Appendix I, page 469.

[7] Inquest Brief, Appendix I, page 469.

[8] Inquest Brief, Appendix I, page 470.

[9] Inquest Brief, Appendix I, page 470.

[10] Inquest Brief, Appendix I, page 470.

52. At 5.18 pm, Acting Senior Sergeant (A/S/Sgt.) Dale Simm attended the scene as did, Inspector Wayne Barclay. Inspector Barclay took charge of the incident and established a command post, in the driveway, outside unit 2/1 Broderick Court, Echuca.

53. Inspector Barclay commenced a planned response to the incident, which included notification and consultation with the Critical Incident Response Team (CIRT), Dog Squad and regional negotiators.

54. At 5.18 pm an update was recorded on the ESTA chronology, indicating a request by Inspector Barclay for the attendance of a regional police negotiator to attend the scene.

55. At 5.19 pm an update was recorded on the ESTA chronology, which related to the earlier request for the CAT Team, and states – "*WBI psych CAT services notified – 1300 363 788 – notified on call worker – unlikely to come out.*"[11]

56. At 5.21 pm an update was recorded on the ESTA chronology, which identified a request by Inspector Barclay for the Melbourne based CIRT to be notified and attend.

57. At 5.27 pm an update was recorded on the ESTA chronology, from LSC Sperling, which states "*spoke to males partner...has been taken away by AV in past.*"[12]

58. At 5.28 pm an update was recorded on the ESTA chronology, from A/S/Sgt. Simm, which states "*male no longer in site...NK if still harming.* [sic]"[13]

59. At 5.50 pm, Inspector Barclay was contacted by Sgt. Lappin of the CIRT and was advised that they were en route to the scene, but were still over 2 hours away.

60. At 5.51 pm an update was recorded on the ESTA chronology, from A/S/Sgt. Simm, which states – "*male is communicating with member at back of premises.*"[14]

61. At 5.55 pm, police negotiators, Sgt. John Trebilcock and Sgt. David O'Dea attended the scene.

62. At 6.00 pm, Inspector Barclay directed negotiator, Sgt. Trebilcock, to the rear of the premises to attempt to communicate with Darren.

63. Sgt. Trebilcock immediately attended the rear of the premises with Sgt. O'Dea and commenced attempting to communicate with Darren via a bathroom window.

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[11] Inquest Brief, Appendix I, page 470.

[12] Inquest Brief, Appendix I, page 470.

[13] Inquest Brief, Appendix I, page 470.

[14] Inquest Brief, Appendix I, page 471.

64. Inspector Barclay obtained the contact mobile number for Darren and made three attempts to ring him. The mobile phone was heard ringing inside the premises, but was not answered by Darren.

65. At 6.10 pm, Inspector Barclay contacted Sgt. Lappin, from the CIRT Team and had a further discussion with him in relation to an immediate action plan.

66. Inspector Barclay also had a conversation with attending ambulance personnel in relation the nature of the injuries to Darren.

67. At 6.17 pm an update was recorded on the ESTA chronology, which states – "*male still speaking with members...in one rear room of house...speaking to negotiators.*"[15]

68. At 6.20 pm, State Emergency Service personnel attended the scene, following a request from Victoria Police, to provide additional lighting.

69. At 6.30 pm, Inspector Martin Dorman attended the scene and received a briefing from Inspector Barclay.

70. As a result of his communications with Darren at the rear of the premises, Sgt. Trebilcock returned to the front of the premises advised Inspector Barclay that he was in the bathroom at the rear and making sounds consistent with moaning and groaning.

71. As a result of the conversation with Sgt. Trebilcock, Inspector Barclay spoke again with Sgt. Lappin and formulated an immediate action plan, articulated as follows –

- *We could not afford to wait CIRT arrival*
- *Entry would be effected by police on scene under my command*
- *There would be two teams*
- *Team 1: 4 members Sgt. Trebilcock, Sgt. O'Dea, LSC Foskett and LSC Pearson would stay at the rear of the premises and continue communicating with Darren. Sgt. Trebilcock verbals only, LSC Foskett with Sgt. O'Dea to pull open the window and curtains with a garden rake from a safe position and LSC Pearson to provide OTST cover by use of OC product.*
- *Team 2: 3 members A/S/Sgt. Simm, SC Wallis and LSC Quanchi. Entry would be through the front door on my command and only when I was assured Darren was in the bathroom, unarmed and it was safe for members to enter. Order of march*

[15] Inquest Brief, Appendix I, page 471.

– *A/S/Sgt. Simm (Semi Auto Pistol), followed by SC Wallis (O/C product) and LSC Quanchi (handcuffs and blanket).*[16]

72. The plan was conveyed to all members, including those not directly involved. Each member was spoken to by Inspector Barclay to ensure they understood the plan. Each team was instructed by Inspector Barclay to rehearse their respective roles.

73. The plan was implemented with Team 1 deployed to the rear of the premises. Inspector Barclay was subsequently advised that Darren was now asking for help. At 6.50 pm Inspector Barclay instructed Team 1 to enter the premises, which they did.

74. Darren was located on the floor of the bathroom inside the premises. He was placed on an evacuation sheet, which had been provided by ambulance personnel at the scene, and brought to the front of the premises.

75. Darren was then placed onto a stretcher and treated by attending ambulance personnel, with the assistance of members of the police force present.

76. At 7.00 pm an update was recorded on the ESTA chronology, which states "*male with severe neck injuries*"[17]. Also at this time a request was made for the attendance of the police air wing (for ambulance transport).

77. At 7.03 pm an update was recorded on the ESTA chronology, from A/S/Sgt. Simm, which states "*male is custody...male with severe neck injuries...AV on scene treating male.*"[18]

78. A short time later Darren was conveyed to the Echuca Hospital, via ambulance. He was taken into the emergency department, where he was attended to by hospital staff. He was transferred to a resuscitation trolley and shortly afterwards lost consciousness.

79. Hospital staff, ambulance personnel and members of the police force attempted resuscitation, but he could not be revived.

80. He was pronounced deceased at 7.42 pm.

81. Following this incident, all members of the police force involved returned to the Echuca Police Station. The Victoria Police Homicide Squad and Professional Standards Command also attended.

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[16] Inquest Brief, page 112.

[17] Inquest Brief, Appendix I, page 471.

[18] Inquest Brief, Appendix I, page 471.

82. All members of the police force involved in this incident were subjected to drug and alcohol testing, in accordance with Victoria Police policy. The results of all tests were negative to the presence of any alcohol or drug.

MIRTAZAPINE

83. Darren had not taken the prescribed Mirtazapine for five days prior to his death, however Dr. Morris O'Dell, VIFM, has provided an expert opinion that "*the effects of the high level of methylamphetamine are more likely to be an explanation for Mr Baxter's behaviour than any withdrawal effect from the relatively brief exposure to mirtazapine.*"[19]

FAMILY CONCERNS

84. I am aware that certain family members hold the view that the attending members of the police force did not act quickly enough. I refer to the statement of Brett where he states "*The police seemed to set up at the front of the house. They didn't appear to be doing anything*".[20] Brett further states "*In relation to the way police handled it, I would say that I thought they should have gone in to get Darren quicker than they did. I also thought they should have let Bobby and I go in to try and get him out. It looked like they were just sitting back and doing nothing, when they should have been trying to get him out of the house.*"[21]

85. Robert has stated "*I've been asked my opinion about the way police handled the situation with Darren on this night. I just think that the police should have done something, rather that just trying to talk to him. There were quite a lot of police there and I think they could have gone in to get Darren out of the house. At the time I thought they should have gone in and used a Tazer* [sic] *to stop Darren from hitting himself.*"[22]

POST INCIDENT REVIEW OF POLICE ACTIONS

86. I have been provided with a post incident review[23] of the police response and management of this incident co-ordinated by Senior Sergeant Tim Hoban, Centre for Operational Safety,

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[19] Inquest Brief page 216.

[20] Inquest Brief page 40.

[21] Inquest Brief, page 42.

[22] Inquest Brief, page 48.

[23] Inquest Brief, Appendix L.

who convened a Post Incident Review Team (PIRT), comprising of senior Victoria Police personnel.

87. The PIRT assessed the police response to the incident, in terms of adherence to current operational safety training and the ten operational safety principles, which have been taught within Victoria Police since 1994.

88. The 10 operational safety principles are:

- Safety First – the safety of police, the public and offenders or suspects is paramount;
- Risk Assessment – is to be applied to all incidents and operations;
- Take Charge – exercise effective command and control;
- Planned Response – take every opportunity to convert an unplanned response into a planned operation;
- Cordon and Containment / Manage – unless impractical, adopt a "cordon and containment" approach;
- Avoid Confrontation – a violent confrontation is to be avoided;
- Avoid Force – the use of force is to be avoided;
- Minimum Force – where the use of force cannot be avoided, only use the minimum amount reasonably necessary;
- Forced Entry Searches – are to be used only as a last resort;
- Resources – it is accepted that the "safety first" principle may require the deployment of more resources, more complex planning and more time to complete.

89. The PIRT concluded "*The consensus regarding this incident is that the response by individuals – and the collective – was within the expectations of training. The CFOS (Centre for Operational Safety) will consider this incident in the context of future training needs.*"[24]

90. In addition to a review of the overall operational response to this incident, the PIRT made comments in respect to the current status regarding the carriage of conducted energy devices (CED's) also referred to as 'tasers' and their possible application in this incident. The police personnel attending and involved in this incident were not issued with CED's. The review found, as follows –

[24] Inquest Brief page 501.

"The current status regarding the carriage of CED's is that they are only carried within Metropolitan Melbourne by the C.I.R.T and Special Operations Group. They are carried outside Melbourne within the Bendigo, Morwell, Traralgon, Moe, Ballarat, Geelong and Corio police commands. Funding pressures currently limit CED carriage to these areas however a Business Case exists for an expansion of this area for the 2014 / 2015 financial year."

91. The review further states:

"Hypothetically, if a CED was carried by Echuca 302, the PIRT concedes it may have been effective in incapacitating BAXTER, during the initial confrontation. The risks of deploying a CED are similar to that of OC in that you must be in close proximity to your target, in order to maximise your chance of an effective deployment. Likewise it may have been effective at any time during a planned attempt to arrest Baxter. The incapacitating effect of a CED may have afforded the responding member an opportunity to overpower Baxter in order to deliver him to medical assistance thus increasing the probability of survival. In doing this however the members would still have been exposed to the risk of blood and other potential containments. This risk would be extremely difficulty to mitigate."[25]

92. The review also determined that all Victoria Police personnel attending and involved in this incident were qualified at operational safety training and were carrying operational safety equipment (other than the two regional negotiators), in accordance with Victoria Police policy.

FINDINGS

Having considered all of the evidence contained in the Inquest Brief and having heard sworn evidence from the Coroner's Investigating Member, I find that Darren Robert Baxter born 25 March 1967 died on 7 May 2013 as a result of complications of self-inflicted incised injuries to the neck.

93. I have outlined in detail the minute-by-minute conduct of the Victoria Police in this Finding in order to respond to the family's initial concerns that more could have been done to deter Darren from his conduct. These situations are fraught with difficulties and one can look at it with the benefit of hindsight and form the view that another outcome could have been possible. Whilst this may be true, that is only with the benefit of hindsight in my view. What was not apparent to by-standers, was the extent of efforts being conducted at

[25] Inquest Brief page 500.

the rear of the premises to engage with Darren in a non-confrontational manner and the efforts being made to have expert assistance to help them deal with the situation. At least two units were on their way from Melbourne when the situation was brought under control in Echuca.

94. Darren's behaviour was unpredictable and he was armed. I do not believe that the community would expect that police members be required to place themselves at risk of injury in attempting to disarm a person in these circumstances.

95. I am satisfied that the members of the police force involved in this incident acted in accordance with Victoria Police policies and procedures and did not contribute to his death.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published as part of the Court record.

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

Ms Diane Vella
Ms Anita Baxter
Ms Lynette Baxter
Mr Brett Packer
Mr Robert Ritchie
Chief Commissioner Ken Lay APM, Chief Commissioner of Victoria Police
Detective Senior Sergeant Shane O'Connell, Investigating Member of Victoria Police

Signature:

JACINTA HEFFEY
CORONER
Date: 28 November 2013