QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Benjamin Anthony Freear**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Maryborough
FILE NO(s):	2019/5507
DELIVERED ON:	24 April 2026
DELIVERED AT:	Brisbane
HEARING DATE(s):	28 February 2023; 3-4 April 2023; 18-19 December 2024
FINDINGS OF:	T Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, avoiding being placed in custody, police shooting, siege, SERT, mental health, diagnosis and treatment of adult ADHD, monitoring of drugs of dependence.

REPRESENTATION:

Counsel Assisting
Ms S Lio-Willie (3-4 April 2023) and Ms C McKeon (18-19 December 2024)

Family
Ms B Stringer and Mr D Payard (instructed by Caxton Community Legal Centre)

Commissioner of Police
Ms S Donkin, QPS Legal Services

Sgt Leonforte, SERT Operators 198, 133 and 190
Ms R Tierney, Gilshenan and Luton

Dr Maryam Sana
Mr R Nattrass (instructed by Avant Law)

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Introduction

1. Benjamin Freear was aged 40 years when he died on a rural property at St Mary, near Tiaro, on 8 December 2019. The night before his death, he had been drinking alcohol at an acquaintance's property at Tiaro. During the evening, his mood and behaviour deteriorated. Across the course of several hours he assaulted his partner, threatened to shoot and kill various neighbours, damaged property and discharged firearms repeatedly.

2. Consequently, numerous calls to emergency services were made by Ben's family and neighbours to report his conduct. Police from the local area responded to the calls but were unable to deescalate Ben. Police negotiators and the Special Emergency Response Team (SERT) were then tasked to respond on the basis that Ben was a person in significant crisis.

3. SERT located Ben at the property at St Mary using a remotely piloted aircraft system (drone) and went there in light armoured vehicles on the morning of 8 December 2019 to locate him.

4. Soon after the arrival of SERT, Ben appeared and drove his 4WD vehicle towards a gate on the property. He fired a rifle at officers in one of the SERT vehicles, who returned fire. Over the course of the next hour, Ben exchanged gunfire with SERT from both inside and outside his 4WD, with SERT vehicles needing to repeatedly reposition.

5. SERT officers were eventually directed to intercept Ben as he drove towards them in his 4WD, with his rifle positioned out his window. They fired at his oncoming vehicle and he eventually stopped about 30 metres from one of the SERT vehicles. He alighted and walked towards one of the SERT officers. Other officers fired at him and he was struck by their bullets, one of which struck his neck.

6. Despite immediate first aid by SERT officers and attending paramedics, Ben was unable to be resuscitated.

7. His cause of death was determined to be a gunshot wound to the neck.

The adequacy of the police investigation

8. Ben died in the course of a police operation. He was also trying to avoid being put into custody by police before he died. Accordingly, pursuant to s.10(2) of the *Coroners Act 2003* (the Act), his death was classified as a death in custody and was subject to mandatory inquest.[1]

9. The Internal Investigation Group of the Ethical Standards Command (ESC) was subsequently deployed to investigate the circumstances of Ben's death, including SERT's actions.[2]

[1] *Coroners Act 2003*, ss 10(2) and 27(1)(a)(i).
[2] Ex A7- Police Report.

10. Detective Senior Sergeant Mash was tasked as Principal Investigator. A 112-page coronial report with various annexures was provided by DSS Mash in July 2021. The report included:

- a summary of circumstances leading up to the death,
- initial procedures following the death, scene and forensic investigations,
- investigative interviews and statements,
- medical history and autopsy examination results,
- antecedents and victimology of Ben,
- notification of his next of kin,
- further inquiries and investigations conducted including the obtaining of CAD recordings

11. The report also considered whether the death was preventable, legal and QPS policy issues, and police training (by way of Operational Skills and Training opinion).[3]

12. The relevant conclusions reached by DSS Mash were:

a) Ben died as a result of a gunshot wound to his neck, most likely fired by SERT Operator 190;

b) All three SERT officers who fired on Ben acted lawfully in the execution of their duty, employing lethal force to avoid grievous bodily harm or death to themselves or their colleagues;

c) The use of force option engaged to resolve this incident was authorised, justified, reasonable, proportionate, appropriate, legally defensible and tactically sound and effective; and

d) There was no evidence to support any breach of discipline or misconduct by any police officer regarding Ben's death.[4]

13. While not expressly stated, the contents of the report supported the conclusion that Ben's death was not preventable from a policing perspective. The investigation recommended that the SERT video capability trial continue.[5]

14. Counsel for Ben's family submitted that DSS Mash should have interviewed Sergeant Leonforte and Senior Constable Burke, two officers from Tiaro Station who responded to the initial call outs.[6] It was recommended *"an instruction be issued to QPS that it should be standard procedure to interview the initial responding officers for the purposes of an investigating report"*.[7]

[3] Ex A7- Police Report.
[4] Ex A7- Police Report at page 104.
[5] Ex A7- Police Report at page 105.
[6] T2-97 at lines 37-T2-98 at line 3.
[7] T2-98 at lines 19-21.

15. I am satisfied that the ESC investigation was appropriately targeted in the circumstances of Ben's death. Whether an investigator interviews a first responder is a matter to be determined in their discretion. Whether the involvement of that responder was material to the circumstances leading up to a person's death will be a relevant consideration.

16. I do not agree that all first responders should be interviewed in each case, and decline to make that recommendation to the Commissioner.

17. I accept the submission from Counsel Assisting that the coronial investigation was professional, extensive and thoroughly considered the circumstances of Ben's death, as well as the use of body worn cameras in SERT deployments and the video capability trial underway at the time.[8]

The inquest

18. An inquest can form part of a coroner's investigation into the cause and circumstances of a death that has been reported to the coroner. As part of the investigative process, it is necessary to seek out and record as many of the facts concerning the death as the public interest requires.

19. The purpose of an inquest is to make the findings required under s 45 of the Act to inform the deceased person's family and the public in a transparent fashion about how the death occurred.

20. In appropriate cases comments can be made on anything connected with a death investigated at an inquest on ways to prevent deaths from happening in similar circumstances, or on matters relating to public health and safety or the administration of justice.

21. However, a coroner must not include in the findings, comments or recommendations, any statement that a person is or may be guilty of a criminal offence or is or may be civilly liable for an action.

22. A pre-inquest conference (PIC) was held in Brisbane on 28 February 2023. Ms Lio-Willie appeared as Counsel Assisting. Leave to appear was granted to Ben's family, the police officers involved in the incident and the Commissioner of the Police.

23. Immediately before the commencement of the PIC, written submissions seeking to widen the scope of the inquest were provided by legal representatives for Ben's family.

24. The family sought to widen the scope of the inquest to include *"consideration and investigation of (Ben's) adult attention deficit hyperactivity disorder (ADHD) diagnosis and the subsequent prescribing of medications to him, particularly dexamphetamine"*. However, further material and witnesses proposed to give evidence on the widened scope were not contemplated within these submissions.

[8] T2-93 at lines 1-6.

25. I reserved my decision on this application, but foreshadowed at the PIC that I was not inclined to disturb the listing dates of 3-5 April 2023, and that if the scope of the inquest was widened, the hearing of these issues would occur at a later date.

26. On 2 March 2023, I determined that the scope of the inquest was to be widened to include the diagnosis of Ben with ADHD in April 2018 (**Issue 5**) and the mental health treatment provided to Ben from April 2018 to the date of his death (**Issue 6**). I determined that these issues would be heard at a date to be fixed, pending the gathering of further medical evidence on these issues and expert reviews of the material.

27. The first tranche of the inquest was held in Hervey Bay between 3 and 4 April 2023. Ms Lio-Willie appeared as Counsel Assisting. This tranche explored the following four issues:

    a) **Issue 1**: the findings required by s.45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death;

    b) **Issue 2:** the appropriateness of the police response to reported concerns about Benjamin Freear on 8 December 2019;

    c) **Issue 3:** the appropriateness of the actions of attending police officers on 9 December 2019;

    d) **Issue 4**: the adequacy of the police investigation into the death of Benjamin Freear;

28. The brief of evidence was tendered and eleven witnesses were called to give oral evidence:

    a) DSS Stuart Mash;
    b) Lisa McGregor;
    c) Nathan Bulgarelli,
    d) Stephen Watson;
    e) Rollo Campbell;
    f) Joanne Whitford-Smith;
    g) Sergeant David Leonforte;
    h) SERT Operator 198;
    i) SERT Operator 133;
    j) SERT Operator 190; and
    k) Sgt Lucas Finney.

29. The second tranche of the inquest was held in Brisbane between 18 and 19 December 2024. Ms McKeon appeared as Counsel Assisting. Leave to appear on behalf of Dr Maryam Sana was granted to Avant Law. This tranche explored the following two issues:

    a) **Issue 5:** The diagnosis of Benjamin Freear with ADHD in April 2018; and

b) **Issue 6:** The mental health treatment provided to Benjamin Freear from April 2018 to the date of his death.

30. Given the divergence in content and evidence between the issues traversed in the first tranche of the inquest (issues 1-4) and this tranche (issues 5-6), an opening on the known facts before the Court relating to issues 5 and 6 was provided by Ms McKeon. The brief including the evidence obtained subsequent to the first tranche was tendered afresh. Dr Maryam Sana, Dr John Flanagan and Dr Gregory Apel gave oral evidence.

31. I am satisfied that all information relevant to and necessary for my findings was made available at both tranches of the inquest.

The evidence

Personal history

32. Ben was born at Gympie on 29 September 1979 to Sharon Ah-Sam and Anthony Freear. He had four siblings and the family moved to Tiaro when Ben was aged about 10 or 11. His parents divorced when he was aged around 13. Ben had difficulties with school due to hyperactivity and fine motor coordination, but completed year 10 through a TAFE program. He predominantly worked on farms from age 16.

33. Ben married Mary Freear in 2007. They had known each other since their teenage years. They raised five children together, four of whom were from their marriage and one of whom was Ms Freear's previous relationship. They were together until about a year before Ben's death.

34. Ms Ah Sam fondly remembered her son as a "true Aussie bushman" who loved the countryside and farming, and as a person who had developed an extensive knowledge of farming, fishing, hunting, welding and engineering.

35. Ms Ah Sam provided a moving family statement in which she reflected that there was 'nothing good' about the suffering that Ben had endured because of mental distress and physical pain in the years before his passing. There was also nothing good about the circumstances leading up to his passing while he was experiencing a breakdown, and the enduring loss felt by his family.

36. Ben and Mary's relationship was volatile at times when Ben was drinking. Mary provided a family statement in which she said that it was difficult to capture Ben's life and character in words as he was a complex and unique man. Mary wanted to ensure that their children remember the positive and wonderful parts of Ben's character.

37. Like Ms Ah Sam, Mary said that Ben was resourceful and knew how to live off the land. He would always share what food was available, including when they lived on country in the community of Aurukun. Mary said that Ben was good at including people and making sure people felt part of the group. He would be

friends with people who were on the fringes of society such as people with disabilities and mental illness. He also gave his time and energy to people generously.

38. It is clear that Ben was loved by his family and his passing has caused them enormous pain. I extend my sincere condolences to them.

39. Sometime during October 2018, Stephen Watson asked Ben to return to Tiaro to work on his property, as there was too much work following the death of Mr Watson's wife. Ben accepted this offer. He and his family moved to a *"bush camp"* on Mr Watson's property at Glenbar Road, St Mary. The bush camp consisted of a shed, bus and a caravan. Mr Watson lived in a residence elsewhere on the land.

40. In January 2019, Ben left the bush camp and took all his equipment with him. While Mary Freear initially stayed at the camp with their children, she and the children moved into a house in town in May 2019.

41. In June 2019, Ben returned to the bush camp. Ben and Mary Freear briefly resumed their relationship around August 2019. However, on around 1 September 2019, after Ms Freear saw Ben shooting at trees, she packed up the children and left the relationship.

42. At the time of his death, Ben was living at the bush camp with Lisa McGregor and her three sons D (16), K (13) and N (12). Ms McGregor and her sons had lived there with Ben since 20 October 2019. While Ms McGregor had known Ben for around four years, the two had been in an intimate relationship for only six weeks prior to his death.[9]

43. Ben had a criminal history that commenced with an entry in 1998 where he was fined for possession of drugs and weapons. Following this, he was sentenced in the Maryborough District Court on 4 September 2008 for two counts of burglary with intent involving actual or threatened violence, two counts of going armed to cause fear, seven counts of common assault and one count of unlawful possession of a weapon. He received a head sentence of two years' imprisonment, with parole release after serving three and a half months in custody.[10]

Medical history

44. Ben had a past medical history of:

    a) Smoking 10 cigarettes daily;
    b) Chronic pain related to variously described conditions such as arthropathy, inflammatory polyarthritis and fibromyalgia;
    c) Recurrent right subacromial bursitis;
    d) Hyperlipidaemia;
    e) Recurrent MSRA infections;

[9] Ex B22-Statement of Lisa McGregor; Ex B22.1- Recorded Statement of Lisa McGregor.
[10] Ex C30- Queensland Criminal History.

f) Alcohol abuse (he reportedly ceased drinking in 2016 but in October 2018 self-reported drinking);
g) Attention Deficit Hyperactivity Disorder (ADHD);
h) Depression;
i) Anxiety;
j) Insomnia; and
k) Left foot fracture.

45. In February 2018, Ben had an episode of suicidal ideation following conflict with Ms Freear. This had occurred after Ben had allegedly returned home to find his 12-year-old son smoking. He left the home and, after obtaining money from his mother, went to visit his brother. They had a fist fight and Ben left in his car. He began to ruminate on bad memories and had a significant panic attack. He considered shooting himself but did not have a weapon with him. He later reported he debated whether to hang himself when his petrol ran out, or present to the Winton Hospital after noticing the hospital sign.[11]

46. According to family members, this was not the first instance Ben had articulated he felt suicidal and reported him expressing suicidal ideation as early as age 18 - 19.[12]

47. On 27 February 2018, Ben attended the Winton Medical Practice. On that day he was admitted to the Winton Hospital ED for management of acute agitation and suicidal ideation. In that respect, hospital notes from 27 February 2018 recorded he had expressed feelings of suicidal ideation by either hanging or with a gun, and past attempts of hanging.[13]

48. On admission, the following psychiatric history was taken:

> *"Denies any psychiatric inpatient admissions*
> *However currently prescribed 20mg Prozac and 10mg Diazepam by local GP for anxiety*
> *Describes a long history of anxiety and mood swings*, 'I have always been able to work my way through these problems in the past by working hard and long, never needed any help or medication'
> *However due to fibro-myalgia Ben is unable to work, is on Newstart, and has lost his means of working through any problems via strong physical work*
> *Mother believes Ben suffered from undiagnosed ADHD as a child. Ben saying there is some evidence fibro-myalgia may develop from ADHD and/or PTSD*
> *Father discharged from the Army …*
> *Ben believing he may be experiencing symptoms of undiagnosed BPAD - describing wide mood swings".*[14]

[11] Ex F10- CWMHS records at page 1.
[12] Ex B1- Recorded statement of Sharon Ah Sam; Ex B13- Recorded statement of Mary Freear.
[13] Ex F8 – Winton Medical Practice medical records; Ex F7- Winton Hospital medical records- page 35 in quotation.
[14] Ex F10- CWMHS records at page 2.

49. Ben reported a *"rugged history of brawling and fighting and associated minor charges"* and said he had completed a two-month prison sentence at age 28.[15]

50. Ben advised from a physical perspective he had been diagnosed with fibromyalgia in 2017 and often experienced pain, including daily strong headaches. He had been assigned a rheumatic specialist but was not open to receiving further care.[16] He told clinicians that Diazepam was the only thing that calmed him down, but was not taking it at that time. He had also trialled Endep, Zoloft, and Arapax without benefit. His other previous medications had included Lyrica, Steroids, Norflex, Avanza, and Tramadol (to which he was allergic).[17]

51. A developmental and family history was taken. In assessing Ben's current functioning and practical issues, Ben told clinicians his relationship with his wife was volatile. He also mentioned an occasion he was beaten and kicked in the head, reporting PSTD and foggy thinking since that event.[18]

52. A Mental State Examination (MSE) was conducted. He was noted as being *"restless ++ in the chair. Often moving his hands over his head, mostly avoidant eye contact"*.[19] The overall clinical impression was that he was anxious and agitated and required a psychiatric consultation.

53. Ben was reviewed by Dr Flanagan, consultant psychiatrist, by way of video conference on 2 March 2018. Ben was discharged after three days of the initial admission after his mental state had been assessed as improved. The plan was for Dr Flanagan to arrange an appointment with him in Rockhampton, with a focus on addressing potential ADHD.[20]

54. On admission, Ben's medications were Diazepam for anxiety (2 mg with one to be taken every 8 hours as required) and Paroxetine for depression (20 mg - Ben told the Hospital he was not taking these).

55. On discharge, the Diazepam prescription was altered to 5mg twice daily as required for the next 5 days, and a prescription of Temazepam (10 mg to be taken at night as required for the next 5 days) was added. The Paroxetine was not amended.[21]

56. On 24 April 2018, Ben first saw Dr Flanagan at his private clinic, Hillcrest Specialist Clinic. Ben's collateral medical history had been obtained by Dr Flanagan from his then GP, Dr Savariar prior to the appointment. During the appointment, Dr Flanagan took:

    a) A general history of his issues including *"brain fog…. talking-like you're echoing, concentration, not connecting, can't keep up with*

[15] Ex F10- CWMHS records at page 2.
[16] Ex F10- CWMHS records at page 2.
[17] Ex F10- CWMHS records at page 2.
[18] Ex F10- CWMHS records at page 3.
[19] Ex F10- CWMHS records at pages 2-4.
[20] Ex F10- CWMHS records at page 10.
[21] Ex F8- Winton Medical Practice medical records at pages 5-6.

conversation…mum tried dragging me to Hospital for ADHD, just called a hyperactive kid, hyperactive, got to grade 9…ended up leaving in grade 9…snap out sometimes, had a couple of episodes…snap out and go into different things, offend people";[22]

b) Ben's personal history;[23] and

c) A treatment history, including his previous treatment with various antidepressants, for which he felt only Prozac helped a bit and that Diazepam helped him mentally and physically.[24]

57. Dr Flanagan then recorded *"Trial of Dexamphetamine 5 mg (100) up to 15 mg* [twice per day], *review* [in three weeks]*."*[25]

58. Ben's three-week review consultation with Dr Flanagan occurred on 22 May 2018. The transcribed notes record *"dex made a hell of an improvement, brain cleared, decision making ability improved, can have conversations, decision making, organised".* Ben advised he tried up to three tablets twice daily but felt he did not need it and had settled on two tablets twice daily. Decreasing his Diazepam intake to improve his restless legs was discussed.[26] The plan was to change Ben to the longer acting form of Lisdexamphetamine if he continued to do well.

59. On 13 June 2018, Dr Flanagan wrote to Dr Savariar, advising that Ben's history was complex but the central issue was a likely diagnosis of adult ADHD. Dr Flanagan advised that Ben's response to his initial trial of Dexamphetamine was very favourable and he found a dose of 10mg twice per day optimal. Dr Flanagan noted his plan was to change Ben to the Lisdexamphetamine if he continued to respond positively.[27]

60. Dr Flanagan saw Ben again at his clinic on 27 June 2018.[28] The notes document Ben reported that his organisation and head had cleared up, his decision making had improved and he had noticed his impulsiveness had flattened out. He had stopped taking Diazepam and was just taking his Dexamphetamine at two 5mg tablets twice per day.

61. He advised taking the two twice per day gave him an *"impressive result".* It was resolved that Ben would consider a change to the longer acting Lisdexamphetamine.[29]

62. On 23 July 2018, Dr Flanagan recorded:

[22] Ex F4.1- Hillcrest Specialist Centre- Transcribed notes of Dr Flanagan at pages 1-4.
[23] Ex F4.1- Hillcrest Specialist Centre- Transcribed notes of Dr Flanagan at page 2.
[24] Ex F4- Hillcrest Specialist Centre- Medical Records at pages 2-3.
[25] Ex F4- Hillcrest Specialist Centre- Medical Records at pages 2-3.
[26] Ex F4.1- Hillcrest Specialist Centre- Transcribed notes of Dr Flanagan at pages 3-4.
[27] Ex F4- Hilcrest Specialist Centre- Medical Records at page 18.
[28] Ex F4.1- Hillcrest Specialist Centre- Transcribed notes of Dr Flanagan at pages 3-4.
[29] Ex F4.1- Hillcrest Specialist Centre- Transcribed notes of Dr Flanagan at pages 3-4.

"Presentation at Chemist, wanting repeat before date, should have another 10 days or so (?)
Story of leaving one bottle at home and tablets being stolen!
Warned
Given 200 today see me before expiry, should still have another 1 repeat".[30]

63. This was the final dated entry in Dr Flanagan's records. Underneath this in the original records is a note dated 22 February 2018 commencing with what looks like *"note above"*. This date is a likely typographical error and the correct date more likely related to a date on or proximate to 23 July 2018. The note was crossed out.[31] The transcribed note stated *"note above: is wanting another script Manish prescribed three twice daily. Apparently found that better. 200- Repeats x 4. Dexamphetamine 3 Tabs BD. Repeat interval- 30 days. Will need to be reviewed before another script is issued."* The further note replacing this stated *"applied for a repeat script (to PBS Authority Line) to be told that a script had been obtained for 100 tablets x 5 repeats at the dose of 3 tablets… (twice daily). No script was given. Needs to be reviewed by one of us."*[32]

64. While it is difficult to determine what exactly transpired and when these events occurred, the following is accurate:

a) A script for Dexamphetamine 5 mg - two tablets twice per day - (200 tablets with one repeat), and no repeats to be dispensed in less than 30 days was issued by Dr Manish Chauhan on 27 August 2018;[33]

b) This script was dispensed on 27 August 2018 by the Guardian Pharmacy at Zilzie;[34]

c) No scripts for Dexamphetamine from any provider had been dispensed to Ben prior to this since 24 July 2018;[35] and

d) The singular repeat authorised by Dr Chauhan was dispensed appropriately on 2 October 2018, being over 30 days after the last dispensation of 27 August 2018.[36]

65. Dr Flanagan treated Ben between April and August 2018. During this period, pursuant to the (now repealed) *Health (Drugs and Poisons) Regulation 1996* (the HDPR) psychiatrists did not have an as-of-right authority to prescribe psychostimulant medications (within certain limits).

66. This is now regulated by the *Medicines and Poisons Act 2019* (the MPA). However, in 2018 psychiatrists could apply for a Patient Class Treatment Approval (PCTA) pursuant to s18 of the HDPR for the treatment of adult patients

[30] Ex F4.1 Hillcrest Specialist Centre- Transcribed notes of Dr Flanagan at page 4.
[31] Ex F4- Hillcrest Specialist Centre- Medical Records at page 16.
[32] Ex F4.1 Hillcrest Specialist Centre- Transcribed Notes of Dr Flanagan at page 1.
[33] Ex F4- Hillcrest Specialist Centre- Medical Records at page 17.
[34] Ex H4- QHealth- Prescription List at line 6; Ex F2- PBS records at page 4.
[35] Ex H4- QHealth- Prescription List at line 3; Ex F2- PBS records at page 4.
[36] Ex H4- QHealth- Prescription List at line 7; Ex F2- PBS records at page 4.

who have ADHD. If approved, a PCTA would provide authority to prescribe *"specified condition drugs"* (namely Lisdexamphetamine up to 70mg daily, Dexamphetamine up to 40mg daily and Methylphenidate up to 80mg daily). This was on the proviso that a confirmed ADHD diagnosis had been made according to DSM-V. This PCTA was also conditional on the patient not being drug dependent at the time or not having any past, present illicit or prescription drug misuse history. If a patient did not meet the criteria stated on the PCTA the psychiatrist would have to obtain an individual treatment approval to prescribe specified condition drugs.[37]

67. During the period Dr Flanagan treated Ben, he held a PCTA.[38] Four scripts for Dexamphetamine 5 mg were issued by Dr Flanagan as follows:

PRESCRIBE_DATE	DISPENSE_DATE	RECEIVED_DATE	DISPENSER_NAME
24/04/2018	24/04/2018	30/04/2018	CHEMIST WAREHOUSE NORTH ROCKHAMPTON
22/05/2018	24/07/2018	31/07/2018	BLACKWATER PHARMACY
22/05/2018	22/05/2018	28/05/2018	CHEMIST WAREHOUSE NORTH ROCKHAMPTON
22/05/2018	29/06/2018	4/07/2018	GUARDIAN PHARMACY ZILZIE[39]

68. Ben was prescribed and dispensed Diazepam and Temazepam during this period by Dr Savariar, which raised no concerns.[40]

69. Dr Chauhan's involvement with Ben extended to the provision of the singular script on 27 August 2018. He also held a PCTA.[41]

70. Dr Sana treated Ben at the Bopple Surgery between 25 October 2018 and 3 December 2019.[42]

71. On 25 October 2018 Ben first saw Dr Sana, having moved from Rockhampton to Tiaro a few months prior. He wanted a referral for the MBH mental health team, and further Dexamphetamine scripts. Dr Sana took a history about his family, social and medical history including his diagnosis of ADHD, did a MSE and assessed him physically.

72. On assessment, Ben denied he was experiencing any side effects from the Dexamphetamine, and in particular advised that despite being anxious at times, his mood was okay, he had no paranoias or delusions, and his sleep, energy and appetite were okay.

73. He advised Dr Sana he was taking 1-2 5mg tablets of diazepam per week and two 5mg tablets of Dexamphetamine three times per day. Dr Sana recorded these as

[37] Ex H3- QHealth- Form 25 response at page 1.
[38] Ex H3- QHealth- Form 25 response at pages 1-2; Ex H6- Dr Flanagan prescribing approval.
[39] Ex H3- QHealth- Form 25 response at page 2; Ex H4 QHealth- Prescription List at lines 2-5.
[40] Ex F2 - PBS at pages 3-4.
[41] Ex B41- Dr Chauhan; Ex H3- QHealth- Form 25 response at pages 1-2; Ex H5- Dr Chauhan prescribing approval.
[42] Ex B38- Sana, Dr Maryam- Bopple Clinic and Ex F3- Bopple Surgery- Medical Records.

"medication started by specialist". Of note, Ben's permitted dosage per his last prescriptions from Dr Chauhan was only for two 5mg tablets of Dexamphetamine twice per day. Importantly, however, Dr Sana did not prescribe Dexamphetamine on that day. She preferred instead to request records from Dr Flanagan and Ben's previous GP, Dr Savariar. The plan was once they were received, a referral to MBH would be sent. Further, Dr Sana recorded *"RED flags discussed with him"*.[43]

74. On 1 November 2018, the requested records were received and reviewed. Dr Sana discovered Ben's correct dose was two 5mg tablets of Dexamphetamine twice per day and confirmed his Diazepam dosage. After reviewing the records, confirming the doses and favourable responses, and obtaining PBS authority to prescribe, Dr Sana provided Ben with a renewal of his prescription for Dexamphetamine at two 5mg tablets twice per day with meals, with one repeat script interval at 20 days. As Dr Sana noted Dr Flanagan planned to switch the medication to Lisdexamphetamine, she determined to organise a referral to a psychiatrist closer to Tiaro at his next appointment.[44] This prescription was dispensed by the Tiaro Pharmacy on 2 November 2018.[45]

75. On 6 November 2018, Ben saw Dr Sana. They discussed his mental health issues in detail and Dr Sana organised a Mental Health Care Plan (MHCP) to address his psychological issues and enable him to access ongoing support from a local psychologist, Dr Harris. The referral had a planned date for review with Dr Sana of 29 November 2018, and noted he *required "reviews with a local psychiatrist, psychologist and adjustment of dose as his symptoms of ADHD gets (sic) worse sometimes."*

76. A referral was sent to a local psychiatrist, Dr Alastair Gilbert, at Hervey Bay in relation to Ben's ADHD, personality issues and psychosocial issues and included the letter from Dr Flanagan. Ben also reported fatigue and tiredness, so urgent blood tests were ordered. Again, Dr Sana noted *"red flags discussed"*.[46]

77. On 14 November 2018, Ben saw Dr Sana in relation to pain in his right knee. Dr Sana assessed and swabbed it, considered it may be infected and prescribed him 500mg of Cephalexin to be taken twice daily for 5 days. She also discussed his blood test results with him, which were largely normal excluding the indication of hyperlipidaemia. She recorded Ben wanted to focus on diet and lifestyle modification for three months.[47]

78. On 21 November 2018, Ben saw Dr Sana for a follow up regarding his knee infection. Ben also had anxiety, so Diazepam 5mg to be taken once daily as

[43] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 1; Ex F3- Bopple Surgery- Medical Records at pages 20-21.
[44] Ex B38- Sana, Dr Maryam- Bopple Clinic at pages 1-2; Ex F3- Bopple Surgery- Medical records at pages 21-22.
[45] Ex H4- QHealth- Prescription List at line 8.
[46] Ex F3- Bopple Surgery at pages 6-14, 15, 18, 22; Ex B38- Sana- Dr Maryam- Bopple Clinic at page 2.
[47] Exhibit B38- Sana, Dr Maryam- Bopple Clinic at page 2; Exhibit F3- Bopple Surgery- Medical Records at pages 127-128.

required was prescribed.[48] A repeat prescription for Dexamphetamine was dispensed by Tiaro Pharmacy to Ben that day.[49]

79. On 30 November 2018, Dr Gilbert advised Dr Sana via facsimile that Dr Phillip Bird at the Sunshine Coast would best support Ben.[50]

80. On 05 December 2018, Ben saw Dr Sana with pain in his right shoulder. He was examined, prescribed Mobic and was referred for an ultrasound and x-ray.[51]

81. On 12 December 2018, the diagnosis of bursitis was confirmed by Dr Sana with Ben. Management was discussed. A further prescription for Diazepam was provided.[52]

82. On 16 January 2019, Ben saw Dr Sana, advising her that he had received a letter from Dr Gilbert stating his clinic did not specialise in adult ADHD and he had been referred to Dr Bird. Dr Sana assessed his mental state with a focus on any active mental illness. Medications, doses, compliance and safety were discussed.

83. A risk assessment was undertaken and Dr Sana assessed that while Ben was anxious, he was not experiencing side effects and was safe to continue to receive his remaining two repeats on the basis he was stable and was *"clearly getting benefit"*. Again, his mood and sleep were assessed as being okay.[53]

84. On 21 February 2019, Ben saw Dr Sana for a renewal of his Dexamphetamine prescription. Dr Sana assessed his mental state with a focus on any active mental illness. Medications, doses, compliance and safety were discussed. A risk assessment was undertaken and Dr Sana assessed that while Ben was anxious, he not experiencing side effects, and was safe to be provided with the same Dexamphetamine prescription on the basis he was stable and *"clearly gaining benefit"*. Again, his mood and sleep were assessed as okay. He also had a swollen lymph node under his jaw, and this was treated.[54] Bart Vanarey Maryborough Pharmacy dispensed his new prescription for Dexamphetamine the same day.[55]

85. On 1 and 8 March 2019, Ben was seen and treated for an abscess in his left forearm post discharge from MBH in relation to cellulitis and the abscess. He was prescribed 5mg of Endone to be taken twice per day with meals for his pain. He was determined to have non-multi-resistant MSRA again and was prescribed

[48] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 2; Ex F3- Bopple Surgery- Medical Records at pages 129-130.
[49] Ex H4- QHealth- Prescription List at line 9.
[50] Ex F3- Bopple Surgery- Medical Records at page 19.
[51] Ex B38- Sana, Dr Maryam- Bopple Surgery at page 2; Ex F3- Bopple Surgery- Medical Records at page 131.
[52] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 2; Ex F3- Bopple Surgery at page 132.
[53] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 2; Ex F3- Bopple Surgery- Medical Records at page 133; Ex F12- Headspace records at page 2.
[54] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 2; Ex F3- Bopple Surgery- Medical Records- at page 133.
[55] Ex H4- QHealth- Prescription List at line 14.

Ciprofloxacin.[56] On 1 March 2019, the prescription for Endone was dispensed by Tiaro Pharmacy to Ben.[57]

86. On 8 March 2019, Ms Ah Sam emailed the Bopple Surgery with *"strong concerns about the medication* [Ben was] *prescribed"*, namely Dexamphetamine.[58] Concerns expressed were:

    a) Ben had suggested he had ADHD, and then was diagnosed with it;

    b) He was running out of medication up to a fortnight before he could fill another script because he was taking more tablets than he was prescribed;

    c) His behaviour and sleep patterns had deteriorated, and he was presenting with irrational, grandiose thinking;

    d) He had left his wife after she had asked him to stop taking his medication given his behaviour;

    e) His medication needed to be reviewed and his family wanted him off the Dexamphetamine; and

    f) He was his usual self when he was not taking Dexamphetamine and there was a marked difference in his behaviour when he was taking it.[59]

87. On 14 March 2019, a repeat prescription for Dexamphetamine was dispensed by Tiaro Pharmacy to Ben.[60]

88. On 21 March 2019, Dr Sana became aware of the email. After considering the concerns it raised, she requested the surgery recall Ben for an urgent appointment. Ben told the surgery he was working and would contact the practice to make an appointment.[61]

89. Sometime between 22 and 23 March 2019, the boyfriend of Ben's sister, completed suicide by shooting himself. Ms Ah Sam reported that Ben was significantly impacted by the death and told her he felt like he had let the deceased man down.

90. On 26 March 2019, Ben saw Dr Sana. Dr Sana informed him about the email from his mother and that it raised concerns about his behaviour, sleep, medication, overuse of his medication and relationship issues.

91. Ben expressly told Dr Sana he did not want her to liaise with his mother. He was

[56] Ex B38- Sana, Dr Maryam- Bopple Clinic at pages 2-3; Ex F3- Bopple Surgery- Medical Records- at pages 135-136.
[57] Ex H4- QHealth- Prescription List at line 20.
[58] Ex F3- Bopple Surgery- Medical records at page 23.
[59] Ex F3- Bopple Surgery- Medical records at page 23.
[60] Ex H4- QHealth- Prescription List at line 18.
[61] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 3; Ex F3- Bopple Surgery- Medical records at page 137.

spoken to about the need for a review of his ADHD and treatment by a psychiatrist, and she sent an urgent referral to Dr Phillip Bird attaching Ms Ah Sam's email. The referral letter asked for the urgent review on the basis he had *"behavioural disturbances mentioned by his mother and difficulty in sleep".* Her notes recorded *"difficult pt to manage, has missed last few appointments…presented today to get the script for Valium, states he has been stressed on the weekend".* The MSE notes confirmed he was anxious at times, had low mood, and that his sleep was poor. He was given his Diazepam scripts only, and the plan was that he be reviewed in two weeks.[62]

92. On 8 April 2019, Ben saw Dr Sana again for a further Diazepam prescription. Dr Sana assessed his mental health conditions, ADHD and anxiety and provided him with a script to keep him stable until his psychiatric review. A further referral was sent to Dr Bird. On this occasion Ben reported his sleep was okay.[63]

93. On 15 April 2019, Dr Bird called Dr Sana and discussed Ben. Dr Bird advised that the earliest he could see Ben would be mid-May 2019.[64] Dr Bird's clinical notes stated *"I note Dr Sana does not think it is a good idea that he continues taking the Dexamphetamine medication. I concurred with this opinion, stating that the medication did not appear to suit him".*[65]

94. Following this conversation, Dr Bird's practice attempted to contact Ben to schedule an appointment with him. When he called back on 30 April 2019, he was advised to go to his GP to discuss the next steps in his management.[66]

95. On 7 May 2019, Ben saw Dr Sana for another Diazepam prescription. Dr Sana emphasised the need for review by Dr Bird, and they again discussed the concerns raised by Ms Ah Sam. Dr Sana assessed Ben's ADHD and mental state, which he reported had improved. He said his sleep was improving with Diazepam. Dr Sana provided him with another prescription for Diazepam and another referral to Dr Harris. Dr Sana's notes recorded *"adult ADHD under control".* [67]

96. On 15 May 2019, Dr Sana received a letter from Dr Bird's clinic advising Ben had not scheduled an appointment and continuity of care was being handed back to Dr Sana.[68]

97. On 31 May 2019, Ben saw Dr Sana for an abscess on his left arm. Dr Sana also assessed Ben's ADHD, and opined it was reasonably stable. Another Diazepam script was provided. Ben advised Dr Sana that he wanted his recurrent staph aureus infections treated before having to travel to a psychiatrist.

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[62] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 3; Ex F3- Bopple Surgery- Medical records at pages 28, 138- 139.
[63] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 3; Ex F3- Bopple Surgery- Medical records at page 140.
[64] Ex B38- Sana, Dr Maryam- Bopple Clinic at page 3; Ex F3- Bopple Surgery- Medical records at page 141.
[65] Ex B37- Bird, Dr Philip- The Gosforth Clinic at page 2; Ex F11- The Gosforth Clinic- Medical Records at page 2.
[66] Ex B37- Bird, Dr Philip- The Gosforth Clinic at page 2.
[67] Ex B38- Sana, Dr Maryam at page 3; Ex F3- Bopple Surgery- Medical records at page 142.
[68] Ex B38- Sana, Dr Maryam at page 3; Ex B37- Bird, Dr Philip- The Gosforth Clinic at page 2.

98. He also advised his joint pains were getting worse so he would not be ready to see the psychiatrist until he could drive the two hours. Ben also mentioned he had limited finances. Dr Sana's ADHD assessment records: *"STABLE, impulsiveness - mild, disorganisation and problems prioritising, poor time management skills, problems focussing on a task, trouble multitasking, excessive activity or restlessness, poor planning, low frustration tolerance, frequent mood swings, problems following through and completing tasks, hot temper, trouble coping with stress".*[69]

99. On 4 June 2019, Ben saw Dr Sana for an early renewal of his prescriptions of Dexamphetamine and Diazepam, stating his car caught fire in an accident and his medications and scripts were destroyed. Dr Sana contacted police during that consultation and it was confirmed a car crash had occurred. Given the circumstances, another GP at the practice, Dr Qaisar Bashir, was asked to attend and review Ben. Dr Bashir reviewed him and it was agreed further prescriptions could be provided. Ben was advised to see Dr Bird and a further referral to Dr Bird was planned for review of Ben's diagnosis and treatment.[70] The prescription for Dexamphetamine was dispensed by Chemist Warehouse Maryborough to Ben that day.[71]

100. Unfortunately, a repeat prescription of one of the scripts supposed to have been lost in the car fire was dispensed to Ben by the Bart Vanarey Maryborough Pharmacy on 7 June 2019.[72] This is one of two occasions Ben was dispensed Dexamphetamine well within the bounds of his intervals, the other occasion being dispensations on 12 and 24 October 2019 on two different scripts.

101. Between 20 June 2019 and 18 November 2019, Ben was seen by Dr Sana relating to physical ailments and not in relation to his ADHD or mental health issues. Throughout this period, Ben was also prescribed Endone (oxycodone) on 20 June 2019 and 8 August 2019 for pain. These were dispensed the same day by the Tiaro Pharmacy.[73]

102. Between 20 June and 14 November 2019, Dexamphetamine was dispensed to Ben on the following dates:

    a) On 25 June 2019 from the prescription issued on 4 June 2019 by Tiaro Pharmacy;[74]

    b) On 16 July 2019 from the prescription issued on 4 June 2019 by Tiaro Pharmacy;[75]

[69] Ex B38- Sana, Dr Maryam at pages 3-4; Ex F3- Bopple Surgery- Medical records at pages 143-144.
[70] Ex B38- Sana, Dr Maryam at page 4; Ex F3- Bopple Surgery- Medical records at page 145.
[71] Ex H4- QHealth- Prescription List at line 23.
[72] Ex H4- QHealth- Prescription List at line 14.
[73] Ex H4- QHealth- Prescription List at lines 27-29.
[74] Ex H4- QHealth- Prescription List at line 24.
[75] Ex H4- QHealth- Prescription List at line 25.

c) On 5 August 2019 from the prescription issued on 4 June 2019 by Tiaro Pharmacy;[76]

d) On 25 August 2019 from the prescription issued on 4 June 2019 by Bart Vanarey Maryborough Pharmacy;[77]

e) On 12 October 2019 from the prescription issued on 4 June 2019 by Chemist Warehouse Gympie;[78]

f) On 24 October 2019 from the prescription issued on 24 October 2019 by Tiaro Pharmacy;[79] and

g) On 14 November 2019 from the prescription issued on 24 October 2019 by Bart Vanarey Maryborough Pharmacy.[80]

103. Of these, the dispensation of Dexamphetamine in e) and f) occurred within the 30 authorised days. This was between two different scripts.

104. On 3 December 2019, Ben saw Dr Sana in relation to a fractured left foot. Dr Sana also assessed Ben's ADHD, underlying anxiety and nicotine dependence. Dr Sana considered Ben's ADHD to be stable. He was prescribed Champix for his nicotine dependence, a risk assessment for which was conducted prior to prescription.

105. The plan was for Ben to be reviewed in three weeks. Dr Sana conducted a MSE that gave no indication Ben was experiencing distress or side effects to Dexamphetamine. His sleep was also reportedly okay. Specialist referral letters to Drs Gilbert and Harris were printed and sent. This was the last time Dr Sana saw Ben before he died.[81] While there is no mention of Dr Sana providing Ben with any fresh Dexamphetamine prescriptions in the records or her statement, one was provided on 3 December 2019 and dispensed by Chemist Warehouse Maryborough that same day.[82]

106. A final prescription was dispensed to Ben by the Tiaro Pharmacy on 5 December 2019.[83]

107. At the time Dr Sana treated Ben, she was required as a general practitioner to hold an approval to prescribe Dexamphetamine (being one of the group of legislated *"special condition drugs")* pursuant to s 78 of the now repealed *Health (Drugs and Poisons) Regulation 1996* (HDPR). Dr Sana did not hold this approval when

[76] Ex H4- QHealth- Prescription List at line 26.
[77] Ex H4- QHealth- Prescription List at line 21.
[78] Ex H4- QHealth- Prescription List at line 22.
[79] Ex H4- QHealth- Prescription List at line 30.
[80] Ex H4- QHealth- Prescription List at line 29.
[81] Ex B38- Sana, Dr Maryam at page 5; Ex F3-Bopple Surgery- Medical records at pages 167-168.
[82] Ex H4- QHealth-Prescription List at line 33.
[83] Ex H4- QHealth- Prescription List at line 31. This is a repeat from the prescription dated 24 October 2019.

she treated Ben.[84]

7 December 2019

108. On the evening of 7 December 2019, Ben, Ms McGregor and her sons K and N attended Nathan Bulgarelli's property at Glenbar Road, Tiaro. Ben appeared to be intoxicated and said he had a few to drink. He said he brought his .303 rifle with him to help Mr Bulgarelli shoot a diseased buck on his farm. Ben was drinking a plastic *"Coke"* bottle full of wine, the two boys were drinking rum and coke, and Mr Bulgarelli and his wife were drinking beer. Mr Bulgarelli did not observe Ms McGregor to be drinking.[85]

109. During the evening, Ben told Mr Bulgarelli and his wife that 2019 had been a *"really shit year"* for him and confided in Mr Bulgarelli about *"the black dog"*. Ben also discussed being hopeful for his relationship with Ms McGregor and wanting it to be like Mr Bulgarelli and his wife's relationship.

110. At about 7:30pm Mr Bulgarelli walked Ben to his car. He was drunk but did not appear depressed. Ben kissed Mr Bulgarelli on the cheek and told him how much he meant to him. Mr Bulgarelli observed Ben to be in a good mood when he left.[86]

111. On the drive back to their camp, Ben started driving erratically and swerving towards trees. Ms McGregor told him to stop driving that way and he replied, *"I'm not violent like the other fucking junkie scum boyfriends"*.[87] He continued to drive erratically until they reached their camp. He then began punching the windscreen of his car and kept yelling. He yelled at Ms McGregor to get out, and to get into her own car.

112. Near the camp, Ms McGregor and her sons got out of Ben's Landcruiser and into her green Holden Commodore. Ben opened her driver's side door and pointed a .303 rifle at her. Ms McGregor got out of the car and tried to grab the firearm from him. He then hit Ms McGregor in the left arm with the butt of the gun. Her son K got out of the car and Ben fired the rifle three times at him. He then shot a further two times into the ground. Ms McGregor again tried to wrestle the firearm from him, and this time he hit her in the arm with the barrel of the gun. She yelled at her sons to run and tried to grab Ben by the throat. He put the barrel of the gun against her head, in between her eyes. He then lowered the rifle and threw it against some scaffolding.

113. Mr Watson and Ms McGregor's other son D drove towards the camp from the main residence, and Ben fired two shots in their direction. When Mr Watson reached the camp, D got out to help his mother. N got into Mr Watson's vehicle and they drove back towards the main residence.

[84] Ex H1- QHealth- Dr Sana prescribing approvals at page 1.
[85] Ex B6- Statement of Nathan Bulgarelli.
[86] Ex B6 – Statement of Nathan Bulgarelli.
[87] Ex B22 – Statement of Lisa McGregor.

114. Ben continued to point the rifle at Ms McGregor and D. Ms McGregor, D and N then got into her vehicle and drove to the main gate where Mr Watson and K were. K then got into her car and Ms McGregor drove them away towards Tiaro.

115. Ben then drove through a gate at Mr Watson's residence and fired another four or five shots. He threatened to kill Mr Watson and pointed the barrel of the rifle at Mr Watson's face. He then fired three shots into the bonnet of Mr Watson's vehicle, and said*, "I'm going to find the others and kill them"*.[88]

116. Shortly before 8:00pm, Ben drove to the Campbell's property at Mungar Road, Tiaro, and crashed into something on the property. Mr Campbell heard a vehicle speeding into his yard and a loud bang. He then heard two gunshots being fired, and the vehicle sped off. His sister called triple zero.[89]

117. At about 8.30pm, Ben drove to the Hogan's property at Mungar Road, Pioneers Rest. He parked near a shipping container at the corner of the property with his vehicle headlights pointed towards the neighbouring property of Mr Barrett. Mr Barrett approached Ben and asked what was going on. Ben threatened to *"blow his head off"*. Ben then fired two shots and Mr Barrett returned to his home. His wife called triple zero.[90]

118. Ben then drove to Mr Hogan's residence and told him he was looking for fuel. Mr Hogan observed Ben to be upset and stressed. Ben told him that he had his .303 rifle in his vehicle, that he just put *"a shot over"* Mr Barrett's head, and he thought the police were looking for him. Ben took some fuel and told Mr Hogan and his wife that he loved them both. He then drove back past Mr Barrett's property and onto Mungar Road.[91]

119. At about 9.45pm, Ben attended Ms Whitford-Smith's residence at Thies Road, Tiaro. Ben called out*, "Hi Jo, are you there"* and then fired two shots. Ben entered Ms Whitford-Smith's home wearing camouflage pants. He was shirtless and shoeless and was holding two rifles. He said he saw a pig and shot at it. She observed Ben to be clearly intoxicated. Ben told her *"I'm in the shit, I've done it this time"*.

120. He told her he had been shooting cars and had put a bullet in someone's engine. Ms Whitford-Smith thought it was drunk talk. Ms Whitford-Smith had a guest staying with her that evening. Ben told them he also had a crossbow in the car. He repeatedly told Ms Whitford-Smith that he would *"be dead by morning"* and started crying. At inquest, Ms Whitford-Smith said Ben also told her he was a *"trained warrior"*, he was *"going to have a battle with the cops"* and that he believed the police were looking for him that night. Ben continued to drink and smoked cannabis. While at Ms Whitford-Smith's home he appeared to calm

[88] Ex B35 – Statement of Stephen Watson.
[89] Ex B10 – Statement of Rollo Campbell; Ex B9 – Statement of Natalie Campbell.
[90] Ex B2 – Statement of David Barrett; Ex B3 – Statement of Karen Barrett.
[91] Ex B15 – Recorded statement of Brenda Hogan; Ex B16 – Recorded statement John Hogan.

down. He left about midnight and drove in the direction away from Mungar Road.[92]

8 December 2019 – Events leading to the death

121. An emergency declaration was made at 5:45am.

122. At approximately 6.50am, QPS Special Emergency Response Team (SERT) officers deployed to Mr Watson's property at 4457 Glenbar Road attempted to locate Ben.

123. Two SERT teams were in light armoured vehicles (LAV) and took up containment positions on the northern and western boundaries of the property. The LAVs were unmarked Landcruisers, one white and one silver. In the white LAV were SERT Operators 198 and 122, and in the silver LAV were SERT Operators 190 and 133. The property itself was uneven terrain and sloped uphill. The operators were at the bottom of this terrain.

124. A remotely piloted aircraft system (RPAS) conducted an initial sweep of Ben's last known locations. As the initial sweep finished, and the LAVs took up their positions, Ben appeared in his Landcruiser and drove towards a gate on the northwest corner of the property, firing upon the white LAV. SERT Operator 198 returned fire.

125. The white LAV tactically repositioned by withdrawing in order to give Ben space but he continued firing. At this time, the silver LAV drove towards Ben and the white LAV. Ben got out of his vehicle and fired towards SERT Operators 122 and 198. SERT Operator 190 got out of the silver LAV. Ben fired towards him and struck the silver LAV. SERT Operator 190 returned fire, got in the LAV and reversed away to tactically reposition.

126. Ben got back in his vehicle and drove towards the silver LAV at speed. As he was driving, he held the rifle outside the driver's side window, resting the barrel on the side mirror and pointed at the silver LAV. The SERT team leader directed the teams to intercept Ben. SERT Operators 190 and 133 fired at Ben but he continued to drive towards them and stopped about 30 meters away from the white LAV team.

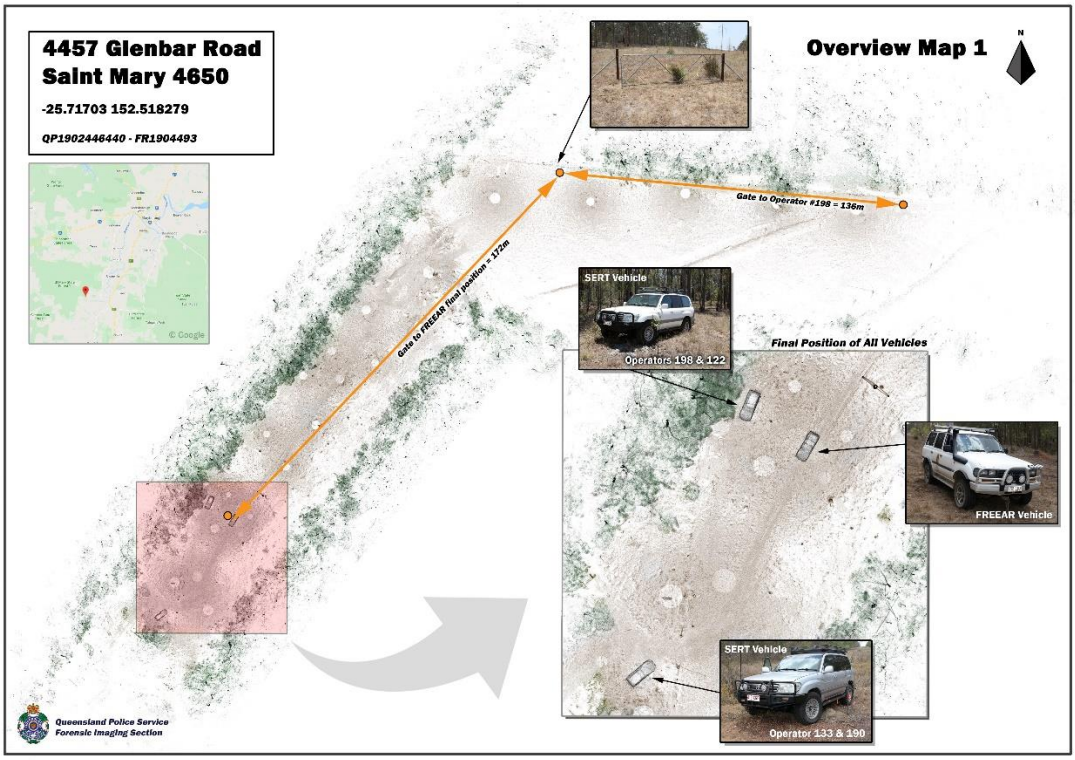
127. Ben got out of his vehicle and started to walk towards SERT Operator 122. After SERT Operator 133 fired two shots, SERT Operator 190 fired one shot, Ben fell to the ground.

128. Tactical first aid was immediately provided by SERT medics. The Queensland Ambulance Service (QAS) were called but responding paramedics pronounced him life extinct on arrival at 7:50am.

129. The emergency declaration was revoked at 9:49am.

[92] Ex B36 – Statement of Joanne Whitford-Smith; T2-91 at lines 13-15.

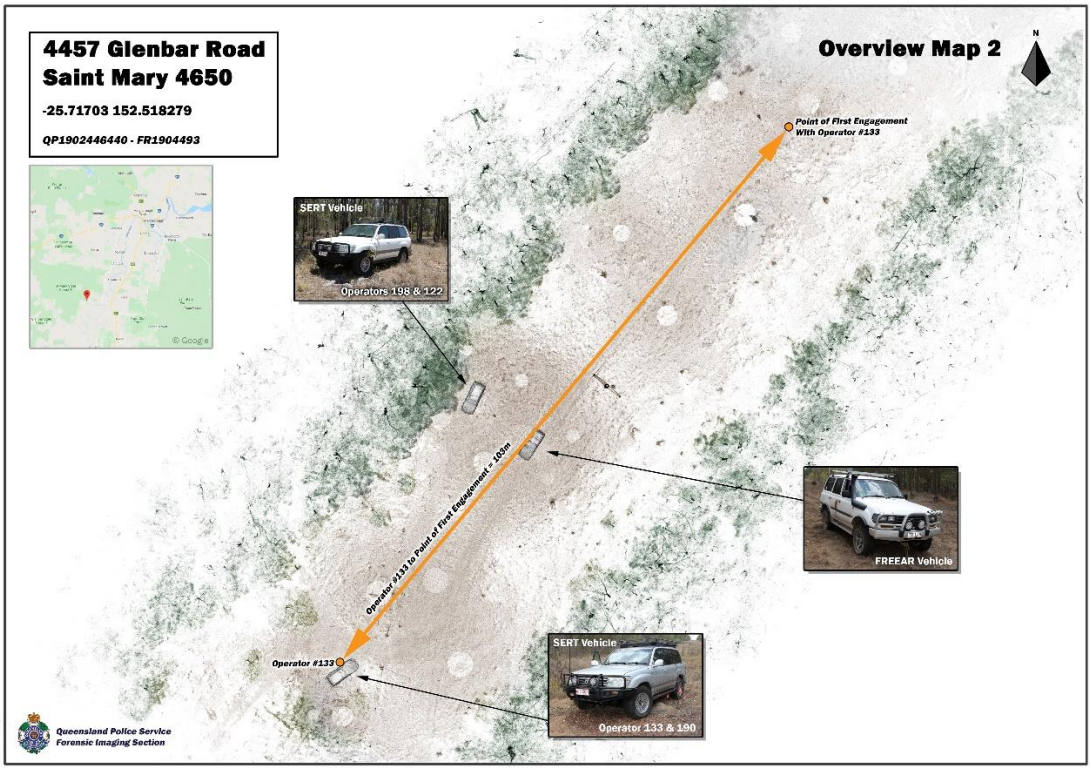
130. The image below shows the position of the LAVs proximate to the gate Ben drove through.



[93]

131. The following image shows the final position of the LAVS and Ben's vehicle, and the distance he covered to drive towards the SERT teams.

[93] Ex D2 – Overview Map 1.



94

Firearms and ballistics examination

132. The Ballistics Unit attended the scene following the shooting, and seized all weapons, shells and casings for testing. Sergeant Bevan Mankeltow of the Ballistics Unit conducted tests on the seized items, and provided a statement to DSS Mash. His findings were considered in DSS Mash's report and the inquest.

133. It was concluded Ben was in possession of two unregistered rifles, namely:

    a) One .303 British calibre Lee-Enfield Rifle No. 1 Mark III repeating bolt action rifle with an erased serial number located near his body; and

    b) One .22LR calibre Stirling Model 20 semi-automatic rifle located in his car.[95]

134. SERT Operator 133 noted the .303 calibre rifle is one of the most lethal firearms known to police[96] because of the weapon's capability for long range, high penetration, and the fact that the design features allow for rapid firing and cycling. This was compared to other bolt action designs of that era. It was initially designed for miliary use.[97] Ballistics examination identified that the magazine had capacity to hold 11 rounds.[98]

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[94] Ex D3 – Overview Map 2.
[95] A7 – Police Report at page 93; Ex C27- Ballistics report, Sgt Bevan Manktelow at pages 1-2.
[96] Ex B29 – ROI of SERT OP 133.
[97] Ex B12 – Statement of Sgt Lucas Finney, at [35]-[36].
[98] Ex C27- Ballistics report, Sgt Bevan Manktelow.

135. A semi-automatic rifle is a type of self-loading rifle that when loaded will fire one shot every time the trigger is pulled without the need to manipulate or action a bolt, lever or pump.[99]

136. Enquiries with the Australian Criminal Intelligence Commission (ACIC), National Firearm Trace Program identified that neither firearm was recorded on the Australian Firearm Information Network and should have been surrendered or placed with a dealer for registration during the 1996 National Firearm Buy-Back and during previous firearms amnesties.[100]

137. The following cartridges and cartridge cases were located at the scene:

    a) One unfired cartridge with a light firing pin impression located in the .303 rifle's chamber;

    b) Six discharged cartridge cases located at the *"eastern"* gate area;

    c) One discharged cartridge case located in the driver's footwell of Ben's Landcruiser;

    d) One unfired cartridge with a light firing pin impression located at Mungar Road, Tiaro (Mr Campbell's property); and

    e) One discharged cartridge case and one unfired cartridge with a light firing pin impression located at Glenbar Road, Tiaro (Mr Watson's property).

138. The ballistics examination confirmed that all of the discharged cartridges and the light firing pin impressions of the unfired cartridges were all created by the .303 rifle.[101]

139. Investigations identified that Ben did not hold a licence or authority under the *Weapons Act 1990* to possess ammunition or the firearms.[102]

Vehicles[103]

140. Ben's Landcruiser was examined, and a number of projectile strikes were located to the front and rear of the vehicle. The projectile strikes at the rear of the vehicle had impacted the rear windows. Because of the extent of the damage, it was difficult to clearly assess the strikes. Sergeant Manktelow was therefore unable to determine if the projectiles were exiting or entering the vehicle. Based on the examination of the interior, Sergeant Manktelow concluded it was most likely that these were all exits, as there was no internal damage indicating a projectile was travelling from the rear of the vehicle towards the front.

[99] Ex B12 – Statement of Sgt Lucas Finney at [33].
[100] Ex A7 – Police Report at page 93.
[101] Ex C27 – Ballistics Report, Sgt Bevan Manktelow.
[102] Ex A7- Police Report at page 94.
[103] C27 – Ballistics Report, Sgt Bevan Manktelow.

141. On the basis that the projectile damage to the rear windows were considered exits, Sergeant Manktelow located at least 37 points of damage that appeared to be the first impact point of an individual projectile. That is, there were at least 37 shots that struck the vehicle.

142. The forensic examination of Ben's vehicle also identified blood within the driver's compartment and determined Ben bled while in the driver's seat.[104]

143. The silver LAV was examined and a projectile defect was located in the driver's door. A total of nine .308WIN calibre discharged cartridge cases and twenty-five .223 REM calibre discharged cartridge cases were located around the vehicle.

144. The white LAV displayed evidence of at least four projectile strikes to the vehicle, the rear driver's side door, the roof, and the roof rack. A single .223REM calibre discharged cartridge case was located in the driver's footwell.

145. The only firearms involved in the incident that could discharge the .308WIN calibre ammunition were the SERT semi-automatic rifles.

Autopsy results

146. On 10 December 2019, Dr Andrzej Kedziora conducted an autopsy consisting of an external and full internal examination of the body, including associated testing. The report was finalised on 8 March 2021 following peer review by Associate Professor Alex Olumbe.[105]

147. Four distinct gunshot wounds were located by Dr Kedziora, who found:

    a) A gunshot wound with an entry point behind the right mastoid process[106] and a multifocal exit point on the left side of the neck. The wound was directed from right to left, and slightly from above to below. It passed between posterior parts of the first and second cervical vertebrae causing extensive fractures, destruction of the upper cervical spinal cord, as well as fractures of the skull and third cervical vertebra. This was the fatal wound **(GSW 1)**;

    b) A superficial gunshot wound to the right upper shoulder with no distinct entry or exit points. The projectile skimmed the skin while travelling from left to right, and then collided with the lateral part of the right clavicle causing its fractures. It then broke into multiple fragments which lodged in the soft tissues in this area. The wound track was directed from left to right, slightly from back to front, and from above to below. This wound did not involve vital structures **(GSW 2)**;

    c) A gunshot wound to the right forearm which entered anteriorly and exited medially. It consisted of a ragged defect, much larger than the entry wound,

[104] Ex B25 – Statement of Sgt Rasmussen.
[105] Ex A5- Autopsy Report.
[106] The bony projection of the skull at the base of the temporal bones located behind the ear lobes.

due to scattering of projectile fragments. The wound would have injured the brachial artery and caused significant bleeding. There was no bony injury **(GSW 3)**; and

d) A gunshot wound to the left upper arm with an entry point at the lateral surface of the proximal upper arm and an exit point at the mid upper arm. The wound track was directed from above to below, from left to right and slightly from back to front. The projectile collided with the shaft of the left humerus and caused a comminuted fracture. It then fragmented and exited the limb, likely together with small bony fragments, through a ragged defect on the anterolateral surface of the mid left upper arm. The injury would have caused disruption of the brachial and radial arteries and caused profuse bleeding **(GSW 4)**.

148. Dr Kedziora otherwise found:

a) A large number of abrasions and lacerations, some containing metallic fragments) on the upper and left anterior parts of the body;

b) A large number of radiopaque particles seen in the superficial soft tissues on postmortem CT consistent with glass and metallic fragments; and

c) No evidence of significant natural disease.

149. Of these findings, Dr Kedziora opined:

a) there were four distinct gunshot wounds (GSW 1-4) and numerous indistinct gunshot-related injuries to the body;

b) All identified entry wounds in the skin had ragged outlines which suggested they were inflicted by projectiles which had collided with or passed through an intermediate target; and

c) The multiple indistinct wounds were caused by small parts of projectiles and possibly glass and metal fragments lodged in soft tissues of the head, neck and torso after colliding with the windshield, side glass and possibly other parts of the vehicle. Some of these skin wounds may have also been caused by bone fragments.

150. No intact projectiles were recovered. The numerous small metallic fragments that were located were provided to police from the Ballistics Unit for examination.

151. Toxicological testing yielded the presence of amphetamine, Diazepam, Nordiazepam, Temazepam, Tapentadol and alcohol in Ben's system. Dr Kedziora's opinion on the results of the analysis was as follows:

a) Amphetamine was present at a non-toxic level;

b) Diazepam was present at a therapeutic/non-toxic level;

c) Nordiazepam (a metabolite of diazepam) was present at a therapeutic/non-toxic level;

d) Temazepam (a metabolite of diazepam) was present at a subtherapeutic/non-toxic level;

e) Tapentadol was present at a therapeutic/non-toxic level; and

f) Alcohol was present in femoral blood, urine and vitreous humour at 88, 158 and 118 mg/L, respectively.

152. Dr Kedziora concluded that the cause of death was a gunshot wound to the neck.

153. I accept the opinion of Dr Kedziora with respect to Ben's cause of death.

Expert pharmacology and toxicology opinion

154. The Court obtained expert evidence from Professor Olaf Drummer, Forensic Pharmacologist and Toxicologist.[107] Professor Drummer was asked to provide an opinion on:

a) The impacts of Dexamphetamine on a person who does have ADHD against those on a person who does not have ADHD, and any adverse impacts the drug may have on a person; and

b) The effects on a person being prescribed a psychostimulant, benzodiazepine, and opioid based medication concurrently.[108]

155. Professor Drummer noted that:

a) Prescription and supply data showed that Dexamphetamine had been dispensed to Ben 27 times from 24 April 2018 until the last supply of 5 December 2019. This totalled 3200 5 mg tablets amounting to, on average, about 5 tablets daily, not accounting for any unused tablets;

b) In the months before his death, Ben was also prescribed and supplied Diazepam and oxycodone, along with antibiotics; and

c) There were no records of him ever being prescribed or supplied Tapentadol in the PBS listings, but medical records indicated he had taken this drug in the past.[109]

156. In Professor Drummer's opinion, the 5mg Dexamphetamine tablets Ben was prescribed were immediate release tablets. This meant that the absorption of the drug would have been much quicker than sustained release preparations (such as

[107] Ex I1- Report of Professor Drummer- Toxicologist.
[108] Ex I1- Report of Professor Drummer- Toxicologist.
[109] Ex I1- Report of Professor Drummer- Toxicologist at pages 2-3.

Lisdexamphetamine) designed to release the drug at a slower rate. The time to peak blood concentration for 5mg Dexamphetamine is about 2 hours.[110]

157. According to Professor Drummer, the elimination half-life of amphetamine can range from 8 to 30 hours. Depending on elimination rate it will be detected in the blood for 2 to 3 days following last use. This also affects the peak blood concentration.[111]

158. Professor Drummer noted dexamphetamine is usually well tolerated and can be effective for treating ADHD, but product information current at the time of Dr Drummer's report noted contraindications for prescribing the drug included "*patients who currently exhibit severe depression, anorexia nervosa, psychotic symptoms or suicidal tendency".*

159. Professor Drummer noted the product warning/precaution that *"emergent aggressive behaviour or a worsening of baseline aggressive behaviour has been reported during stimulant therapy",* but qualified this to the effect that patients with ADHD may experience aggression as part of their medical condition. The further warning/precaution noted was *that "administration of Dexamphetamine may exacerbate symptoms of behaviour disturbance and thought disorder in patients with a pre-existing psychotic disorder"*.[112]

160. Professor Drummer opined that:

    a) Ben's postmortem concentration of Dexamphetamine (0.04mg/kg) was broadly consistent with his prescribed dose. This did not mean that he did not use more than his prescribed 20 mg daily. However, if he did there was no toxicological evidence of gross misuse or overdose that was more likely to trigger serious adverse events;

    b) Based on the information provided, Ben had stopped using Dexamphetamine for approximately four weeks up to October 2019. The dispensing data indicated he received 100 tablets on 12 and 24 October, 14 November and 05 December 2019. These two months would have been more than sufficient for him to become accustomed to the drug again and for the concentrations in his body to achieve a steady state;

    c) Diazepam and Tapentadol were found in his blood. The levels were consistent with usual therapeutic use;

    d) Blood concentration results of these drugs did not give any indication of when he took any of them, or the dosage;

    e) Diazepam and Tapentadol are not contraindicated in combination with Dexamphetamine;

[110] Ex I1- Report of Professor Drummer- Toxicologist at page 3.
[111] Ex I1- Report of Professor Drummer- Toxicologist at page 3.
[112] Ex I1- Report of Professor Drummer- Toxicologist at pages 3-4.

f) Dexamphetamine is generally regarded as a relatively safe and effective drug for the treatment of ADHD, but *"a person's mental state can affect their response, let alone the circumstance he finds himself in"*;

g) Alcohol was present in Ben's system at the time of his death at a concentration that would have affected his behaviour, but the degree to which this drug did affect his behaviour and mental state was dependent upon his history of alcohol use and associated behaviours; and

h) Tapentadol is a drug used for the short-term treatment of severe pain, usually when other options have failed. While the concentration detected in Ben's postmortem femoral blood did not suggest misuse from a dose perspective, the drug has the potential to increase sedation and possibly cloud cognitive function when used in combination with Diazepam and alcohol, and possibly also amphetamine.[113]

Conclusions on Inquest Issues

161. The adequacy of the police investigation into Ben's death (issue 4) has been addressed above.

Issue 1 – the Findings required by s. 45 of the Coroners Act

162. The *Coroners Act 2003* requires me to find, if possible, the cause of a person's death, who the deceased person was and when, where and how they came to die. As a result of considering all the evidence pertaining to this death, including the material contained within the brief of evidence, I make the following findings.

Identity of the deceased –	Benjamin Anthony Freear
How he died –	On the evening 7 December 2019, Ben assaulted his partner, threatened other neighbours, damaged property, and discharged firearms. This prompted several people to call for urgent police assistance. Attending police could not engage or locate Ben. Special Emergency Response Team Operators attended the property the following morning. Ben drove towards police in his vehicle while discharging his rifle. After he left his vehicle, he continued to shoot at police and he was fatally shot.
Place of death –	4457 Glenbar Road TIARO QLD 4650 AUSTRALIA
Date of death–	8 December 2019

[113] Ex I1- Report of Professor Drummer- Toxicologist at pages 5-6.

Cause of death – Gunshot wound to neck

Issue 2 - The appropriateness of the police response to reported concerns about Benjamin Freear on 7 December 2019

163. Sergeant Leonforte was the Officer in Charge (OIC) of Tiaro Police Station and rostered on a 4:00pm to 12:00am shift on 7 December 2019. He was also a trained police negotiator.

164. At 7:33pm, Ben's son, N, called police requesting assistance because he had an argument with his father at a farm outside of Tiaro. N did not wish to stay with his father and was walking to the Tiaro Police Station to be collected by his mother.[114] However, N and his mother never arrived at the police station.

165. At 8:11pm, Ms Campbell called triple zero and advised that *"Ben Freear"* had fired a gun and was in his vehicle driving towards Tiaro in a white Landcruiser. Tiaro Police Station was alerted by the Police Communication Centre that the job was priority Code 2, requiring a lights and sirens response to attend Mr Campbell's property.[115]

166. Sergeant Leonforte rang Ms Campbell and confirmed the details. He formed the opinion that the call for service was high risk. Sergeant Leonforte and his partner Senior Constable Burke dressed in ballistics vests and left the station in marked police sedan, BM455. They drove towards Mungar Road. After they crossed the Mungar Bridge, they travelled a short distance and observed a white 4WD driving towards Tiaro. The police officers performed a U-turn. As they did so, they noticed the 4WD also did the same and parked on the side of the road.

167. Police approached the vehicle and found Mr Watson in shock as the sole occupant of the car. Mr Watson told officers that Ben shot at him, and they observed a bullet hole in Mr Watson's vehicle. Police directed Mr Watson to drive to the Tiaro police station.

168. Police updated the police communication centre of a secondary offence location (Mr Watson's property) and advised that Ben was armed with a .303 rifle. Sergeant Leonforte further advised that Ben was having a mental health breakdown, discharging a firearm, driving a white Landcruiser, and also had a domestic violence disturbance with his partner, whose identity was unknown.

169. Sergeant Leonforte then received information that a woman in a green coloured vehicle with her children had been shot at 5 kilometres north of Tiaro. As a result, Sergeant Leonforte and SC Burke drove towards Tiaro. Shortly after reaching the Bruce Highway, another report came through of shots being discharged near Pioneers Rest Mungar Road, and police diverted towards that address.

[114] Ex B19 – Statement of Sgt Leonforte; Ex C19 – Incident Log CAD 3636.
[115] Ex B19 – Statement of Sgt Leonforte; Ex C16 – Incident Log CAD 3830.

170. At 8:46pm, Ms Barrett called triple zero and reported that Ben had parked up next to a container on the corner of her property with a spotlight on his vehicle directed at their house. Her husband drove to the container to speak with Ben. He had shot at Mr Barrett but did not injure him.[116]

171. Sergeant Leonforte stated that multiple Maryborough Police units were attending Tiaro enroute from multiple locations. Sergeant Leonforte attended the Campbell property and observed the damage caused to Mr Campbell's vehicle.

172. Shortly before 9:00pm, Sergeant Leonforte received information that Ben was at an address on Mungar Road. Maryborough Police concurrently established vehicle cordon points north of Mungar Road.

173. At 9:11pm, Karen Barrett called triple zero again and advised that Ben's vehicle had left the property and was driving towards Maryborough.[117]

174. Sergeant Leonforte requested police negotiators. He tried to call Ben's mobile multiple times during the evening but the calls went directly to voicemail except for one. During the call Ben answered, Sergeant Leonforte told Ben he had received different reports about him discharging a firearm and wanted to find out if he was ok. Ben responded with words to the effect of, *"I don't want to talk about it,"* and *"you just try and find me and see what happens to you, see how good a shot you are."*[118]

175. Sergeant Leonforte considered Ben was a person in crisis, but he did not sound intoxicated. He then arranged for all attending Maryborough Police units to meet at a designated police forward command location for a briefing.

176. Sergeant Leonforte then contacted the on call Commissioned Officer and requested that SERT be advised, and that consideration for their dispatch to be made. He and SC Burke continued to conduct patrols and visit multiple back tracks and roads in an attempt to locate Ben.

177. Sergeant Leonforte took up with the SERT Inspector shortly after 3:00am. They later attended a briefing with the SERT team shortly after 5:00am at Wilsons Road, Tiaro.

178. Counsel Assisting submitted that Sergeant Leonforte recognised the risk Ben presented to the community and to himself, and recognised that SERT were the appropriate team to be deployed. It was submitted that the police response to the calls for service throughout the evening of 7 December 2019 was appropriate in the circumstances.

179. This response included immediate investigations commencing, patrols being arranged by local police units, and requests for police negotiators and SERT attendance.[119]

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[116] Ex C17 – Incident Log CAD 4035.
[117] Ex C18 – Incident Log CAD 4162.
[118] Ex B18 – Statement of Sgt Leonforte at [38].
[119] T2-92 at lines 4-14.

180. I agree that the police response to concerns about Ben on 7 December 2019 was appropriate.

181. Counsel for Ben's family submitted I should recommend that Queensland Health consider expanding the use of QScript to allow the QPS to receive real-time information when they are dealing with a person suffering a mental health crisis through information sharing protocols that already exist between these agencies.[120]

182. This submission was opposed by legal representatives for the attending police and the Commissioner of Police.

183. Having regard to the rationale for the establishment of the prescription monitoring system, I do not agree that it would be appropriate to allow the QPS to access QScript in the way submitted by the family.

Issue 3 - The appropriateness of the actions of attending police officers on 8 December 2019

184. The actions of the attending SERT officers are set out above.

Incident management[121]

185. The SERT Commander was Operator 143 and the SERT Tactical Commander was Operator 88.

186. An incident action plan (IAP) was formulated by Operator 88 in conjunction with Operator 102, the Team Leader and Emergency Action Commander.

187. Operator 145 was the SERT intelligence officer present at the incident and gave a situation briefing to the attending Operators.

188. The resources available to SERT included the Armoured Tactical Vehicle (BearCat), two light armoured Toyota Landcruisers (LAV), a number of unarmoured police vehicles, a police negotiator, RPAS and a police dog. The SERT Commander had requested the use of a helicopter (PolAir and QGAir Rescue Helicopter) but this resource was not available because of weather conditions.

189. As Ben's whereabouts were not known, the plan was to isolate, contain, and attempt to locate him from a safe distance and then negotiate using a loudspeaker system from the BearCat.

190. The plan was to use the three armoured vehicles to isolate and contain the property (inner cordon), then move forward to one of Ben's last known locations to contain that area and commence negotiations. The RPAS and police dog were

[120] T2-95 at lines 11-16.
[121] Ex B12 – Statement of Sgt Finney.

in support to clear areas in and around the stronghold. Unarmoured police vehicles were placed on the road outside the property to form the outer cordon.

191. After the RPAS had finished an initial sweep at one of Ben's last known locations, and the two LAVs had taken up position on the inner cordon, Ben emerged in his vehicle. He then started firing upon SERT Operators 122 and 198 in the white LAV. SERT Operators 122 and 198 tactically repositioned in an attempt to give Ben space. However, Ben continued firing, forcing a confrontation with police.

192. After the initial shots fired by Ben, SERT Operators in the BearCat used the loudspeaker system to announce the police presence and attempt negotiations with Ben to deescalate the situation.

193. A police negotiator also tried to contact Ben via mobile telephone.

194. Sergeant Finney, a Frontline Skills Training officer, considered the police response and incident management on 8 December 2019. He concluded that the management of the incident by SERT and the plans developed to apprehend Ben were consistent with QPS policy and procedure.

195. Sergeant Finney was also of the opinion that the actions of SERT Operators prior to and after Ben firing upon them did not escalate the situation.[122] Sergeant Finney's evidence was considered by DSS Mash in his investigation and was also included in the brief of evidence at inquest[123].

SERT Briefings

196. SERT teams arrived at Wilsons Road and first had a briefing, during which the teams were provided the following intelligence update:

    a) Ben was an experienced bushman, shooter and hunter;[124]

    b) There were grave concerns for his welfare and possible actions given his conduct the previous evening, and that he was still armed;

    c) The QPS officers were responding to a domestic violence incident and attempted murder, wilful damage, threatening violence while armed, unlawful discharge of a weapon, and possession of a weapon;

    d) Ben's whereabouts were unknown, but he was in a white Landcruiser station wagon;

    e) There were mental health concerns and, in the past, he had witnessed a suicide which had adversely affected him;

[122] Ex B12 – Statement of Sgt Finney at [136].
[123] Ex A7- Police Report; Ex B12 – Statement of Sgt Finney.
[124] Ex B28 – ROI of SERT OP 122.

f) Ben wished to engage police in a shootout and he was actively seeking police;[125]

g) Ben had possible access to a .303 firearm and a crossbow; and

h) That the response was classified as high risk.

197. The ultimate goal articulated by the attending SERT officers was *"to arrest the POI"*.[126]

Use of force

198. The response by the SERT Operators in discharging their firearms was considered by Sergeant Finney in the opinion he provided to DSS Mash.[127]

199. Sergeant Finney discussed the actions of Operators shooting at Ben and his vehicle as he drove towards them. Sergeant Finney explained that when a police officer is required to shoot at a moving vehicle, officer's intention is to stop the vehicle from moving.

200. While it may appear that rendering a vehicle inoperable is the simplest way to achieve this, the materials used in the construction of most vehicles mean it is highly unlikely that a projectile from small arms would cause enough damage to render a vehicle inoperable.[128]

201. Consequently, in most circumstances where a police officer is required to shoot at a moving vehicle, the officer will fire at the driver of the vehicle in an attempt to incapacitate the driver.

202. When a projectile fired from small arms passes through hard vehicle surfaces, it can significantly affect the performance of the projectile and the projectile's direction of travel. Therefore, an officer will likely have to fire numerous rounds at the driver before they can achieve the desired outcome.[129]

203. Sergeant Finney concluded the Operators complied with QPS policy and discharged their firearms at Ben's moving vehicle in response to Ben threatening deadly force, and there were no other reasonable options available to them to stop the threat posed by Ben.[130]

204. Sergeant Finney also considered the SERT Operators responded in accordance with QPS training generally, and fired their weapons until the threat posed by Ben no longer existed.[131]

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[125] Ex B28.1 – Transcript of ROI of SERT OP 122 at [240] – OP 122 could not recall if that information was provided to the team as a result of witness accounts, or if it was via flags on QPRIME.
[126] B27, B28, B29, B31, B32- ROIs of SERT Ops 102, 122, 133, 190 and 198.
[127] Ex B12 – Statement of Sgt Finney; Ex A7- Police Report at pages 101-102.
[128] Ex B12- Statement of Sgt Finney at [84].
[129] Ex B12- Statement of Sgt Finney at [85]-[86].
[130] Ex B12- Statement of Sgt Finney at [87].
[131] Ex B12- Statement of Sgt Finney at [100].

205. Ultimately, Sergeant Finney concluded that the use of lethal force by each of the SERT Operators was justifiable, and in response to an honestly perceived imminent and legitimate threat to their own life and the life of the other Operators. Further, an attempt to deploy the less lethal use of force options would have unnecessarily exposed the SERT Operators to unacceptable risk, and would have been a tactically poor decision.[132]

Medical care and treatment provided to Ben once he was shot

206. Once Ben was shot, SERT operators identified it was safe to approach him and immediately provided tactical first aid, including rendering CPR. The QAS and medivac were also called to attend the scene. CPR was ceased due to the assessment that Ben had no pulse, and the nature of the injuries sustained. Ben was clearly deceased when the QAS arrived at 7:57am.[133]

207. Sergeant Finney considered SERT Operators 122, 133, 190 and 198 fulfilled their obligations to render first aid to Ben as soon as reasonably practicable.[134]

Body worn camera / dashboard camera

208. None of the SERT Operators were issued with a body worn camera (BWC). Neither of the two LAVs was fitted with a dashboard camera. Video footage of the incident would have assisted the investigation and the inquest.

209. Acting Superintendent Partrige of the Specialist Response Group identified the number of challenges with the use of BWC by SERT operator in overt operations, including:[135]

    a) Carriage and positioning of devices being problematic due to the amount and variety of equipment carried by operators on their tactical vests;

    b) The manner in which SERT marksmen deploy operationally does not lend itself to the effective mounting of BWC on the body or head, given the variety of terrain;

    c) In most cases, the distance over which SERT marksmen operate renders BWC incapable of capturing video of a person subject to marksmen attention or action;

    d) The drawn-out nature of SERT deployments would require camera equipment to record for extended periods (in some cases in excess of 15 hours);

    e) Given the highly protected nature of SERT deployments, the secure storage of camera recordings would be of critical importance; and

[132] Ex B12 – Statement of Sgt Finney at [140] – [143] and [155]-[156].
[133] Ex C5 – QAS electronic Ambulance Report Form.
[134] Ex B12 – Statement of Sgt Finney at [142].
[135] Ex B24 – Statement of A/Superintendent Partrige at [6].

f) The protection of the identities of SERT operators and other police tactical group members requires further consideration.

210. On 19 December 2020, SERT commenced a BWC trial in overt operations by operators in a training environment.[136] After Ben's death, the trial was implemented by the QPS. At its conclusion, an instruction was issued requiring SERT officers to carry BWCs for their deployment unless justifiable circumstances existed.[137]

211. SERT has also received new LAVs, which are fitted with operational cameras capable of livestreaming and recording vision. The LAVs used on the day of Ben's death were an older model not fitted with a camera. The use of dashboard cameras had been discontinued due to repeated failures of camera mounting systems, and an inability to easily duplicate power sources within the vehicles.[138]

212. Counsel Assisting submitted that given the short and dynamic period in which the events of 8 December 2019 transpired, the SERT Operatives feared for their lives and were left with no option other than to use lethal force against Ben despite their plan to negotiate with him and take him into custody.

213. Consistent with the conclusions of Sergeant Finney and DSS Mash, I consider that the decision to use lethal force was an appropriate response in this instance, and complied with the QPS Situational Use of Force Model and OPMs.

214. Counsel for Ben's family submitted that I should recommend that the QPS look into specific mental health training that is *"more appropriate and relevant to SERT Operatives to assist in their dealings of people who may be suffering a mental health crisis than what is currently available"*.[139]

215. The Commissioner submitted that the evidence provided by all SERT Operators was that they received regular mental health training. This was the same training provided to general duties officers. It was submitted that no further specific training in relation to mental health was provided to SERT officers because, by the time SERT were involved, ultimately those considerations are of less relevance. I accept those submissions with respect to this incident.

Issue 5 - The diagnosis of Benjamin Freear with ADHD in April 2018

Issue 6 - The mental health treatment provided to Benjamin Freear from 2018 to the date of death

216. It is convenient to deal with Issues 5 and 6 together. The evidence relating to his mental health treatment has been discussed previously.

[136] Ex B24 – Statement of A/Superintendent Partrige, at [8].
[137] Ex B39- Statement of Superintendent Wright; T2-103 at lines 4-9.
[138] Ex B24 – Statement of A/Superintendent Partrige at paras [9]-[10].
[139] T2-97 at lines 33-35.

217. The Court obtained an expert report from Dr Greg Apel, Psychiatrist, in relation to Ben's psychiatric profile and treatment. Dr Apel was asked to provide his opinion on, *inter alia*:

a) The appropriateness of Ben's ADHD diagnosis;

b) The appropriateness of the medication Ben was prescribed for his diagnosis; and

c) The effects of his prescribed medication in general.[140]

218. In relation to Issue 5, Dr Apel opined that the diagnosis of ADHD in Ben was reasonable. In forming this opinion, other psychiatric diagnoses were considered.[141] Dr Apel confirmed this opinion in oral evidence.

219. Ben was diagnosed with ADHD by Dr Flanagan, a clinician with very lengthy experience who had provided a wide range of services to central west Queensland and the central west corridor. His qualifications dated back to the 1960s, and he has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 1980.

220. Dr Flanagan told the Court he had a diagnostic impression of ADHD formed on 2 March 2018, and a likely diagnosis of ADHD embedded in a personality disorder on 24 April 2018.

221. Dr Flanagan stated he had a strong clinical impression that, after taking a full psychiatric history, Ben had ADHD based on the clinical symptoms he described (both in childhood and as an adult) and considered Ben met diagnostic criteria for ADHD.

222. In addition to his notes, Dr Flanagan articulated that the history provided and observed including an itinerant-type lifestyle, impulse control issues, aggression, drug (including ice) and alcohol misuse, and problems with attention and concentration. He advised that these were on the background of *"obvious"* personality issues. Dr Flanagan characterised these as a Cluster B- type personality disorder.

223. In oral evidence, Dr Flanagan stated that when he first saw Ben at the Winton Hospital, that he presented as being a person in crisis and in a suicidal fugue. He noted Ben was driving west with the intention of killing himself and had then decided to go to Hospital to ask for help. He considered this was a dramatic presentation initially, noting that people without personality disorders would not behave or present in crisis to that extent.

224. Dr Flanagan noted that Ben was a mature man, and he accepted the history provided to him with his usual reservations. Dr Flanagan opted to trial short-acting Dexamphetamine in a conservative dose to ensure Ben did not experience

[140] Ex I2- Expert Report- Dr Gregory Apel; Ex I2.1- Briefing letter to Dr Apel.
[141] Ex I2- Expert Report- Dr Gregory Apel at page 7.

negative side effects, and to titrate it upwards in the coming weeks if necessary to ensure the optimal dose was taken.

225. Dr Flanagan stated that Dexamphetamine was and is one of two first-line drugs used to treat ADHD, and that during the three in person appointments he had with Ben, he observed Ben to be benefiting from the treatment. However, as Ben did not return to see him, Dr Flanagan's plan to transition Ben to the longer-acting Lisdexamphetamine could not be implemented.

226. After considering the evidence of Dr Apel and Dr Flanagan I conclude the diagnosis of Ben with ADHD in April 2018 was clinically reasonable, adequate and appropriate.

227. Apart from minor mental health care provided in a general practice setting by Dr Savariar to Ben in the first part of 2018, two practitioners provided Ben with mental health treatment from 2018 until the day Ben died. These were Drs Flanagan and Sana.

228. Insofar as Issue 6 was concerned, namely the mental health treatment provided to Ben from April 2018, Dr Apel opined that:

    a) The amount of Dexamphetamine prescribed to Ben was reasonable. His initial prescription of 30 mg a day in total was a middle of the road dose, and what he ended up on was reasonable also;

    b) Ben's average intake of this medication was unremarkable and showed a consistency of intake over time, which in turn indicated stability in Ben's mental health picture;

    c) Records demonstrated to Dr Apel that there was consistency of not only a prescriber, but also a pharmacy;

    d) While the records did not (and could not) indicate the exact pattern of his intake, his average use was reassuring;

    e) Ben was functioning reasonably well on stimulant medication. While data was missing to demonstrate functional improvement on Dexamphetamine, Dr Apel suspected this may well have been present;

    f) A trial of a person on medication for ADHD even in situations where there is ambiguity of diagnosis is quite reasonable as a general principle;

    g) Psychostimulant medication can have adverse effects like agitation, paranoid or delusional thinking, sleep disturbance, loss of appetite, excessive self-confidence, and reduced engagement with negative feedback from others. General practice records documented that these were specifically asked about, and Ben appeared generally

well. He also noted these psychiatric reports were made regularly by his GP, with checks on his mental state, and tests for blood pressure;

h) Ben had a continuity in his general practitioners reviewing him, evidencing a longitudinal awareness of Ben's state which put greater value on Ben denying any side effects during this period; and

i) The general practitioner records do not indicate Ben was pressuring Dr Sana to increase his dose or collect his supply early which was a positive sign (commonly people who misuse psychostimulants present with these features).

229. In considering Dr Flanagan's care of Ben, Dr Apel noted that while his records were difficult to read, they appeared to document a fairly thorough review of matters, including an adequate history. It was unclear to Dr Apel if Dr Flanagan had obtained a collateral history, but Dr Apel's report was absent of criticism or comment about this aspect.[142]

230. In considering Dr Sana's care of Ben, Dr Apel noted that there were significant efforts by the general practice to engage formal psychiatric care after the letter from his mother expressing concerns about the diagnosis, with a referral to Dr Philip Bird, a specialist psychiatrist with a strong interest in ADHD. Dr Bird's practice indicated that an appointment was not available as Dr Bird was away but *"an appointment was made for May 2018, but there is no further record of whether this occurred."* [143]

231. Dr Apel noted that current monitoring advice in respect of ADHD would be specialist psychiatric review on an annual basis once treatment is taken over by a general practitioner. This ensures fresh evaluation of the diagnosis, consideration of issues and medication review. He advised more frequent review would be precipitated if there were complicating factors like drug or alcohol use, or prescription issues. Of course, this is balanced against availability of specialist psychiatric care. In rural areas and the public system this is far more difficult - public psychiatry services are essentially built around emergency medicine and structures are not built to manage conditions like ADHD.[144]

232. On the whole, and with reference to both issues, Dr Apel opined that:

a) The picture of the latter part of Ben's life was one of functional decline and progressive disconnection from support systems. He had not been working since 2017 and suffered significant pain from polyarthritis. He lost his driver's licence in mid-2019;

b) There was a disconnection from the support of the family home with his wife and children;

[142] Ex I2- Expert Report- Dr Gregory Apel at page 7.
[143] Ex I2- Expert Report- Dr Gregory Apel at page 4.
[144] Ex I2- Expert Report- Dr Gregory Apel at page 8.

c) The overall picture was that there were so many unknowns in Ben's case that it was impossible to clearly attribute the events leading to his death to his diagnosis of ADHD or the prescription of the Dexamphetamine;

d) If there were clearly toxic levels of amphetamine in his system at death, these would be a strong indicator that Dexamphetamine had a role in the events but this was not so here; and

e) As such it was not clear whether his behaviour leading to his death and the use of firearms was related to amphetamine usage or was driven by other factors.[145]

233. Otherwise, Dr Apel noted that postmortem/toxicological findings should be interpreted conservatively and concluded:

a) Alcohol use was indicated at 0.08% BAC which was over the limit for driving but not indicative of gross intoxication. It was significant, however, in the context of a man who had reportedly given up alcohol. If this were his initial reuse of alcohol after long abstinence, he could have been more impaired than he expected;

b) Measurement of the amphetamine levels in his blood were consistent with therapeutic levels of intake. Toxic effects including psychosis, however, can occur in normal or low blood levels, noting that manifest behaviour has momentum of its own and can be somewhat separate from drug levels in the blood;

c) Levels of Diazepam and the metabolite Nordazepam were consistent with a therapeutic intake; and

d) Tapentadol was present in his system at a *"not large"* level, noting that this drug was not prescribed to him by any practitioner and was from an unclear source.[146]

234. In terms of the amount of Dexamphetamine, Oxycodone and Diazepam Ben took post diagnosis in April 2018:

a) From August 2018 to December 2018, Ben's Diazepam use went down to about 50 tablets per month, which was a reduction;

b) Between 24 April and 21 January 2019, he had about five Dexamphetamine tablets per day. Over this period of time he was collecting this monthly;

c) Oxycodone scripts were used in March 2019, June 2019 and August 2019. This use was patchy for this reason;

d) Ben's Diazepam use over the year of 2019 was about 35 tablets a month;

[145] Ex I2- Expert Report- Dr Gregory Apel at page 12.
[146] Ex I2- Expert Report- Dr Gregory Apel at page 5.

e) The PBS records of Dexamphetamine intake were not remarkable with an average intake of about five tablets per day, which was consistent with his usual range of 2 to 3 tablets of 20-30 mg per day. He was collecting these scripts monthly;

f) The Diazepam use was about 2 tablets a day or 10mg;[147] and

g) Patchy use of Dexamphetamine between September and October 2019 may well have been a destabilising factor but it was difficult to be specific about this.[148]

235. Dr Apel considered the above to be unremarkable. His opinion was that it showed a general consistency of intake over time.[149] He noted that the likelihood of abuse or recreational use gets far higher if doses exceed 60mg.

236. At inquest, Dr Apel advised the Court that in his opinion, the mental health treatment of Ben by Dr Flanagan and Dr Sana was reasonable and appropriate.

237. In oral evidence, Dr Sana advised the Court that she had significant experience working in rural and remote towns as a general practitioner. Prior to that she worked in NSW as a psychiatry registrar. She advised that at the time she treated Ben, challenges to treating patients' physical and mental health included access to services and specialists, difficulties with travelling and accessing technology and telehealth, difficulties developing rapport and establishing trust with patients, and stigma attached to mental health conditions. She said the situation had since improved as patients have better access to telehealth, more available services, and prescribers and dispensers have access to QScript and other validation services.

238. While Dr Sana's memory at inquest was limited in some respects, it is difficult to criticise her given the passage of time. In her oral evidence Dr Sana presented as a cautious, meticulous practitioner with a set of regular, risk focussed practices with respect to Ben's mental health. This extended to MSE-based and physical clinical assessments, as well as regular consideration of medicinal side effects.

239. While Dr Sana prescribed without holding a PCTA, authority was obtained via the PBS line on the basis that the script was a continuation. I note Dr Sana's evidence was that the practice management software took prescribing staff automatically to that line.

240. As agreed by Dr Sana, the advent of QScript has completely changed the landscape for prescribers of monitored medicines with very clear rules and safeguards for prescribers and patients alike.

241. While Ben managed to obtain Dexamphetamine before his scheduled interval twice (7 June 2019 and 24 October 2019) a repetition of that situation in today's landscape is circumvented by the implementation of QScript. Dr Sana correctly

[147] Ex I2- Expert Report- Dr Gregory Apel at page 6.
[148] Ex I2- Expert Report- Dr Gregory Apel at page 11.
[149] Ex I2- Expert Report- Dr Gregory Apel at page 6.

identified this during questioning and made appropriate concessions during questioning about the dispensation of the script on 7 June 2019.

242. Attempts were swiftly made by Dr Sana to refer Ben on a MHCP to specialist psychiatrists, and the only psychologist working in Tiaro.

243. Ultimately, Ben did not attend for reasons outside Dr Sana's control, including his choice to treat his physical health first, restrictions on being able to travel, limited finances and disinclination towards telehealth, potentially due to lack of services and coverage, not to mention unavailability of services.

244. It is difficult to criticise Dr Sana for her efforts, particularly as there is no positive onus on practitioners to ensure patients actually attend specialist appointments. Upon receiving concerns from Ben's mother, Dr Sana was required to respect Ben's specific instructions to her not to speak to his mother.

245. Dr Sana considered the concerns and advised in oral evidence that she at the time had no concerns about the diagnosis, she had not on speaking with MODDS been advised of any dispensing concerns, and she had not observed any of the behavioural disturbances his mother had described.

246. An urgent referral was triggered to investigate a sleep issue raised by Ben and also out of an abundance of caution given the matters raised, not to mention to get the appointment at the earliest time possible.

247. Dr Sana said her clinical opinion was that Ben could not be ceased abruptly from Dexamphetamine due to the physical and psychiatric repercussions and could not be ceased abruptly without specialist consultation. She said much of Ben's anxiety was related to his pain, and that his pain condition had worsened over time. She also advised on her final appointment with Ben, she noticed no signs of clinical distress from a mental health perspective.

248. Counsel Assisting submitted that Dr Sana's performance with respect to Ben's mental health treatment was appropriate. Dr Sana made all reasonable attempts to refer him for timely specialist treatment, to address the concerns raised by Ms Ah Sam, and her prescribing was undertaken only after thorough review and risk assessment at each consultation.

249. I accept this submission and conclude that the mental health treatment provided to Ben by Dr Sana was appropriate.

250. I also consider that the mental health treatment provided to Ben by Dr Flanagan was appropriate.

251. The mental health care provided to Ben from 2018 onwards was clinically appropriate. The doctors who engaged with him delivered mental health care with reasonable care and skill in a rural environment. The decision to prescribe and continue to prescribe Ben Dexamphetamine by Dr Flanagan and Dr Sana was clinically appropriate and followed an assessment of the risks, weighed against the benefits he was receiving from the drug.

252. Given the concerns raised about the regulation of the medication prescribed to Ben, it is appropriate to refer to the scheme regulating those drugs at the time of his death and the current scheme.

253. Classification of the relevant drugs prescribed to Ben under the Standard for the Uniform Scheduling of Medicines and Poisons (the Poisons Standard) was as follows:

    a) Dexamphetamine - Schedule 8. This drug was classified pursuant to the HDPR as a controlled and special condition drug between Ben's diagnosis and death;

    b) Diazepam and Temazepam - Schedule 4. These drugs were classified pursuant to the HDPR as restricted drugs and restricted drugs of dependency between Ben's diagnosis and death; and

    c) Oxycodone - Schedule 8. This drug was classified as a controlled drug between Ben's diagnosis and death.[150]

254. These classifications remain in place.

255. At all material times between Ben's diagnosis and date of death Queensland Health used the Monitoring of Drugs of Dependence (MODDS) database to collect and monitor information about Schedule 8 medicines dispensed.

256. Schedule 4 medicines were not captured. Dispensers were required to send Queensland Health a copy of the written instruction within 14 days or within 7 days if it was in electronic form. This information was stored in MODDS.[151]

257. MODDS was maintained by the Prevention Division of Queensland Health. Public health officers reviewed and uploaded prescriptions, provided advice to health practitioners about prescription histories, HDPR or MPA requirements and conducted surveillance of and investigations into suspected offences under the legislation. Practitioners did not have direct access to MODDS but would need to call 13 S8INFO.[152]

258. Between Ben's diagnosis and date of death an approval was required to prescribe and dispense Dexamphetamine pursuant to the now repealed HDPR. [153]

259. An approval for prescribing Diazepam and Temazepam was only required where a practitioner reasonably suspected the person was drug dependent.[154]

[150] Ex H7- MMCU Response to Form 25 at page 1.
[151] Ex H7- MMCU Response to Form 25 at pages 3-4.
[152] Ex H7- MMCU Response to Form 25 at page 4.
[153] Ex H7- MMCU Response to Form 25 at page 5.
[154] Ex H7- MMCU Response to Form 25 at page 7.

260. In 2017, Queensland Health established a compliance and enforcement framework, which, relevant to Ben's case, included doctors prescribing psychostimulants without an approval.[155]

261. Since Ben's death in December 2019, the *Health Act 1937* and the HDPR have been repealed. On 27 September 2021, those instruments were replaced with the MPA and subordinate regulations, including the *Medicines and Poisons (Medicines) Regulation 2021* (MPMR). These provide the current framework for the prescription of Dexamphetamines, benzodiazepines and Oxycodone.

262. From 27 September 2021, Dexamphetamines, benzodiazepines and Oxycodone have been classified as high-risk medicines (medicines that cannot be self-prescribed or self-administered), diversion risk medicines and monitored medicines. The latter are defined as medicines identified by Queensland Health as potentially presenting a high risk of harm to patients and the community as a result of overdose, dependence, misuse and/or diversion. Dexamphetamines are also categorised as a restricted medicine, namely those for which prescribing approvals are limited to certain specialists due to risks associated with their use.[156]

263. From 16 November 2020, QScript began to be used by Queensland Health regulators in conjunction with MODDS. QScript is a monitoring system that collects real-time prescription and dispensing information about monitored medicines, including Dexamphetamine, benzodiazepines and Oxycodone. Prescribers and pharmacists can view it to support their clinical decision making and create alerts in high-risk clinical scenarios.[157] This has replaced the MODDS system and the 13 S8INFO line.[158]

264. Following the introduction of QScript, and in conjunction with other regulatory measures introduced with the MPA such as the Modern Medicines Standard, psychiatrists were provided with an as-of-right authority to prescribe dexamphetamine to adults with ADHD within a maximum dosage of 40mg per day.

265. In all other circumstances, a person needed to be authorised to prescribe Dexamphetamine in accordance with s 62 of the MPA. The relevant type of substance authority for this purpose is a prescribing approval as described under s 67 of the MPA.[159] In practical terms this is done over the telephone.

266. Further, following the introduction of QScript, medical practitioners have an as-of right authority under the MPMR to prescribe benzodiazepines and Oxycodone without the need for an approval.[160]

267. From 28 October 2021:

[155] Ex H7- MMCU Response to Form 25 at pages 8-9.
[156] Ex H7- MMCU Response to Form 25 at page 10.
[157] Ex H7- MMCU Response to Form 25 at pages 10-12.
[158] Ex H7- MMCU Response to Form 25 at pages 12-13.
[159] Ex H7- MMCU Response to Form 25 at pages 14-16.
[160] Ex H7- MMCU Response to Form 25 at page 16.

a) all medical practitioners and pharmacists were required by law to check QScript for patient records before prescribing or dispensing monitored medicines or giving a treatment dose of a monitored medicine for a patient;[161]

b) They are now required to comply with the MMS in these circumstances; and

c) Dispensers of monitored medicines must upload records in QScript.[162]

268. Queensland Health has provided a risk based, education first approach to monitoring and enforcement of medicines offences under the MPA and MPMR.

269. A phased approach to monitoring and enforcement has been implemented, with a focus on education and guidance.

270. Responses available to support, direct and enforce compliance include advice and guidance, education, information, inspections, warning letters, compliance notices and enforcement actions such as infringement notices, show cause notices, administrative action and prosecution. Strategies in effect include the Not Look Up (NLU) Strategy, the MMS Strategy, and the Amphetamines and Methylphenidate (AM) strategy.

271. The AM strategy involves both proactive and reactive compliance monitoring and adopts an education first approach to practitioners identified as prescribing psychostimulants without an authority or appropriate prescribing approval. Proactive monitoring is undertaken using a risk-based approach, with a focus on health practitioners identified as having prescribed psychostimulants on a specified number of occasions during the monitoring period.[163]

272. Additionally, requirements for persons to report the loss or theft (alleged or otherwise) of Schedule 8 medicines to the chief executive, and the details to be included on prescriptions for Schedule 8 medicines are legislated.[164]

273. In considering inquest issues 5 and 6, the events leading up to and during Ben's admission to Winton Hospital demonstrated what must be borne in mind in this case - that Ben's diagnosis, treatment and mental health care cannot be considered in isolation or in a vacuum.

274. The events occurred in the context of Ben's broader circumstances, including clinical, psychosocial and external factors. In considering Ben's mental health treatment throughout this time, its efficacy cannot be judged without considering the practical realities. These included his capacity and willingness to attend mental health specialists given his finances, issues with travelling and comorbid physical ailments.

[161] Ex H7- MMCU Response to Form 25 at page 16.
[162] Ex H7- MMCU Response to Form 25 at page 18.
[163] Ex H7- MMCU Response to Form 25 at page 22.
[164] Ex H7- MMCU Response to Form 25 at page 22.

275. Systemic impediments also need be considered. The practical reality of the mental health system in rural Queensland is designed primarily for emergency mental health treatment. It is not well-equipped, particularly in the public system, to offer services to people with conditions such as ADHD.

Comments and recommendations

276. Section 46 of the *Coroners Act 2003* provides that, whenever appropriate, a coroner may comment on anything connected with a death investigated at an inquest that relates to:

    (a) public health or safety; or
    (b) the administration of justice; or
    (c) ways to prevent deaths from happening in similar circumstances in the future.

277. I do not consider it necessary to make any comments or recommendations in respect of Ben's death.

278. I close the inquest.

Terry Ryan
State Coroner