IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 0898

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Michael Theodore Anthony

Delivered On:	23 February 2015
Delivered At:	Melbourne Coroners Court
Hearing Date:	19 April 2013
Findings of:	John Olle, Coroner
Representation:	Marcia Malinova Anthony, Self-represented
Counsel Assisting the Coroner:	Jodie Burns, Senior Legal Counsel

I, JOHN OLLE, Coroner having investigated the death of MICHAEL THEODORE ANTHONY

AND having held an inquest in relation to this death on 19 April 2013
at the Coroners Court Melbourne
find that the identity of the deceased was MICHAEL THEODORE ANTHONY
born on 22 of November, 1982
and the death occurred between 7 and 9 March 2011
at Braybrook Hotel, 353 Ballarat Road, Braybrook.
from:

I(a) TOXICITY TO HEROIN

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

BACKGROUND

1. Michael Anthony (Michael) was born on 22 November 1982 and was 28 years old at the time of his death. He lived with his mother, Marcia Malinova Anthony (Marcia), at their property at 20 Quail Crescent in Melton and had an older brother, Simon, who died from a heroin overdose in 1999. Michael was not in a relationship at the time of his death and had no known dependants. He left school at the age of 18, started working in a foundry and then left that shortly thereafter. He was not working at the time of his death.

2. At 12 years of age Michael started using illicit drugs when he was introduced to cannabis and magic mushrooms by his friends. At 15 years he progressed to heroin and Marcia concedes that he was addicted to that drug shortly thereafter. In 1999, Michael's brother, Simon, died in his arms as a result of a heroin overdose and Michael was severely affected by his death.

3. On the day Simon died, Michael had pushed them both to get heroin together and, in particular, from Michael's dealer. Michael felt incredibly responsible for Simon's death. Simon was only a recreational user at the time, and after his death Michael became very depressed. However, this was never diagnosed by a doctor. Michael often said to Marcia

that he wanted to die because of what happened to Simon and that he felt responsible for his death.

4. When Michael was around 20 years old he started using methylamphetamines and he then, at 28 years of age and shortly before he died, started using and abusing Xanax and Valium. At the time of his death he was using heroin, methylamphetamines, Xanax and Valium on a daily basis. The drugs and quantities he was using remain unknown.

5. At the time of his death, Michael had been infected with Hepatitis C. It was not known how long he had Hepatitus C; however, he had no other known illnesses. During his 28 years, he lived in Queensland, South Australia and Victoria at various times. He had an extensive criminal history, predominantly committed to support his significant drug habit.

PURPOSE OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation is to independently investigate a reportable death[1] to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred[2]. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[3]

7. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role[4]. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health

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1 The Coroners Act 2008, like its predecessor the Coroners Act 1985, requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear "to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury" and the death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".

2 Section 67(1) of the Coroners Act 2008. All references which follow are to the provisions of this Act, unless otherwise stipulated

3 This is the effect of the authorities- see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

4 The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the Coroners Act 1985 where this role was generally accepted as "implicit".

or safety or the administration of justice.[5] These are effectively the vehicles by which the prevention role may be advanced.[6]

8. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

9. Constable Luke Dalli was the nominated coroner's investigator and he prepared the inquest brief.

10. In discharging my statutory functions under the *Coroners Act 2008*, in particular section 67, the inquest brief contained sufficient evidence to allow me to find Michael's identity,[7] his cause of death[8] and the circumstances, albeit limited, within which he died.[9]

11. Section 52(2) of the *Coroners Act 2008* provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

12. Identity and the medical cause of Michael's death were not in dispute. Michael was not in custody or care at the time of his death. I conducted an inquest because Marcia wrote to me with her concerns about her son's death, in particular that she believed that his death was as a result of homicide.

13. This finding draws on the totality of the material, the product of the coronial investigation of Michael's death. That is, the court records maintained during the coronial investigation, the inquest brief and the inquest. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

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5 See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
6 See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

7 *Coroners Act 2008* (Vic) s 67(1)(a).

8 *Coroners Act 2008* (Vic) s 67(1)(b).

9 *Coroners Act 2008* (Vic) s 67(1)(c).

FAMILY CONCERNS

14. Letters received from Marcia prior to the inquest detailed her concerns about Michael's death. In particular, Marcia stated:

> In my mind I have no doubt whatsoever that the case of Michael Anthony's death is not a case of heroin overdose as it appears. It is a murder case. Michael used a lot of drugs and his tolerance was great. He was using heroin up to a few thousand dollars a day. And the $80 patch, which he purchased on 7th of March, could not kill him, unless it was mixed with a deadly substance.....After examining the photographs I have the uneasy feeling that the hotel management has something great to hide... After I lost both sons, nothing matters any more – but the truth. What I face now is shameful. The truth about the death of Michael is locked in the surveillance tapes of the hotel, the missing wrap, the syringe used. But the tapes are hidden. By the law Braybrook hotel is obliged to provide the tapes and the police is obliged to get them. ..Until the tapes are made available I will not stop to fight for the truth. Until the two people who were with Michael just prior to his death are identified I will NOT stop looking for answers.[10]

IDENTITY OF THE DECEASED

15. Constable Dalli gave evidence at the inquest that the first thing he did in relation to identifying the deceased was to:

> Look at the documentation that he had in his possession, and I identified him from a driver's licence which was found in his possession. There was a name on it and there was a photograph on that licence, and that resembled the deceased. In the other documentation, too, there was personal identification cards and documents which led me to believe it was - that he was Michael Anthony.[11]

16. I formally find that the deceased was Michael Theodore Anthony born 22 of November, 1982.

MEDICAL CAUSE OF DEATH

17. On 16 March, 2011, Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem examination on Michael and determined that his medical cause of death is toxicity to heroin.

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[10] Letter to Coroner's Court of Victoria from Marcia Malinova-Anthony dated 11 April 2013.
[11] Inquest transcript, pages 12-13

18. Dr Burke prepared an Autopsy Report (Report), dated 12 April 2011, in which he commented:

- the post mortem examination showed no evidence of any injury that would have contributed to or led to his death.
- the post mortem examination showed no evidence of any natural disease process that would lead to sudden death.[12]

19. Dr Burke, in his Report, stated that he identified that sections of Michael's lungs showed pneumonia[13] and 'track marks' to the left cubital fossa (upper limbs).[14]

20. Toxicological tests of blood samples taken from Michael's body taken at the time of autopsy showed the presence of 6-monoacetylmorphine (~0.03 mg/L), Morphine (0.33 mg/L), Codeine (0.06 mg/L), Alprazolam (0.2 mg/L), and Diazepam (~0.03 mg/L).

CIRCUMSTANCES SURROUNDING MICHAEL'S DEATH

21. I rely upon Marcia's account of what Michael did in the days before he died. Marcia states that on the morning of 7 March 2011, which was Monday, Michael came home, woke her up and told her that the police had picked him up. He said he was leaving to go and get drugs from the Footscray area and that he would be back later in the afternoon. Michael then told Marcia that the next day he would "go and get detoxification from the drugs."[15] This was the last conversation Michael had with Marcia.

22. On 8 March 2011, Michael attended the Braybrook Hotel at 353 Ballarat Road, Braybrook (the Hotel). Michael's movements after leaving his home and attending at the Hotel are unknown. However, Marcia was clear that he did not travel using his car because it had been impounded.

23. At some stage whilst in the Hotel Michael went inside a toilet cubicle in the gaming area and locked himself inside.

24. Les Smeaton, security guard for the AVS Group states that on 8 March 2011, at approximately 9.20pm, as part of his rostered shift, he conducted a search of the male toilets and observed that the second cubicle was locked. Smeaton stated, "I then knocked

[12] Inquest Brief, page 16.
[13] Inquest Brief, page 16.
[14] Inquest Brief, page 12.
[15] Inquest Brief, page 28.

on the door and called out if anyone was there. There was no answer, so I continued my duties."[16]

25. Mr Smeaton stated that at approximately 3.50am on 9 March 2011, he conducted another search of the male toilets and observed that the second cubicle was still occupied. Mr Smeaton again called out and there was no answer. Mr Smeaton approached the hotel manger, Mathew Shead, and advised that they needed to open the door. Mr Shead provided Mr Smeaton with two screwdrivers, one flat head and a Phillips head. Mr Smeaton attempted to open the door but did not want to use excessive force so he, with the assistance of Mr Shead, forced the door open.

26. Mr Smeaton stated that after the door was opened (inwards) he entered the cubicle and observed a male hunched over on the ground. The male was very cold and had no detectable pulse. Mr Smeaton said to Mr Shead "I think he is dead." [17]

27. Mr Shead rang emergency services. Ambulance and the Melbourne Fire Brigade arrived first and paramedics declared Michael to be deceased.

28. Upon the arrival of police, Constables Dalli and Priestly immediately commenced an investigation into the circumstances of Michael's death. Constable Dalli requested Mr Shead, in his capacity as the hotel manager, to provide the CCTV footage. Mr Shead stated:

> As soon as I checked the hard drive, we couldn't check certain cameras and I noticed there was a glitch in the system. Footage from different times and dates were missing. I was unable to view continuous footage and was unable to work out (sic) what had happened. I was unable to view and burn footage that was requested. I made a report to Canvex – the camera people to let them know in case they could fix the system. We were able to reset the drive and I pulled up some footage of the guy I had seen on the day – the guy who had died. When this occurred Police weren't present. On the footage, I saw him walking around the entrance at about the time I had left the venue. That was all I could get on the footage. Because of problems with our system, this footage got lost when our system crashed a few days later. As a result I could not play or provide a copy of the footage to Police. There was no one else who would have seen this footage. The footage got lost on the hard drive when it crashed a few days later again.[18]

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[16] Inquest Brief, page 39.
[17] Inquest Brief, page 39.
[18] Inquest Brief, page 44

29. At Inquest Constable Dalli gave evidence that he had since been advised by Detective Senior Crevetin and Constable Claire Turner that they tried to view the footage on the night, but due to issues with the CCTV system they were not able to view it because of a perceived error.[19]

30. Mr Shead stated that the toilets at the Hotel were searched regularly, however, "on the 7th of March, 2011, the cubicle where the deceased person was found was not checked due to security and staff assuming that maintenance had locked the cubicle for ongoing works. The toilet cubicle where the person died was previously under repair due to a major water leak and it was assumed by staff and security that maintenance had locked the cubicle awaiting further repair."[20] Maintenance log entries obtained during the investigation corroborated Mr Shead's evidence. The relevant log states "1.3.11 mans toilet and gaming. Gaming room toilet flooding" [21] A management diary entry from 7 March 2011 states "Mens toilet still leaking in gaming."[22]

31. Mr Shead stated, "We have never had a person die in a toilet cubicle before, so up until the incident occurred, nobody knew how important it was to ensure that everything is okay when a toilet door is locked and there is no response from the person inside."[23]

32. Constable Dalli's evidence was that upon arrival he inspected the toilet cubicle that Michael was found in. The door was opened inwards, the lock was not damaged "but appeared manipulated in such a way that was consistent with the manner Smeaton explained the venue manager had opened the door."[24]

33. Constable Dalli formed the opinion that Michael appeared to have fallen off the toilet and was crouched over on the ground. He was holding a packet that contained a used syringe in his left hand and was lying in a pool of liquid that appeared to be blood. Constable Dalli searched Michael's clothing and found a spoon in his left pant pocket. DSC Crevatin and Constable Turner also assisted with the investigation and, in Constable Dalli's presence, located a number of items including an empty syringe, three syringe packets containing needles, Xanax tri score tablets, a mobile phone, an empty Kalma tablet container, empty Xanax container, wallet with a drivers licence, Medicare and other cards in Michael's name, keys and a sum of money.

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[19] Inquest transcript, page 9
[20] Inquest Brief, page 48.1, Statement of Matthew Shead dated 10 November 2011.
[21] Inquest Brief, page 48.4.
[22] Inquest Brief, page 48.5
[23] Inquest Brief, page 48.1.
[24] Inquest Brief, page 56 and Inquest Transcript page 14.

THE INQUEST

34. On 19 April 2013 I conducted an inquest and Constable Dalli gave evidence. Mr Shead was also summonsed to give evidence, but failed to appear.[25]

35. Constable Dalli's evidence detailed a number of matters he believed could have assisted him in his role of coroner's investigator and he provided his opinion on possible prevention matters.

The installation of toilet doors that span the length of the floor to the roof in public areas

36. Whilst Constable Dalli did not measure the toilet cubicle, he stated that it was, "probably say a metre by less than a metre. There was only space for one person in there, in my opinion."[26] The toilet was designed so that the toilet door spanned the length of the floor to the roof, with no way for anyone to look inside to see who was there. The door opened inwards.

37. Constable Dalli raised the valid concern that toilet doors, in public areas, that span the length of the floor to the roof, create a high risk that a person requiring assistance or being rendered unconscious can become enclosed. Furthermore, it inhibits the ability to render assistance in a timely manner because it is difficult to identify whether someone is inside and needs help.[27]

38. Constable Dalli acknowledged that whilst he could not be sure whether the heroin injection occurred inside or outside the toilet, due to the design of the toilet, he was "A hundred per cent" sure he could eliminate the role of any other person being involved with Michael's death.[28]

39. After the Inquest enquiries were made with the Building Commission as to the building requirements for toilet doors in public areas. The Building Commission identified two clauses from the online version of the *National Construction Code Series 2012 Volume One: Building Code of Australia Class 2 to Class 9 Buildings*, which are relevant to the construction of toilet partitions and doors in a public toilet.

40. The first clause, FP2.5, is a mandatory provision, known as a Performance Requirement and requires duty holders under the Code to ensure "a sanitary compartment must be

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[25] A warrant was no issued for Mr Shead to be arrested and brought to Court because the evidence of Constable Dalli was sufficient for me to discharge my statutory obligations.
[26] Inquest Transcript page 14.
[27] Inquest Transcript, page 14
[28] Inquest Transcript page 17.

constructed with sufficient space or other means to permit an unconscious occupant to be removed from the compartment."

41. The second clause, F2.5, is a Deemed-to-Satisfy provision which is non-mandatory but is an acceptable means of satisfying the Performance Requirement. I note that there is a Victorian variation to F2.5(c) but this is only relevant to early childhood centres.[29]

42. Relevantly, F2.5 provides the following guidance for the construction of sanitary compartments:

> F5.2(a) Other than in an early childhood centre, sanitary compartments must have doors and partitions that separate adjacent compartments and extend—
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> (i) from floor level to the ceiling in the case of a unisex facility; or
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> (ii) to a height of not less than 1.5 m above the floor if primary school children are the principal users; or
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> (iii) 1.8 m above the floor in all other cases. [30]
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> F5.2(b) The door to a fully enclosed sanitary compartment must—
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> (i) open outwards; or
>
> (ii) slide; or
>
> (iii) be readily removable from the outside of the sanitary compartment,
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> unless there is a clear space of at least 1.2 m between the closet pan within the sanitary compartment and the doorway. [31]

43. The cubicle within which Michael was found was not a unisex toilet and had an inward opening door. Constable Dalli's evidence that the toilet was approximately 1 metre by 1 metre makes it unlikely that there was a clear space of at least 1.2 m between the closet pan within the sanitary compartment and the doorway. It is unknown whether the door was readily removable from the outside. Despite this, I am satisfied that once the Hotel staff decided to open the door it appears to have been a relatively simple task.

44. Therefore, I am satisfied that the Building Code, as it existed at the time of Michael's death and currently exists unchanged does not require any amendment. However, I note that

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[29] The Building Code of Australia Volume One - Part F2.5(c) also provides that in an early childhood centre, facilities for use by children must have each sanitary compartment screened by a partition which, except for the doorway, is opaque for a height of at least 900 mm but not more than 1200 mm above the floor level.

[30] F2.5(a) came into operation on 8 April 1991.

[31] F2.5(b) came into operation on 1 July 1988.

adherence to the Building Code is important and I impress upon the Hotel to ensure its toilets are compliant.

Licensees infrequently checking that surveillance recording systems are working properly

45. Constable Dalli gave evidence that he was aware of a number of instances where licensed venue operators had failed to capture events that could have helped the licence holder to protect the integrity of their venue. This had also frustrated investigators, such as in this case, because evidence, which may otherwise be vital to an investigation, was not recorded due to a failure to identify that the surveillance recording systems was not working properly.

46. Since Michael's death the Victorian Commission for Gambling and Liquor Regulation (VCGLR) commenced in February 2012. Prior to the commencement of the VCGLR, and as at 7 March 2011, the Director of Liquor Licensing was responsible for liquor regulation and the Victorian Commission for Gambling Regulation in gaming venues.

47. The VCGLR now administers both the *Gambling Regulation Act 2003* (GRA) and the *Liquor Control Reform Act 1998* (LCRA) and associated regulations to ensure licensed operators can demonstrate that they have installed and are regularly maintaining their surveillance recording system.

48. Since the inquest the VCGLR provided information that as at 7 March 2011, the licensee of the Hotel held a late night (general) liquor licence under section 11A of the LCRA and was a licensed venue operator under the GRA.

49. The VCGLR advised that the requirements for all liquor licensees to install and maintain surveillance recording systems (i.e. CCTV) in their venues for liquor licences is covered by section 188 (1) of the LCRA which provides that:

> The Commission may impose a condition on a liquor licence requiring the licensee to fit security cameras that comply with the prescribed standards on the licensed premises or any authorised premises, or on any other premises, land, fixtures or objects that are under the control of the licensee and that are in the vicinity of the licensed premises or authorised premises.

50. The decision whether or not to impose such a condition is discretionary and the VCGLR does not require all venues supplying liquor to have CCTV systems. However, the VCGLR generally requires CCTV systems to be installed in venues where the venue is authorised to trade past 1.00am and the licensee provides live or recorded amplified music, as these

factors are considered to increase the risk of harm occurring at such premises. The decision as to whether a venue is 'high risk' is made on a venue-by-venue basis. The VCGLR acknowledged that the cost of installing CCTV systems can be prohibitive for some venues. The VCGLR confirmed that in relation to the Hotel's liquor licence, there was no condition requiring the licensee to have a CCTV system at the Hotel.

51. In relation to the Hotel's gaming venue operator's licence, as at 7 March 2011 and remains unchanged, Rule 4 of VCGR 32 provides that "the venue operator must ensure that the operation of the gaming machine area and each gaming machine must be subject to continual supervision. Supervision may be electronic or physical or a combination of both". However, whether the required supervision standard is met by electronic or physical supervision is a matter for the particular venue to determine.

52. The VCGLR did note that when it imposes a condition relating to CCTV on a licence, it generally takes the following form:

> When live or recorded amplified music other than background music is provided: The licensee shall install and maintain a surveillance recording system able to clearly identify individuals which shows time and date and provides continuous linages of all entrances and exists, bars and entertainment/dance floor areas. The surveillance recording system must operate from 30 minutes before the start of the entertainment being provided until 30 minutes after closure. A copy of the recorded images must be available on request for immediate viewing or removal by Victoria Police, or a person authorised in writing by the Victorian Commission for Gambling and Liquor Regulation, or otherwise retained for at least 1 month. The positioning of the cameras is to be to the satisfaction of the Licensing Inspector. Signs, as described below, are to be displayed in all areas subject to camera surveillance. Such signs shall read: "For the safety and security of patrons and staff this area is under electronic surveillance. Crowd controllers, licensed under the Private Security Act, are to be employed at a ratio of 2 crowd controllers for the first 100 patrons and 1 crowd controller for each additional 100 patrons or part thereof. One crowd controller is to be present outside the premises to monitor patrons arriving and departing the premises. Crowd controllers are to be present from 30 minutes before the start of the entertainment being provided, until 30 minutes after closure.

53. The VCGLR also advised that the above conditions were designed to reduce the potential for the conduct of the venue to have an unacceptable impact on the amenity of the area

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[32] This rule came into force on 21 February 2007.

surrounding the premises, and to minimise the potential for anti-social behaviour to occur in and around premises.

54. Whilst the Hotel did not have a condition on its liquor license to have CCTV I note the compliance standards is such that a licensee is required to meet in relation to installation, maintenance and auditing of CCTV. This is contained within regulations 7 and 8 of the Liquor Control Reform Regulations 2009 (LCRR). In particular regulation 7 relates to the minimum frame rate for security cameras and video recorders and regulation 8 deals with standards for the quality of the stored image.

55. The VCGLR also advised that on 16 August 2012, and after Michael's death, Standards for CCTV[33], as they relate to the conduct of gaming venues, were introduced (the Standards). The VCGLR's venue standards required the CCTV system installed at a gaming venue to:

a. Record continuously (defined as without interruption) 24 hours a day, 7 days per week;

b. Record a minimum rate of 6 frames per second;

c. Have auto-embedded time, date and camera ID on all pictures; and

d. Store images at an adequate resolution and picture quality to enable the identification of an individual, at all entrances and exits and at the cashier station, and for recognition of an individual at other areas within the gaming machine area.

56. The VCGLR noted that when these standards were introduced, venue operators were not expected to upgrade or replace their systems specifically to meet the requirements as at 16 August 2012 if their systems were considered to be satisfactory under the previous arrangements and no concerns had been raised by the VCGLR's inspectors with a venue's CCTV system. However, it was proposed that venue operators meet the requirements when they next upgraded or replaced their systems, or when a major refurbishment or relocation of the gaming area takes place.

57. The VCGLR also advised that it does audit conditions imposed on liquor licences when doing inspections. If such a condition is imposed on the licence the licensee must demonstrate that their system is meeting the standards imposed by regulations 7 and 8 of the LCRA. CCTV cameras are checked by inspectors when conducting an inspection of

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[33] VCGLR Standard ST4 – Electronic and Physical Supervision for the conduct of Faming pursuant to section 10.1.B(1)(b) of the *Gambling Regulation Act 2003*

premises to ensure the gaming machine area and each gaming machine is subject to continual supervision, as required under the rules. This check is included in the 'venue operations review' checklist that is used by inspectors during inspections.

58. Whilst I agree with Constable Dalli as to the importance of optimal operation of CCTV systems, I will not make any recommendations given the introduction of the Standards.

59. I am satisfied that Michael died shortly after he locked himself in the cubicle. It follows, CCTV footage would not have prevented the tragic outcome.

Victoria Police Report of Death Forms - Form 83

60. Constable Dalli also raised concerns about the Victoria Police 'Report of Death Form' (Form 83) and that at the time of him assuming the role of coroner's investigator for this matter there was no section that lists factors that may mean another work unit or member will be investigating the circumstances surrounding reportable deaths on behalf of the Coroner.

61. Since the Inquest enquiries were made with the Chief Commissioner of Police, who through the Victorian Government Solicitor's Office advised they were grateful for the opportunity to address the issue and clarified that the Victoria Police Manual[34] addresses this issue. In particular:

    a. section 1.2 of Victoria Police Policy Rule "Deceased Persons" details the use of the Form 83; and

    b. section 2 of the Victoria Police Procedure and Guidelines "Deceased Persons" contains a table which details the investigative notification requirements relating to specific deaths and identified the relevant unit Victoria Police work unit with the investigative responsibility.

62. The Chief Commissioner of Police acknowledged that it is important for the Court to be notified of the contact details of the police member who is ultimately assigned responsibility to investigate a death, that the Victoria Police Manual relating to 'Deceased Persons' was under review and that this issue will be considered.

63. I note at the time of finalising this finding this review not complete. However, in the consultation process with the Court this issue had been raised.

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[34] Victoria Police Manual Policy - "Deceased Persons", Victoria Police Manual Procedures and Guidelines "Deceased Persons".

FINDINGS

Having considered all of the evidence, I find that Michael Anthony, born 22 of November, 1982 died on 9 March 2011, aged 29, as a result of toxicity to heroin. I empathise with the grief suffered by Marcia and acknowledge that she has now lost both of her beloved loved sons, which is an immeasurable tragedy.

There is no evidence of foul play or third party involvement. I am satisfied Michael died as a result of unintentional overdose, in circumstances of self administration of heroin.

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

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

Marcia Anthony, mother of Michael Anthony
The Braybrook Hotel
Chief Commissioner of Victoria Police
Victorian Commission for Gambling and Liquor Regulation
The Building Commission
Constable Luke Dalli, Coroner's Investigator (now Detective Senior Constable).

Signature:

JOHN OLLE
CORONER
Date: **23 February 2015**