IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2013 002010

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the ***Coroners Act 2008***[1]

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of MIROSLAW DZICZKOWSKI

without holding an inquest:

find that the identity of the deceased was MIROSLAW DZICZKOWSKI

born on 1 November 1972

and the death occurred between 30 January 2013 and 9 May 2013

at Log Cabin Caravan Park, 355 McCelland Drive, Langwarrin, Victoria, 3910

from:

1a UNDETERMINED

Pursuant to section 67(1) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Miroslaw Dziczkowski (known as Mirek) was the 40-year old only son of Czelawa and Bronislaw who together sought political asylum in Australia after leaving Poland in 1980. As a child, Mr Dziczkowski was sociable, active in sport and a good student who completed secondary school successfully. He went on to obtain an Associate Diploma in Business and Marketing at a teritary institution and then worked full time for the Department of Transport.

[1] As amended on 17 May 2017 to correct a clerical mistake in the case reference number pursuant to section 76 of the *Coroners Act* 2008.

2. However, in 1996, when he was 24 years old, Mr Dziczkowski was diagnosed with paranoid schizophrenia and had the first of 11 admissions to inpatient psychiatric units. When experiencing mental ill-health, Mr Dziczkowski suffered hallucinations and delusions, was at high risk to himself through self-neglect and often became ill abruptly. On one occasion he required medical treatment for rapid weight loss after absconding from treatment and, when found by police, he was dehydrated, exhausted and eating grass in Policeman's Paddock.

3. Mr Dziczkowski received mental health treatment pursuant to a Community Treatment Order [CTO] under the *Mental Health Act* 1986 [MH Act]. His care was delivered by the Dandenong Continuing Care Team [DCCT] and medications – a weekly blister pack of antidepressants, anticholinergics and vitamin supplements, and a fortnightly depot injection of the antispychotic, zuclopenthixol decoanate – were supplied by Monash Health. Although he was compliant with medications and appointments with DCCT, he had a history of absconding and being difficult to locate, without any early indication of deterioration in his mental health. His absconding always involved an element of planning, but the first indication for DCCT would be Mr Dziczkowski's failure to collect or receive medications. Thus, DCCT's case management was intensive and proactive and if he failed to attend an appointment his Caseworker would contact Mr Dziczkowski's family, revoke his CTO and file a missing person report with police within 24 hours.

4. Mr Dziczkowski had been unable to sustain employment since being diagnosed with schizophrenia and so was in receipt of a Disability Support Pension. He had few expenses beyond the necessities of daily life and tended not to socialise with anyone but his parents. By January 2013, Mr Dziczkowski had been living independently at Shawlands Caravan Park [Shawlands] in Dandenong for a number of years and had paid rent in advance until April 2013. He visited his parents regularly, sometimes staying at the family home overnight.

5. On 18 January 2013, Monash Health applied to extend Mr Dziczkowski's CTO. Although he was invited to attend the hearing before the Mental Health

Review Board, Mr Dziczkowski refused stating that his attendance would not make any difference to proceedings. His CTO was extended.

6. On 21 January 2013, Mr Dziczkowski attended a scheduled appointment at DCCT, during which he received his medications (including a depot injection) and was weighed. His weight was recorded as 82.1kgs.

7. On 24 January 2013, Mr Dziczkowski spent the day at his parents' home and stayed there overnight. His mother tried to persuade him to stay longer, as she often did, but the next morning, Mr Dziczkowski left saying that he intended to take a bus to Dandenong to do some shopping.

8. Around lunchtime on 27 January 2013, Mr Dziczkowski's parents arrived at his caravan for an impromptu visit but did not find him at home. Later that day Mr Dziczkowski telephoned his mother and spoke to her briefly, mentioning that he was going into the city. Mrs Dziczkowski recalled nothing unusal about her interaction with her son during the call.

9. On 30 January 2013 Mr Dziczkowski failed to attend his next scheduled appointment with DCCT, and did not collect his weekly medications. His Caseworker, Daniel Stinson, contacted Mr Dziczkowski's parents and brought his absence to the attention of the treating team whereupon his CTO was revoked.

10. On 31 January 2013 Mr Dziczkowski was reported to Dandenong Police as a missing person by David Wilson of Monash Health. Throughout February 2013, Mr Dziczkowski's disappearance was investigated by Dandenong Police Uniform Division until, following a 30-day review in accordance with Victoria Police policy, the missing person investigation was assigned to D/S/C Marisa Owens of Greater Dandenong Criminal Investigation Unit. On 6 March 2013, the Detective spoke to DCCT's Mr Stinson (who reiterated concern about Mr Dziczkowski's wellbeing), attended Shawlands and searched Mr Dziczkowski's caravan, finding it clean and tidy and obtained details of his bank accounts and mobile telephone. The Manager confirmed that Mr Dziczkowski had not been seen there for about a month, that his personal effects had been removed and that other unidentified caravan parks had called 'recently' seeking references. D/S/C Owens also spoke to Mr

Dziczkowski's parents in person and they recounted that their son had recently expressed frustration with the effects of his mental illness and articulated and intention to try living without his medications. The Detective also made inquiries at four caravan parks in the vicinity but Mr Dziczkowski was not staying at any of them.

11. During March and April 2013, D/S/C Owens received information pursuant to her requests about Mr Dziczkowski's mobile telephone use, banking transactions, contact with Centrelink and Medicare and possible international travel. Mr Dziczkowski did not appear to have had any contact with federal government agencies and mobile telephone searches were unproductive. The bank advised that between mid-January and 29 January 2013, the latter being the date of his last transaction, Mr Dziczkowski had withdrawn $7300. In mid-April 2013, D/S/C Owens commenced preparations for a media release concerning Mr Dziczkowski's disappearance.

12. On 9 May 2013, Bronislaw Dziczkowski received a telephone call from Ms Auld, an employee of Log Cabin Caravan Park in Langwarrin [Log Cabin], who advised him that his son was staying at the caravan park but that he had not paid rent or had any power for the previous two weeks. Bronislaw Dziczkowski asked that a welfare check be conducted and then telephoned D/S/C Owens to inform her of this development.

13. At about midday, a male presumptively identified as Mr Dziczkowski[2] was found deceased, clothed in shorts, and slouched forward sitting on the toilet in his cabin. Emergency services were called and upon arrival, police observed that there was no food in the cupboards or fridge, and that cash, personal papers (including a driver's licence) and cabin keys were laid out on a table together with two notes. In the notes, Mr Dziczkowski left instructions to his father about his financial affairs and explained his intention to commit suicide by starvation. Mr Dziczkowski had been staying at Log Cabin since 26 January 2013.

14. Forensic Pathologist, Dr Yeliena Baber of the Victorian Institute of Forensic

[2] Mr Dziczkowski's identity was later confirmed by DNA comparative analysis conducted at the Victorian Institute of Forensic Medicine.

Medicine, performed an autopsy and reviewed the circumstances of the death as reported by police to the coroner. Dr Baber observed that Mr Dziczkowski was thin, weighing 53kgs, and had no signs of injury or evidence of significant natural disease. Histology was unremarkable and toxicological analysis did not detect any alcohol, common drugs or poisons. Dr Baber concluded that the cause of Mr Dziczkowski's death remained undetermined after autopsy and ancillary investigations. She noted that it was not possible at autopsy to prove or refute starvation as a cause of death and that the mechanism of death was most probably one of natural disease.

15. At my request, the Coroners Prevention Unit [CPU][3] reviewed Mr Dziczkowski's mental health records and provided advice about DCCT's clinical management and care. The CPU noted that Mr Dziczkowski's treatments were provided in accordance with clinical guidelines and were of the least restrictive nature possible in the circumstances. Mental State and Risk Assessments, consultant psychiatrist and medical reviews were frequent and documented and current Treatment and Crisis Action and Relapse Prevention plans were in place.

16. Mr Stinson's contact with Mr Dziczkowski and his parents was frequent (planned and unplanned), and focused on Mr Dziczkowski's compliance, indicators of deteriorating mental health and attempts to increase his social connectedness. Mr Stinson's contact with Mr Dziczkowski's family continued after he went missing and the Caseworker contacted police for updates or to express DCCT's concerns by telephone and email many times during the missing person investigation.

17. The CPU concluded, and I find, that the clinical management and care provided to Mr Dziczkowski by DCCT over the duration of his illness was comprehensive and focused on his quality of life, his safety and that of others.

18. I find that Mr Dziczkowski died at Log Cabin Caravan Park, Langwarrin, at some time between his disappearance on 30 January 2013 and the day he was

[3] The Coroners Prevention Unit [CPU] was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. CPU is staffed by independent, skilled investigators and health care clinicians.

found, 9 May 2013, most likely during the last two weeks of that period.

19. At the time of his death, Mr Dziczkowski was a "person placed in custody or care" as defined in section 3[4] of the *Coroners Act* 2008 [the Act] because he was receiving treatment as an involuntary psychiatric patient. Upon revocation of his CTO when he failed to attend his DCCT appointment on 30 January 2013, Mr Dziczkowski remained an involuntary patient, and pursuant to section 14D(3)(b) of the MH Act, was deemed to be absent without leave from an approved mental health service.

20. Mr Dziczkowski's designation as a "person placed in custody or care" is significant. This is because the Act recognizes that people in the control, care or custody of the State are vulnerable and therefore, irrespective of the nature of the death, requires it to be reported to the Coroner and so subject to the independent scrutiny and accountability of a coronial investigation.

21. As an additional protection, until the insertion of section 52(3A) into the Act in November 2014, all deaths of people placed in custody or care required a mandatory inquest. Now, the Coroner is no longer required to hold an inquest if satisfied that the death was due to natural causes but must publish Findings made concerning natural causes deaths of people in custody or care.[5] Of course, the Act preserves a discretionary power to hold an inquest in relation to any death a coroner is investigating.[6]

22. In accordance with the opinion provided by Dr Baber, I am satisfied that Mr Dziczkowski's death was due to natural causes even though the cause of his death remains undetermined after an autopsy and ancillary testing.

23. In light of the large amount of cash he withdrew from the bank during January 2013, his relocation from Shawlands to Log Cabin without notice, his lack of contact with his parents and avoidance of DCCT's treatment, I am satisfied that Mr Dziczkowski planned his disappearance and intended to make it difficult for anyone, especially those closest to him, to find him. By isolating

[4] See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".
[5] Section 73(1B).
[6] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

himself in this way, particularly without access to the medication necessary to manage his schizophrenia, there is little doubt that Mr Dziczkowski's mental state deteriorated in the more than three months he was missing. Given his stated intention to commit suicide by starvation, it is tolerably clear that Mr Dziczkowski intended to end his own life, however, I am unable to determine at what point in time he formed this intention and when he embarked upon a course of action likely to result in his death in the absence of third party intervention.

24. Monash Health reported Mr Dziczkowski as a missing person to police promptly and provided pertinent information that would assist the police investigation of his disappearance. Mr Wilson, and later, Mr Stinson, also clearly articulated concerns for Mr Dziczkowski's safety, particularly if his mental health was untreated. If he did not resume contact with his parents or DCCT, the police's missing person investigation – and his being found by police – was likely the only way Mr Dziczkowski's self-destructive course might be interrupted.

25. In these circumstances, albeit no clear causal connection can be made between the police response to the missing person report and Mr Dziczkowski's death, that response appears somewhat perfunctory. Repeated, largely unsuccessful, telephone calls to the same four telephone numbers for an entire month by various members of Dandenong Uniform added little, if any value, to the quest to locate Mr Dziczkowski.

26. Indeed, it was not until D/S/C/ Owens was allocated the missing person investigation in early March 2013, and attended Shawlands, that leads were developed and pursued. It is evident that once police learned that Mr Dziczkowski was looking for accommodation in an alternative caravan park some of D/S/C/ Owens' investigative efforts were stymied by Shawlands' managers not maintaining records of those who had contacted them about Mr Dziczkowski.

27. At my request, the Chief Commissioner of Police [CCP] was asked to provide a statement assessing the adequacy of the response by Dandenong Police

Uniform members[7] after Mr Dziczkowski was reported missing and whether the response complied with relevant policies and procedures. Local Area Commander for Greater Dandenong, Inspector Sean Murray, responded on behalf of the CCP, and advised as follows:

a) Processing missing person reports is a core function of front line policing, especially among general duties uniform members working at the front desk of police stations.[8] Such members ordinarily receive missing person reports by telephone or in person in the first instance[9] and are tasked to make ongoing enquiries, among their other duties, when an investigation is not allocated to the Crime Investigation Unit [CIU].

b) The Victorian Police Manual– Guidelines – Missing Persons Investigation [VPM][10] directs the member to whom a missing person report is made to complete a Missing Persons Report and Risk Assessment Form, known as Form L18A. Form L18A is endorsed by a supervisor with the appropriate level of risk – low, medium or high – and submitted to Central Data Entry Bureau. Risk ratings help determine the initial course of a missing person investigation, with investigations categorised as 'low'[11] or 'medium'[12] risk remaining at the local level and progressed by members performing desk duties with supervision and oversight provided by senior members, and those categorised as 'high'[13] risk allocated to the CIU.

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[7] Between the day Mr Dziczkowski was reported missing and when the missing person investigation was reallocated to CIU, 30 days later.

[8] Inspector Murray referred to statistics suggesting that Victoria Police investigate about 5,500 missing person reports each year with about 85% of all individuals returning or being located within seven days of report and 99.5% of all missing persons being located eventually. In his experience, the most common categories of missing person are children living in the care of the Department of Health and Human Services, teenagers, the elderly, young children and people with mental health issues. Accordingly, police members receive training in relation to missing person investigations at the police academy and upon induction at a police station.

[9] Leading to their designation as the 'nominal investigator'.

[10] All references to the VPM relate to the version last amended 30 July 2012 and in effect at the time of Mr Dziczkowski's disappearance unless otherwise indicated.

[11] Low risk assessment category is defined as 'no apparent threat or danger to either the missing person or the public'.

[12] Medium risk assessment category is defined as 'missing person or the public possibly facing some danger'.

[13] High risk assessment category is defined as 'risk posed is immediate and there are substantial grounds for believing that the missing person or the public is in danger'.

c) Part 2 of the Form L18A is a risk assessment tool containing 22 risk factors the presence of which will 'guide'[14] categorisation of the risk associated with the missing person/circumstances of disappearance and the type of investigative response required. Risk assessment weighting is described as contingent upon the 'circumstances of each case'.[15] The form's instructions also state – in bold typeface – that '[i]f ANY of the above Risk Factors 1 to 8[16] are present, then the Risk Assessment MUST be HIGH' (emphasis in original).[17]

d) The VPM directs that the LEAP case progress narrative is updated regularly and that inquiries to locate the missing person are undertaken. The VPM stipulates that an assigned supervisor check all active missing person reports at intervals of 3, 7, 14, 30 and 60 days and s/he must confirm with any facility that has reported a person missing that the person remains missing and whether any power to arrest remains current. If after 30 days a missing person has not been located, the nominal investigator should update the CIU of the risk assessment and categorisation[18] and the investigation will be reallocated to the CIU.[19]

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[14] The Form L18A incorporates four 'dot points' of advice/instruction between the 'Risk Factor Guide' and the 'risk Assessment Categories & Description' sections. The first states that 'the above risk indicator is a guide only & the below Risk Assessment weighting will depend on the circumstances of each case'. The second indicated the risk indicator is a tool to assist 'making professional judgment of risk levels', and the third, confirms that 'supervisors have responsibility for oversighting risk assessment'.

[15] See generally Form L18A.

[16] These eight risk factors are that the missing person is: (1) suspected to be subject of a significant crime in progress (e.g. abduction); (2) likely to cause self-harm or attempt suicide; (3) last seen near a body of water; (4) vulnerable due to age, infirmity or any other similar factor; (5) the subject of a recent history of serious family conflict/abuse; (6) Known to have left behind personal belongings/items required for a period of absence; (7) reported missing by a person other an someone they normally reside with; and (8) the presence of circumstances that give rise to an aspect of suspicious or concern (specify in narrative).

[17] See generally the Form L18A used at the time of Mr Dziczkowski's disappearance.

[18] I note that since Mr Dziczkowski's death section 2.1 of the relevant VPM has been amended to require the investigating member to 'ensure that the [case] narrative … is updated regularly, including a CIU update of risk assessment and categorization after 7 days' rather than after 30 days [see VPM version updated on 11 June 2013]. I note that in a letter dated 22 November 2016, the Chief Commissioner of Police confirmed that the effect of the amendment, had it been in force at the time of Mr Dziczkowski's disappearance, would have been to require the nominal investigator to update the CIU of the risk assessment and categorization after 7 days. The CIU may have, therefore, had input into whether the risk assessment was still accurate or assees whether the investigation should be transferred to the CIU at that juncture.

[19] Individuals missing after 30 days are regarded as 'long term missing persons' and, in accordance with the Victoria Police Accountability & Resource Model 13/14, missing person investigations are reallocated to the CIU.

e) The investigation into Mr Dziczkowski's disappearance was generally in accordance with police policy, however, some aspects of the missing person investigation 'could have been handled differently'.[20] It is noted that the Case Progress Narrative created at the time of the missing person report clearly stated that Mr Dziczkowski was a paranoid schizophrenic whose CTO was revoked after he failed to attend an appointment with DCCT, that he had not received his required medications and, if not taking them, may stop eating and drinking as he had during an earlier disappearance; the reporting party had concerns about his deteriorating physical and mental health.[21] These circumstances 'could have warranted one or more of'[22] risk factors one to eight being marked on Form L18A but they were not.[23] Indeed, risk factor 7, that Mr Dziczkowski had been reported missing by someone other than a person with whom he ordinarily lived, was checked and 'should have' produced a high risk categorisation 'using the Form L18A as a guide'.[24]

f) It is understandable that the investigating member and the supervisor 'guided solely by the definition of 'high' on the Form L18A' did not consider that the risk associated with Mr Dziczkowski's disappearance had reached the threshold of imminent and significant danger specified.[25]

g) Having categorised the level of risk as 'medium' attempting telephone contact with Mr Dziczkowski (and others) and initiating a KALOF[26] was a 'reasonable approach'.[27] Telephoning family, friends and regular contacts of a missing person is a 'sound response' that 'in many cases' leads to finding the missing person.[28] These are also enquiries that can

[20] Statement of Inspector Sean Murray dated 12 August 2016.
[21] Missing Person Report [Incident No. 130033720].
[22] Statement of Inspector Sean Murray dated 12 August 2016.
[23] Such as (2) likely to cause self-harm or attempt suicide' or (4) vulnerable due to age, infirmity or similar factor or (8) the presence of circumstances that give rise to an aspect of suspicion or concern.
[24] Statement of Inspector Sean Murray dated 12 August 2016.
[25] Ibid.
[26] KALOF means 'Keep A Look Out For'.
[27] Statement of Inspector Sean Murray dated 12 August 2016.
[28] Ibid.

be performed by police members tasked with desk duties. Similarly, a KALOF is 'also often'[29] a successful way to locate a missing person, particularly where s/he has mental health issues and may consequently come to the attention of the public or of police.

h) In circumstances where making telephone calls to regular contacts does not progress the investigation and the missing person does not otherwise come into contact with the police through a KALOF, 'consideration ought to be given to other methods of investigation'.[30] Section sergeants reviewing the missing person investigation at the prescribed intervals 'could have considered'[31] tasking a divisional van unit to attend Mr Dziczkowski's home at Shawlands. Attendance at a missing person's residence is 'accepted practice in a routine investigation' if telephone contact is unsuccessful 'in the first two or three days'.[32] However, there was no visit to Shawlands by police in the first month, investigating members having 'accepted advice that there were no suspicious circumstances at the caravan' provided by Mr Dziczkowski's parents.[33]

i) While the initial risk categorisation of Mr Dziczkowski's disappearance was 'not unreasonable', risk assessments ought to be reviewed and considered regularly and on an ongoing basis.[34] A missing person's risk may increase over time. Even if Mr Dziczkowski was not at immediate risk when he was first reported missing, consideration ought to have been given to whether his risk of harm had increased the longer he was uncontactable, particularly given his known history of self-neglect when unmedicated.[35]

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[29] Statement of Inspector Sean Murray dated 12 August 2016.
[30] Ibid.
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ibid. I note that in a letter dated 22 November 2016 via his legal representatives, the Chief Commissioner of Police confirmed that there is no 'formal, documented policy which establishes an obligation to review risk assessments on a regular and ongoing basis. Rather it is 'fundamental to policing that Victoria Police members manage and assess operational risk in the course of their duties. For example, risk assessment is one of the ten Operational Safety Principles that members are required to apply in the course of their duties'.
[35] Statement of Inspector Sean Murray dated 12 August 2016.

j) Mr Dziczkowski's disappearance was re-allocated, to the Greater Dandenong CIU, 30 days after he went missing in accordance with police policy.[36]

28. I accept that the response of Dandenong Police Uniform members to the report of Mr Dziczkowski's disappearance was generally in accordance with the VPM.

29. Nonetheless, given everything that was known about Mr Dziczkowski – including his involuntary treatment status under the MH Act and the danger he posed to himself when unwell – and *when* this information was known to police, I am not satisfied that Dandenong Police Uniform members' efforts to locate Mr Dziczkowski were adequate. Such efforts may have been adequate for another kind of missing person, but not for a man with a history of serious mental illness known to neglect himself when he is unwell and/or not compliant with his medication regime.

30. Given the relationship between risk categorisation and operational response in missing person investigations, the importance of accurate assessment of risks and *re-assessment* of risks as necessary due to the emergence of fresh intelligence or the passage of time, cannot be underestimated. The evidence before me does not support a finding that Mr Dziczkowski's risks factors were correctly identified at the outset or that his risk of harm was appropriately categorised throughout the period that his whereabouts remained unknown. Indeed, there is no evidence before me that the nominal investigator or any supervising officer re-assessed Mr Dziczkowski's risk level at any of the 3, 7, and 14-day interval reviews mandated by the VPM or at any time including when the investigation was reallocated to the CIU 30 days after he went missing.

31. That said, I am unable to conclude with the requisite degree of certainty that had the police's search efforts been more timely or comprehensive, that they would have found Mr Dziczkowski in time to prevent his death.

[36] Statement of Inspector Sean Murray dated 12 August 2016.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comments in connection with the death:

1. It is tolerably clear from a plain reading of Form L18A and Inspector Murray's effort to rationalise the decision to categorise Mr Dziczkowski's risk as 'medium' when a risk factor mandating a 'high' risk categorisation was present, that the form's instructions are, at best, confusing and, at worst, contradictory.

2. As such, the instructions on Form L18A did little to promote the sound exercise of professional judgment about risk categorisation in this case and would do less to promote consistency in the assessment of risk in missing person cases generally, and the concomitant assignment of operational priorities.

3. I note that Part 1 of Form L18A enables the nominal investigator to identify a missing person as an involuntary psychiatric patient, indicating that powers of apprehension exist. Surprisingly, no comparable criterion exists in the Risk Factor Guide in Part 2 of the form. While 'suffering from … mental health problems' is risk indicator 14 of 22, no mental health-related factor other than 'likely to cause self-harm or attempt suicide' appears among those factors mandating a 'high' risk categorisation. This is an unexpected omission, particularly in light of mental health legislation[37] and the police powers of apprehension sometimes arising from it.

4. The Chief Commissioner of Police's advice,[38] in effect, that management and assessment of operational risk is so fundamental to policing that it has not been reduced to formal documented policy sits uncomfortably with Inspector Murray's implicit concession that assessment of Mr Dziczkowski's risk of harm ought to have been regularly reviewed while he remained missing and was not. [39]

[37] The Mental Health Act 1986 applicable at the time of Mr Dziczkowski was superseded by the Mental Health Act 2014.
[38] Letter to the Court dated 22 November 2016 from the Chief Commissioner of Police's legal representatives.
[39] Statement of Inspector Sean Murray dated 12 August 2016.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act* 2008, I make the following recommendations in connection with the death:

1. That the Chief Commissioner of Police consider revision of Form L18A, and in particular, the Risk Factor Guide that appears in Part 2, so that:
    a. Risk indicators include the missing person's status under mental health legislation; and
    b. The instructions provide clear guidance for nominal and supervising members assessing the identified risks, especially by resolving the apparent inconsistency between the mandatory instructions applicable to risk indicators 1 to 8 and the general instruction that weighting of risk factors 'will depend on the circumstances of each case'.
2. That the Chief Commissioner of Police consider introducing a process and policy through which risk assessments are reviewed by a supervising officer at specified intervals to account for the likelihood that a missing person's risk of harm is not static over time and which monitors compliance with this process.

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

Mr Dziczkowski's family

Monash Health

Chief Psychiatrist

Chief Commissioner of Police

D/S/C M. Owens, Greater Dandenong Criminal Investigation Unit

Signature:

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Coroner Paresa Antoniadis Spanos

Date: 5 December 2016