



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002051

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of Simon Christopher Gaskill

Delivered On: 17 April 2026

Delivered At: Coroners Court of Victoria,
65 Kavanagh Street, Southbank

Hearing Dates: 23 and 24 February 2026

Findings of: Coroner Ingrid Giles

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Keywords: unascertained cause of death; alcohol dependence;
discharge planning; homelessness; police contact death;
adequacy of police investigation; identification process

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Simon mattered. Simon was not “just a homeless guy” or just a “body in the dunes”. He was my brother. He was a son. He was an uncle. He was a friend. He was loved. He deserved dignity in death. He deserved to be taken seriously. His death deserved a proper investigation — not one shaped by prejudicial assumptions, marked by serious failures and carried out with a level of care that fell well short of what any family should expect.

Nothing can bring Simon back. But acknowledgment matters. Being heard matters. And ensuring that every person is treated as someone who matters — regardless of their circumstances, regardless of their struggles, regardless of their social standing — Simon mattered.

- Family Coronial Impact Statement on behalf of Simon’s family

SUMMARY

1. Simon Christopher Gaskill (**Simon**) was 50 years old when he was found deceased on 15 April 2022 at the foreshore sand dunes at Ocean Grove Beach, Ocean Grove, in Victoria.
2. He is remembered as a gentle soul, a gifted surfer, a good mate, and a free-spirited person who was easy-going and loved nature. He loved ‘old-time’ music such as Bob Dylan and Pink Floyd, and is described by his sister as someone who was well-liked and intelligent. He held numerous jobs in his lifetime, including as a nursery worker and groundsperson.
3. In the years before his death, Simon suffered a significant decline in his physical and mental health in the setting of chronic excessive alcohol and synthetic marijuana use. His behaviours while under the influence of, or withdrawing from, alcohol and other substances led to conflict in his relationships and estrangement from his family. An intervention order was in place for his family’s protection, and Simon was not permitted to attend their property in Anakie.
4. Subsequently, Simon commenced living in caravan parks in the Barwon region, and ultimately, ‘sleeping rough’ in a tent in the dunes at Ocean Grove Beach. He was unable to work and was reliant on Centrelink payments for his day-to-day existence. His bank records reflect modest purchases from local stores, and he received care and support from local community members.
5. In December 2021, four months prior to his death, Simon was admitted to University Hospital Geelong for treatment of severe alcohol withdrawal symptoms, including a witnessed seizure. While Simon assured hospital employees that he could find himself accommodation, he was effectively discharged to homelessness with a plan for further investigations via outpatient clinics which ultimately did not proceed.
6. By the time Simon’s body was found, his body had undergone significant decomposition. As a result, and despite extensive and thorough forensic medical investigations, a cause of death has been unable to be established.
7. There were significant failures in the initial police investigations of Simon’s death that led to multiple coronial investigators being appointed, along with the involvement of Professional Standards Command and the Independent Broad-based Anti-Corruption Commission (**IBAC**). An inquest was held into Simon’s death to determine what went wrong with the investigation, and the way in which similar deficiencies could be prevented in the future. The inquest also

identified opportunities for systems improvements in the coordination and management of care for patients experiencing homelessness and alcohol dependence.

THE CORONIAL INVESTIGATION

Jurisdiction

8. Simon's death was a 'reportable death' under section 4 of the *Coroners Act 2008 (Vic)* (**the Coroners Act**) as his death occurred in Victoria, and his death was unexpected.¹

Purpose of the coronial jurisdiction

9. The jurisdiction of the Coroners Court of Victoria (**Court**) is inquisitorial.² The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.³
10. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
11. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.
12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.
13. Coroners are empowered to advance their prevention role by:
 - (a) reporting to the Attorney-General on a death;
 - (b) commenting on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

¹ Coroners Act, s 4(2)(a).

² Coroners Act, s 89(4).

³ Coroners Act, Preamble, s 67.

- (c) making recommendations to any Minister of public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.⁴
14. Coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.⁵ It is not the role of the coroner to lay or apportion blame, but to establish the facts.⁶

Standard of proof

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.⁷ The strength of evidence necessary to prove relevant facts varies according to the nature of the facts the circumstances in which they are sought to be proved.⁸
16. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.⁹
17. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.¹⁰ Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.¹¹

⁴ Coroners Act, s 67(3), 72(1) and (2).

⁵ Coroners Act, s 69(2).

⁶ *Keown v Khan* (1999) 1 VR 69.

⁷ *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

⁸ *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s 140 of the Evidence Act 1995 (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ

⁹ (1938) 60 CLR 336.

¹⁰ *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

¹¹ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

Coronial investigation

18. On 15 April 2022, Leading Senior Constable Glenn Kelly (**LSC Kelly**) of the Bellarine Police Station completed and submitted a Police Report of Death for the Coroner ('Form 83') to the Court, which was checked by his supervisor, Sergeant Mick Knight (**Sgt Knight**).
19. The Form 83 set out a brief summary of the circumstances of death as follows:

“The deceased was found face down in the sand dunes near Beacon 16w Ocean Grove. The finder was taking a short cut to the beach through bush and bracken and located the body badly deceased not far [from] a two man tent. The male appears to be homeless and the body had been decaying for some time maybe months. The body is so badly decomposed that it was not possible to confirm sex on face value. A back pack located on the back of the deceased contained prescription medication in the name of Simon Christopher GASKILL with the prescribing Dr D CINNAMON from university Hospital Geelong. NII (sic) further details known. Geelong CIU and Geelong Crime Scene in attendance, nil crime scene required.”
20. Deputy State Coroner Jacqui Hawkins, as she then was, initially had carriage of the investigation and made directions concerning the forensic investigations to be undertaken.
21. On 25 July 2022, after considering the medical examiner’s report and other information reported to her Honour in the investigation, Deputy State Coroner Hawkins made Findings without Inquest into the death pursuant to section 67 of the Act. No findings were made as to the circumstances in which the death occurred pursuant to section 67(2) of the Act.
22. On 26 April 2023, Simon’s sister, Amanda, applied to the Court under section 77 of the Act requesting the Findings be set aside and the investigation into Simon’s death to be re-opened. The application was accompanied by supporting material setting out new facts and circumstances which were not available to Deputy State Coroner Hawkins at the time the Findings were made.
23. On 8 May 2023, Deputy State Coroner Hawkins granted the application and made orders setting aside the Findings and re-opened the investigation into Simon’s death.¹²
24. Detective Senior Constable Mitchell Hardisty (**DSC Hardisty**) of the Geelong Criminal Investigation Unit (**CIU**) was subsequently appointed the coronial investigator by Victoria

¹² Determination following application to set aside finding of Deputy State Coroner Jacqui Hawkins delivered on 8 May 2023.

Police, overseen by his supervisor, Detective Sergeant Adam Radley (**DSgt Radley**). DSC Hardisty had attended the scene on 15 April 2022 and undertook initial enquiries on the day Simon's body was located to ascertain the identity of the deceased, together with other members of the Geelong CIU.¹³

25. At the time of DSC Hardisty's appointment, the role of the coroner's investigator (also referred to as coronial investigator) operated by convention and informal arrangements between the Coroners Court and Victoria Police. Since these events, the Coroners Act has been amended to expressly define and formalise the role of coronial investigator.¹⁴
26. Deputy State Coroner Hawkins directed DSC Hardisty conduct further investigations to assist the Court in better understanding the circumstances of Simon's death and prepare and submit a full coronial brief of evidence. DSC Hardisty conducted inquiries on behalf of the Court and obtained statements from witnesses – including from Simon's sister Amanda, father Christopher, friend Cameron Miller, and treating general practitioner at Lara Medical Centre.
27. DSC Hardisty subsequently submitted a coronial brief of evidence to the Court in October 2023. This brief is referred to for the purpose of this Finding as the '**First Coronial Brief**'.
28. The First Coronial Brief comprised the witness statements as described above, as well as:
 - (a) a statement from the walker who found Simon's body which had been provided to police on the day Simon's body was located;
 - (b) a statement from DSC Hardisty;
 - (c) scene photographs;
 - (d) medical records from Lara Medical Centre;
 - (e) call charge records from Simon's mobile phone service; and

¹³ First Statement of DSC Hardisty dated 10 October 2023, IB p 168.

¹⁴ On 11 October 2023, the *Justice Legislation Amendment Act 2023* (Vic) commenced, which amended the Coroners Act to define the role of coronial investigator under s 3(1) of the Coroners Act as '*a police officer who is nominated by the Chief Commissioner of Police to assist a coroner in relation to an investigation into a reportable death*'. Further, section 15A was inserted into the Act to provide that a coroner may, by written notice, direct a coronial investigator in relation to an investigation. This provision was introduced in response to a recommendation by Deputy State Coroner English (as she then was) in the [Finding into Death with Inquest into the Death of Tanya Day](#) (COR 2017 6424) delivered on 9 April 2020.

- (f) body worn camera (**BWC**) footage recorded by police officers who attended the scene when Simon's body was located, as well as from an earlier interaction police had with Simon in Anakie on 24 December 2021.
29. The First Coronial Brief also included a summary of Simon's history and relevant events leading up to Simon being found deceased on 15 April 2022. This included information about a further interaction Simon had with police on 18 February 2022 at Geelong Westfield Shopping Centre, two months before he was found deceased.
30. In October 2023, Deputy State Coroner Hawkins retired from the Court and I took carriage of the investigation.
31. After reviewing the First Coronial Brief, I directed further investigative steps be undertaken into the circumstances surrounding Simon's death. I requested and received additional medical records and a statement from Barwon Health¹⁵ concerning Simon's clinical care and management during his admission in December 2021, as well as a copy of BWC footage recorded by attending police officers of the interaction with Simon on 18 February 2022. I also directed that a copy of the First Coronial Brief be provided to Simon's family in accordance with section 115 of the Coroners Act.
32. In early July 2024, after reviewing the coronial brief, Amanda submitted a letter to the Court raising concerns about the police investigation into Simon's death. With Amanda's permission, and at my direction, Court staff provided a copy of that letter to the Chief Commissioner of Victoria Police for their consideration and response.
33. On 5 August 2024, Victoria Police appointed Detective Sergeant Adam Tink (**D/Sgt Tink**) from the Ballarat Sexual Offences and Child Abuse Investigation Team (**SOCIT**) to review the police investigation and identify whether there were any additional avenues of enquiry relevant to the coronial investigation into the cause and circumstances of the death. D/Sgt Tink was also briefly appointed as coronial investigator.
34. On 8 August 2024, D/Sgt Tink wrote to the Court to propose further lines of inquiry be undertaken to assist in the investigation. He noted that further enquiries had established that

¹⁵ This statement was provided on behalf of Barwon Health by Dr Christopher McAulay-Powell, a general medical consultant Visiting Medical Officer at Barwon Health, who was the ward service consultant for the hospital's Rapid Assessment and Planning Unit, where Simon was admitted at University Hospital Geelong in December 2021.

a '000' call was made in relation to Simon on 25 March 2022, reporting an alleged altercation at a residence in Ocean Grove, and that Simon's mobile phone had been handed in to Bellarine Police Station later that day.

35. In late August 2024, carriage of the coronial investigation was reassigned by Victoria Police to Detective Leading Senior Constable Leigh Smyth (**DLSC Smyth**) of the Homicide Squad, who was at that time in the position of Detective Acting Sergeant. The matter was transferred to the Homicide Squad due to the expertise of the unit in complex death investigations and to ensure further independence from a regional level for the continued investigation into Simon's death.¹⁶ However, the position of Victoria Police was – and remains, after DLSC Smyth's further investigations – that there were no suspicious circumstances arising from Simon's death or third-party involvement.¹⁷
36. On 30 August 2024, DLSC Smyth was confirmed as the new coronial investigator at a Mention Hearing. I directed DLSC Smyth file a fresh coronial brief with the Court addressing the additional lines of inquiry identified.
37. On 22 November 2024, DLSC Smyth submitted a coronial brief to the Court. This brief is referred to for the purpose of this Finding as the '**Second Coronial Brief**'.
38. The Second Coronial Brief was substantial, comprising the culmination of extensive further enquiries into Simon's personal history and his movements in the months and weeks prior to his death, including proximate police contact shortly before his death. The Second Coronial Brief included additional statements from witnesses who interacted with Simon in the months, weeks and days immediately preceding his death, forensic examination of Simon's laptop, and statements, notes and audiovisual footage documenting police interactions with Simon in the months and days prior to Simon's death, which have assisted the Court in better understanding the circumstances in which Simon died, and narrowing the likely period in which his death occurred. For the first time, the Court received evidence that Simon had had recent police contact in the lead-up to his death, having been dropped off by police vehicle at the Riverside Campground, near the dunes, by two police members in the early hours of 25 March 2022, following the reported altercation with a resident in Ocean Grove.

¹⁶ First Statement of Detective Acting Sergeant Leigh Smyth, IB p 188.

¹⁷ Transcript of Mention Hearing held on 30 August 2024, DLSC Smyth, T-9.

39. DLSC Smyth subsequently assisted the Court with obtaining further materials at my direction, which supplemented the Second Coronial Brief. These materials were included in the final version of the brief prepared for Inquest, referred to as the '**Inquest Brief**'.¹⁸

Other inquiries and investigations

40. Victoria Police Professional Standards Command (**PSC**) conducted an internal investigation of the police investigation into Simon's death in response to a formal complaint submitted by Amanda concerning the thoroughness of the initial police investigation.
41. Two reports were subsequently produced by senior members of Victoria Police who were independent from the initial investigation into Simon's death:
- (a) a Final Investigation Report¹⁹ completed on 29 April 2025 by D/Sgt Tink into complaints raised by Amanda concerning the police investigation into Simon's death,
 - (b) a Supplementary Investigation Report²⁰ by Detective Senior Sergeant Shaun Bingham (**D/S/Sgt Bingham**) of the Ballarat CIU into the adequacy of supervision provided to LSC Kelly and DSC Hardisty. This report is undated but was provided to the court on 16 September 2025.
- (together, the **PSC Reports**).
42. D/Sgt Tink and D/S/Sgt Bingham identified significant inadequacies and duty failures in the initial police investigation into Simon's death including in respect of:
- (a) delay in notifying the next of kin and taking steps to formally identify the deceased;
 - (b) failure to establish a timeline prior to death and the last person to see Simon alive;
 - (c) failure to examine personal belongings and appropriately handle exhibits;
 - (d) failure to identify proximate police contact with the deceased on 25 March 2022 and obtain relevant evidentiary material concerning this interaction;

¹⁸ All references in footnotes to 'IB' (Inquest Brief) are to materials from the Second Coronial Brief and supplementary materials obtained by DLSC Smyth at my direction or by the Court.

¹⁹ Victoria Police Professional Standards Command Final Investigation Report dated 29 April 2025, IB pp 847-859.

²⁰ Victoria Police Professional Standards Command Supplementary Investigation Report undated, IB pp 860-863.

- (e) failure to identify that police had possession of Simon's mobile phone at Bellarine Police Station since 25 March 2022;
 - (f) failure to correctly analyse Simon's phone records and provision of incorrect information to the Coroner and family of the deceased concerning these records;
 - (g) failure to contact any of the persons identified via Simon's phone records;
 - (h) failure to thoroughly analyse Simon's laptop computer;
 - (i) failure to communicate with family regarding the progress of investigation and unprofessional conduct in manner of communication with family;
 - (j) failure to make enquiries regarding the evidentiary value of Simon's phone to the coronial investigation or attempt to return Simon's mobile phone to his next of kin;
 - (k) failure to provide adequate supervision of and discharge supervisory accountabilities in the initial coronial investigation immediately after Simon was found deceased.²¹
43. The Final Investigation Report also found that members who attended an incident involving Simon on 25 March 2022 failed to activate their body worn cameras (**BWC**) as required under the Victoria Police activation framework for attendance at Emergency Services Telecommunication Authority (**ESTA**) (now known as 'Triple Zero Victoria') tasks.²²
44. In preparing their reports, D/Sgt Tink and D/S/Sgt Bingham reviewed and considered relevant documentary evidence concerning the initial police investigation, including the Form 83, the First Coronial Brief, statements provided by investigating police members for the Second Coronial Brief, and the police roster for the relevant period.
45. Three members subject to adverse findings in the PSC Reports – LSC Kelly, DSC Hardisty and Sgt Knight – were not interviewed for the purposes of the reviews, having retired, resigned or been on long term leave (and subsequently retired) from Victoria Police at the time the reviews were conducted. Accordingly, they did not have the opportunity to respond to criticisms made in the PSC Reports concerning their conduct. However, as part of my investigation and in the course of the natural justice process, I have given notice to each

²¹ Victoria Police Professional Standards Command Final Investigation Report dated 29 April 2025, IB pp 850-53, 858; Victoria Police Professional Standards Command Supplementary Investigation Report undated, IB p 862.

²² Victoria Police Professional Standards Command Final Investigation Report dated 29 April 2025, IB p 857.

affected current and former police member of my proposed adverse comments,²³ via their legal counsel, and have given them the opportunity to make submissions through counsel prior to finalisation of my Finding.²⁴

46. While the PSC reports have been of assistance to, and informed my investigation, the coronial investigation is independent, and I have formed my own view on the evidence before me. My investigation has identified systemic issues and opportunities for improvement in police investigations into reportable deaths which were not captured in the PSC Reports, as discussed further below.

Inquest into Simon's death

47. Coroners retain a discretion to hold an inquest into any death they are investigating.²⁵ This discretion must be exercised in a manner consistent with the purposes and objects of the Act.
48. In deciding whether to conduct an inquest, a Coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about, and the likelihood that an inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.
49. I determined that an inquest was warranted to ventilate issues concerning the adequacy of the police investigation into Simon's death to assist in maintaining public confidence in the administration of justice and conduct of coronial investigations in the State of Victoria. The inquest also provided an opportunity to hear additional oral evidence about the forensic investigations into Simon's medical cause of death and the circumstances leading to his death, and to explore whether there were any opportunities for systems improvements in the treatment of, and interventions for people suffering from, chronic alcohol dependence who face barriers in accessing treatment and support services.

²³ Letter to Legal Representative for Chief Commissioner of Police – Procedural Fairness – Notice of Proposed Comments and Recommendations dated 19 January 2026.

²⁴ It is noted that, in these proceedings, Counsel for the Chief Commissioner of Police represented the interests not only of the Chief Commissioner of Police but of all police members involved in the incident except for the coronial investigator at the time of inquest (Detective Leading Senior Constable Leigh Smyth) – see Transcript (T) T-1, lines 27-31.

²⁵ Coroners Act, s 52(1).

Scope of inquest

50. The inquest examined:

- (a) the medical cause and circumstances of Simon's death;
- (b) the adequacy of the police investigations into Simon's death; and
- (c) whether there are any opportunities for system improvements, including in respect of:
 - i. coordination and management of care (including discharge planning) for patients who face barriers to accessing treatment and support services due to homelessness, alcohol dependence and/or mental illness; and
 - ii. the management of police investigations of reportable deaths on behalf of a coroner, including in assisting in the identification of the body, and providing the coroner with information which is or may be relevant to the investigation of the death.

Inquest hearing

51. At inquest, I heard evidence from:

- (a) Ms Amanda Gaskill, Simon's sister;
- (b) Dr Judith Fronczek, forensic pathologist, Victorian Institute of Forensic Medicine (**VIFM**);
- (c) Detective Leading Senior Constable Leigh Smyth, Coronial Investigator, Homicide Squad of Victoria Police; and
- (d) Professor Ajai Verma (**Professor Verma**), Chief Medical Officer, Barwon Health.

52. I also received a family coronial impact statement from Amanda Gaskill, on behalf of Simon's family, which, while not evidence, gave me greater insight into who Simon was, and the impact on his family of his death and the subsequent police investigations.

53. In addition, I had the benefit of receiving submissions from Counsel Assisting and the interested parties concerning proposed findings and recommendations arising from the investigation into Simon's death.

Finding into death with inquest

54. This finding draws on the totality of the materials produced to the Court throughout the coronial investigation and inquest into Simon's death. That is, the court records, the Inquest Brief, evidence adduced during the inquest, and submissions provided by Counsel Assisting and Counsel representing the interested parties.²⁶
55. I have considered all the material. However, in writing this Finding, I do not purport to summarise all the evidence. I have referred only to such information and in such detail as is warranted by the forensic significance and for narrative clarity. The absence of any reference to any aspect of the evidence does not mean that it has not been considered.

BACKGROUND

56. The focus of my investigation was on establishing the cause and circumstances in which Simon's death occurred. However, I consider it appropriate to set out in some detail relevant aspects of Simon's personal history and events leading to his death, to provide context to his death and the comments on matters connected with the death, relating to public health and safety and the administration of justice, which follow.

Simon's personal history

57. Simon was born in Sunshine, Victoria to parents Chris and Dianne. He has one younger sister, Amanda.²⁷
58. Simon spent much of his childhood in the Skenes Creek and Apollo Bay areas, pursuing his love of surfing.²⁸ When he was a teenager, Simon was offered a sponsorship with a surf brand, but ultimately declined this as he did not want to turn his passion into work.²⁹ He continued to take every opportunity to travel to the coast to surf when he could.³⁰

²⁶ The Inquest Brief prepared by Detective Leading Senior Constable Leigh Smyth updated 11 December 2025 was tendered at Inquest (Exhibit #1), together with Additional Materials 1 to 9 (Exhibit #2), the First Coronial Brief prepared by Detective Senior Constable Mitchell Hardisty in October 2023 (Exhibit #3), Barwon Health Medical Records (Exhibit #4), and Lara Medical Centre Records (Exhibit #5).

²⁷ Statement of Chris Gaskill, IB p 2; First Statement of Amanda Gaskill, Inquest Brief (IB) p 7.

²⁸ Statement of Chris Gaskill, IB p 2; First Statement of Amanda Gaskill, IB p 7.

²⁹ First Statement of Amanda Gaskill, IB p 7.

³⁰ First Statement of Amanda Gaskill, IB p 8.

59. Simon completed an apprenticeship in horticulture and worked at a nursery and as a groundskeeper. He later worked at Bunnings for over a decade,³¹ but lost this employment during the COVID-19 pandemic.³² At the time of his death, Simon was in receipt of Jobseeker payments.³³
60. Simon was described as an outgoing, free-spirited person who never aspired to be materialistic and was easy-going and had a great sense of humour. Amanda noted that Simon “*was a mentor for young people from Apollo Bay who had gone off the rails. He would do anything to try and help anyone*”, and “*was always one of those people who made people feel special, he loved having a chat and went the extra mile*”.³⁴
61. As a young adult – like many young adults – Simon enjoyed partying and drinking recreationally. Over time, his alcohol use increased, and he also began smoking marijuana and later used a synthetic marijuana he referred to as ‘Spice’.³⁵ By his mid-30s, Simon was using alcohol heavily, and his mental health deteriorated as he used alcohol to manage ongoing anxiety and became increasingly reclusive. Simon’s family observed that his demeanour changed from easy going and laidback to argumentative and angry, and he began to suffer paranoia and delusions. His behaviour became unpredictable and created increasing friction in his relationships.³⁶
62. Simon was subsequently diagnosed with general anxiety disorder, depression and alcohol addiction, and was prescribed antidepressants.³⁷ Over the following years, with the encouragement and support of his family, Simon attended a number of alcohol rehabilitation clinics in an effort to reduce his drinking but would relapse soon after completing each detoxification program.³⁸
63. Simon does not appear to have had a regular primary health practitioner in the community in the years immediately preceding his death. He last attended Lara Medical Centre, his

³¹ Statement of Chris Gaskill, IB pp 2-3.

³² Statement of Gabrielle Smales, IB p 44; Statement of Mitchell Greenaway, IB p 219.

³³ Statement of Ioka Fuamatu, IB p 80.

³⁴ First Statement of Amanda Gaskill, IB p 8.

³⁵ Statement of Chris Gaskill, IB pp 2-3; First Statement of Amanda Gaskill, IB p 8.

³⁶ Statement of Chris Gaskill, IB pp 3-4; First Statement of Amanda Gaskill, IB p 10.

³⁷ Medical records of Lara Medical Centre; Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 70.

³⁸ Statement of Chris Gaskill, IB p 4; First Statement of Amanda Gaskill, IB pp 9-10; Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 70.

nominated medical clinic in 2018,³⁹ and last filled a prescription of sertraline, an antidepressant, on 29 June 2021.⁴⁰ Simon did not have any further medical appointments funded through the public health system in the year prior to his death, aside from a hospital admission in December 2021, detailed further below.⁴¹

64. Simon lived with his sister and her family in Anakie (a town between Geelong and Bacchus Marsh in Victoria) for about twelve years. However, in April 2021, he was asked to leave the property due to his increasingly problematic behaviour towards his family. An interim and final intervention order was made prohibiting Simon from going to the Anakie property.⁴² Amanda described at Inquest that she felt conflicted about this, '*obviously wanting to help him but at the same time wanting it to be a safe environment for my girls.*'⁴³
65. When Simon left the property, Amanda organised and paid for motel accommodation in Geelong for Simon, but he declined this, indicating he would move to Ocean Grove and stay with a friend.⁴⁴ Simon subsequently camped at local caravan parks located along the foreshore of Ocean Grove and Queenscliff, including the Riverview Family Caravan Park and Barwon Heads Caravan Park.⁴⁵ Records indicate he last stayed at Riverview Family Caravan Park from 13 September 2021 to 29 October 2021.⁴⁶
66. Upon leaving the Riverview Family Caravan Park at the end of October 2021, Simon is believed to have set up his tent in the sand dunes in the foreshore area of Ocean Grove beach with aerial images of the foreshore during this period indicating Simon continued to reside in the area in a tent for the next six months.⁴⁷ Simon used the public toilet showers near the Ocean Grove Surf Club to wash, and the barbeque facilities for cooking.⁴⁸

³⁹ Exhibit 55 – Lara Medical Centre records, IB.

⁴⁰ Exhibit 56 – PBS Records, IB.

⁴¹ Medicare Certificate dated 4 October 2024, IB p 876.

⁴² Appendix A: Interim Intervention Order dated 1 April 2021; Appendix B: Final Intervention Order dated 23 June 2021, IB.

⁴³ Evidence of Amanda Gaskill, T-28 lines 2-4.

⁴⁴ First Statement of Amanda Gaskill, IB p 11.

⁴⁵ Statement of Leanne Swanborough, Riverview Family Caravan Park, IB p 26; Statement of Alanna Begg, Barwon Heads Caravan Park, IB p 30

⁴⁶ Statement of Leanne Swanborough, Riverview Family Caravan Park, IB p 26.

⁴⁷ First Statement of Detective Acting Sergeant Leigh Smyth, IB p 201.

⁴⁸ Statement of Gabrielle Smales, IB p 43.

Admission to Barwon Health in December 2021

Fall at Riverview Family Caravan Park

67. On 5 December 2021, Simon was found collapsed near a toilet block at the Riverview Family Caravan Park, unconscious and face down.⁴⁹ He appeared undernourished.⁵⁰
68. Emergency services were called and attended and found Simon in an altered conscious state, being disorientated to time and place but with no apparent injuries. He appeared to have suffered a medical episode.⁵¹ Simon denied any alcohol use that day. An empty cask of wine was found in his backpack.⁵²
69. Attending police activated their body worn camera (**BWC**) footage during their attendance at this incident, but the footage was categorised as ‘non-evidentiary’ and subsequently deleted after 90 days in accordance with Victoria Police requirements for the retention and disposal of BWC footage,⁵³ and accordingly was not available for my investigation. I make no criticism in relation to the deletion of this footage, which occurred prior to Simon’s death.

Emergency Department Admission, Seizure and Initial Investigations

70. Simon was transported by ambulance to University Hospital Geelong Emergency Department for assessment.⁵⁴ University Hospital Geelong is part of Barwon Health.
71. Simon was known to Barwon Health and had prior documented diagnoses with the health service of alcohol and substance use disorder, anxiety and depression.⁵⁵
72. On examination, Simon was noted to be engaging and tremulous. He initially scored 9 on the Alcohol Withdrawal Scale (**AWS**) scale, indicating he was suffering from moderate withdrawal symptoms.⁵⁶ He was also noted to have an unsteady gait, vomited, and had a witnessed seizure in the Emergency Department shortly after his admission.⁵⁷

⁴⁹ Statement of Paula Bissinella, IB pp 52-3; Statement of Paul Bissinella, IB pp 54-55.

⁵⁰ Statement of Gabrielle Smales, IB p 42.

⁵¹ Statement of First Constable Lauren La Spina, IB p 57.

⁵² Statement of Ambulance Victoria Paramedic Isaak Egan, IB pp 59-60.

⁵³ Appendix G: Body Worn Camera Axon Audit for FC La Spina, IB p 248; Appendix H: Body Worn Camera Axon Audit for Dean Pierce, IB p 250.

⁵⁴ Statement of Ambulance Victoria Paramedic Isaak Egan, IB p 60.

⁵⁵ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 61.

⁵⁶ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 62.

⁵⁷ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 61-2.

73. Simon reported to clinicians that he had attempted to cease his alcohol consumption by going ‘*cold turkey*’ and said he had last consumed alcohol four days prior, having previously consumed two bottles of wine per day. He reported a recent history of tremors, shaking and weakness, particularly in the last three days, and in respect of the incident precipitating his admission to hospital, said he had tripped over resulting in a fall with a head strike.⁵⁸
74. Dr Christopher McAulay-Powell, Visting Medical Officer at Barwon Health, explained in his statement for the Court that patients suffering from an alcohol use disorder who subsequently attempt to cease alcohol consumption can experience withdrawal symptoms such as tremors, sweating, anxiety, palpitations or seizures. Symptoms of alcohol withdrawal can last several days.⁵⁹ Patients with alcohol misuse can also be deficient in thiamine which can precipitate a neurological condition called Wernicke’s encephalopathy resulting in confusion, eye movement issues and unsteady gait. Routinely, patients with alcohol use disorder are treated with high doses of thiamine in an effort to prevent this complication.⁶⁰
75. Simon was admitted to the hospital under the General Medical Team for alcohol withdrawal, with routine admission blood tests, ongoing AWS monitoring, and four-hourly neurological observations to monitor for concussion-related symptoms given the fall prior to his presentation.⁶¹ He underwent a computed tomography (CT) scan of his brain and cervical spine given the fall precipitating his admission, which revealed no acute intracranial injury, but approximately 40-50% central height loss of the T4 vertebral body of the spine of indeterminate age.⁶² He was prescribed 10 to 20mg diazepam on a two-hourly basis to manage symptoms of alcohol withdrawal, and 300mg thiamine intravenously for thiamine replacement.⁶³
76. Initially, Simon indicated a motivation to cease alcohol use and enquired about a rehabilitation/withdrawal admission. However, later the same day, notes indicate he did not want drug and alcohol admission.⁶⁴ He informed treating clinicians that he felt he had “*strong*

⁵⁸ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 61-2.

⁵⁹ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 62.

⁶⁰ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 62.

⁶¹ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 62.

⁶² Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 62; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, p 45.

⁶³ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 62.

⁶⁴ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, pp 103-4.

willpower” and could cease this habit on his own, and did not like Alcoholics Anonymous.⁶⁵ It was initially planned for Simon to self-refer himself to the hospital’s Drug and Alcohol Services (**DAS**) if he was willing to do so.⁶⁶

77. On admission, it was noted in Simon’s Alert Summary that he had a Communication Support Need for reading.⁶⁷ On Risk Screenings, he was also found to have a body mass index of 18.8, indicating malnutrition, and was recommended for referral to a dietitian.⁶⁸
78. The Daily General Care Plan incorrectly documented that Simon lived with his sister, and under the ‘Discharge Risk Assessment’ the box ‘N’ was checked next to ‘Patient lives alone’.⁶⁹ However, as was identified early during Simon’s admission, he had no fixed place of abode⁷⁰ and was not living with his sister, or any other person. No updates appear to have been made to Simon’s Daily General Care Plan to correct the information concerning his home and family situation or Discharge Risk Assessment prior to discharge.⁷¹

Transfer to Rapid Assessment and Planning Unit and ongoing treatment

79. On 6 December 2021, Simon was transferred to the Rapid Assessment and Planning Unit (**RAPU**). The RAPU is a general medical unit/team at Barwon Health, with patients anticipated to be discharged within 2-3 days after appropriate treatment.⁷² It is routine for patients diagnosed with alcohol withdrawal to be admitted to the RAPU.⁷³
80. Blood tests indicated Simon’s potassium levels were lower than the expected range. Dr McAulay-Powell explained that alcohol misuse is associated with nutritional issues, and some patients can also experience electrolyte abnormalities.⁷⁴ The seizure was suspected to be

⁶⁵ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 63; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, pp 104-5.

⁶⁶ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 63; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, p 105.

⁶⁷ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 12.

⁶⁸ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 176.

⁶⁹ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 160.

⁷⁰ Documented as living in ‘tent in Barwon Heads’ for 3-4 months, on Consultant Review on 6 December 2021, Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 100.

⁷¹ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 160.

⁷² Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 63.

⁷³ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 61.

⁷⁴ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 63.

likely alcohol related, and Simon was continued on AWS monitoring and thiamine replacement, with ongoing monitoring for further electrolyte or nutritional complications.⁷⁵

81. Simon was also seen by a Social Worker who documented that Simon lived with his sister and that he reported no financial or social concerns and declined a referral to Drug and Alcohol Services or social work. No further social work interaction was planned at that stage, with referral to be made as requested.⁷⁶ However, I note this history conflicted with earlier and subsequent entries in Simon's medical records that documented Simon had been living in a tent in Barwon Heads for three to four months and had no fixed place of abode.⁷⁷
82. The treating team sought Simon's permission to contact his sister to obtain collateral history. Simon did not initially consent to this and again declined referral to Alcohol and Other Drug (AOD) service providers.⁷⁸
83. Over the following day, Simon was witnessed to fall on a couple of occasions and was noted to be confused, and at times had to be restrained due to agitation and aggression towards staff. His behaviour was attributed to severe alcohol withdrawal symptoms, and his AWS score increased to 21.⁷⁹ On review of Simon's mental health history, the clinical liaison nurse noted prior family concerns raised nine months earlier with the Barwon Health Mental Health Drugs and Alcohol Service (MHDAS) concerning his long standing alcohol dependence and synthetic cannabis use, and delusional thoughts, yelling, screaming and swearing. This history was conveyed to Simon's treating team.⁸⁰
84. On 7 December 2021, Simon was reviewed by the hospital psychiatric team. He was observed to have a coarse tremor bilaterally with disorganised thought form and impaired insight and judgment with worsening confusion and agitation. This behaviour was atypical for the usual pattern of alcohol withdrawal, and he was deemed not suitable for early discharge.⁸¹

⁷⁵ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 63.

⁷⁶ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 63; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, p 106.

⁷⁷ Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, pp 100, 108.

⁷⁸ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 63; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, p 111.

⁷⁹ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 64-5.

⁸⁰ Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, p 107.

⁸¹ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 64-5; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, p 116-8.

85. At this time, Simon provided consent for the clinical team to contact his sister Amanda for collateral information. The RPU Resident subsequently telephoned Amanda to seek information about Simon's baseline behaviour. Amanda provided a history of Simon's mental health issues, history of alcohol and drug consumption, and observations that he had exhibited increased delusions, possible hallucinations, and increasingly aggressive and bizarre behaviour. She also reported that Simon had been evicted from her property in April, and there was an intervention order in place.⁸² At Inquest, Amanda stated she was glad to receive the call from the hospital and glad to be able to help.⁸³
86. Simon continued to exhibit aggressive behaviour towards staff members and was noted to hallucinate and attempt to speak to individuals who were not present at the time. His AWS score increased further to 45, indicating ongoing severe alcohol withdrawal symptoms. Simon was administered diazepam, olanzapine and quetiapine and mechanically restrained for the safety of himself and staff.⁸⁴
87. Due to his ongoing delirium, a decision was made to wean Simon off sedative and psychotropic medications which were identified as possibly prolonging his confused state, with ongoing monitoring and a plan to consider further investigations when Simon was more settled and it was appropriate to do so. Simon continued to have falls and be unsteady on his feet and was categorised as a high falls risk patient.⁸⁵
88. By 9 December 2021, Simon had settled and was vastly improved, although he continued to experience mild confusion and disorientation and his inflammatory markers were trending upwards. Plans were developed for a chest x-ray, blood and urine tests, an MRI brain scan, and consideration of lumbar puncture to investigate potential neurological causes of Simon's evolving clinical picture, such as encephalitis.⁸⁶
89. On 10 December 2021, Simon underwent further radiological investigations including a CT thoracic and lumbar spine and an MRI brain and spine. The CT indicated Simon had a burst

⁸² First Statement of Amanda Gaskill, IB p 12; Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 65; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, pp 122-3.

⁸³ Evidence of Amanda Gaskill, T-29 lines 7-9.

⁸⁴ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 65-6.

⁸⁵ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 66-7.

⁸⁶ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 67; Barwon Health Medical Records UR 219723 DMR 15.4.21 to 11.4.24, pp 141-2.

fracture at T4 with 60% height loss, bony retropulsion by 3mm resulting in central canal narrowing and mildly depressed superior endplate compression fractures at T3 and T5.⁸⁷ The MRI revealed no acute intracranial pathology, no abnormal enhancement, and no epileptogenic focus. The MRI indicated there was a compression fracture at the T4 level and subtle superior endplate compression fractures at T3 and T5.⁸⁸

90. The proposed lumbar puncture was ultimately not proceeded with due to the improvement in Simon's presentation and impression that it was likely polypharmacy had contributed to delirium on a background of long-standing polysubstance misuse and suspected withdrawal with a likely provoked seizure in the context of alcohol.⁸⁹
91. On neurological and psychiatric review on 10 December 2021, Simon presented as pleasant and polite, with no irritability, aggression or evidence of auditory or visual hallucinations. He was found to be orientated to time, person and place but continued to exhibit a postural and kinetic tremor in his upper and lower limbs and a wide based ataxic gait. It was considered likely Simon had experienced a provoked seizure due to either excessive alcohol consumption or alcohol withdrawal, probably exacerbated by concurrent marijuana use.
92. Simon was open about his alcohol overuse and past efforts to attempt alcohol detoxification and disclosed to clinicians that "*He always makes sure he has enough money to buy alcohol, even if it meant skipping meals*"⁹⁰. It was noted that "*Simon is keen to see drug and alcohol so should be linked up again for another detox attempt*".⁹¹
93. Simon continued to indicate a desire to be linked in with the hospital's DAS for the remainder of his inpatient admission.⁹² However, a planned inpatient AOD review did not proceed as Simon was discharged before this could occur.⁹³

⁸⁷ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 68.

⁸⁸ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 69; Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 70.

⁸⁹ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 68.

⁹⁰ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 148.

⁹¹ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 68-9; Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 148-150.

⁹² Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, pp 154-5.

⁹³ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 868.

Discharge planning

94. On 10 December 2021, a social worker spoke with Simon about his accommodation post-discharge. Simon reported that he was currently unable to stay with his sister, but that he could live with friends or ‘*camp inland*’. He was provided with contact details for the Salvation Army in relation to crisis accommodation ‘*if required*’.⁹⁴ However, it is unknown if Simon attempted to engage with this service. A retrospective clinical note documented that ‘*Nil further S/W required for d/c planning*’.⁹⁵
95. On 11 December 2021, at 10am, Simon was reviewed by an Occupational Therapist. Simon was calm and cooperative, and stated his memory of where his tent was located was “*patchy*”. He was unsure whether his tent was at Riverside or Barwon Heads Caravan Parks, or in the sand dunes near the Riverside Caravan Park.
96. In relation to discharge planning, the Occupational Therapist noted:
- Pt appears much improved, however expresses ongoing concerns re: ETOH [alcohol] and would like to be linked in w/ DAS. Unclear D/C destination at present as pt now unable to recall exact location of tent (believes either in Baron Heads or Ocean Grove Caravan Park or in the dunes in a non-paid plot).*⁹⁶
97. The Occupational Therapist documented a plan to liaise with social work regarding housing support needed on discharge as Simon was unsure of exact location of tent due to being intoxicated when pitched.⁹⁷ Subsequently, social work documented a retrospective entry made at 10.41am outlining the discussion social work had with Simon the previous day.⁹⁸ It does not appear that any further discussion was had with Simon concerning his destination upon discharge.
98. At 11.30am, Simon was assessed by a general medical registrar who found Simon was medically appropriate for discharge.⁹⁹ A post-discharge management plan was created for Simon to undergo additional investigations as an outpatient, including a dual x-ray

⁹⁴ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 69; Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 156.

⁹⁵ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 156.

⁹⁶ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, pp 154-5.

⁹⁷ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 155.

⁹⁸ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, pp 155-6.

⁹⁹ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 157.

absorptiometry (**DEXA**) scan to investigate a potential diagnosis of osteoporosis in light of the T4 fracture and a liver ultrasound given his history of alcohol abuse, and he was recommended to commence acamprosate.¹⁰⁰

99. The registrar documented that Simon was to be referred to AOD on discharge, and that he be reviewed by AOD the following week. It was further noted that Simon was “*appropriate for discharge if accommodation found*”.¹⁰¹ However, no further reference to Simon’s post-discharge accommodation plans or destination on discharge is documented in Simon’s medical record. Nor was there any reference to Simon’s homeless status or need for AOD referral documented in the ‘Individual Needs/Discharge Planning’ section of his care plan.¹⁰²

Discharge from Barwon Health and outpatient appointments

100. On Sunday 12 December 2021, Simon was discharged from the hospital with a plan to undergo further investigations via outpatient follow up,¹⁰³ and a prescription was given for acamprosate.¹⁰⁴ Simon was discharged to homelessness. He sent a message to his friend Cameron Miller shortly before discharge to say that he had just had lunch, was waiting for his medication, and was feeling ok.
101. On discharge, Simon was provided with a document titled ‘*My Service Diary*’ which noted the appointments and services arranged to support Simon after his discharge, including bone and liver scans, follow up therapy through AOD, psychiatry services, and medical follow up via Barwon Health Outpatients and his General Practitioner. This document stated that the AOD, Barwon Health Outpatients General Medical Clinic and Medical Imaging services “*will contact you to arrange appointment*”. The document also instructed Simon to call his General Practitioner (**GP**) to arrange an appointment.¹⁰⁵

¹⁰⁰ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 69. Acamprosate is a prescription medication used to help people with alcohol dependence maintain abstinence after they have stopped drinking by reducing cravings.

¹⁰¹ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 157.

¹⁰² Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, pp 161-168.

¹⁰³ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 157.

¹⁰⁴ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB pp 69-70.

¹⁰⁵ Statement of Dr Christopher McAulay-Powell, Barwon Health, IB p 70; Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 291.

102. Barwon Health subsequently scheduled Simon to undergo a liver ultrasound on 17 December 2021, a General Medicine Clinic outpatient appointment on 18 February 2022 and a DEXA scan on 29 April 2022.¹⁰⁶
103. Barwon Health telephoned Simon via his mobile phone on 13 December 2021 to inform him of the details of the ultrasound appointment, which was scheduled for four days later (17 December 2021). However, he did not attend, and the appointment was not rescheduled.
104. Details of the scheduled DEXA scan and outpatient clinic appointments were sent to Simon by letter via his former address (being his sister's home in Anakie) on 17 December 2021 and 14 January 2022 respectively.¹⁰⁷ There is no evidence Simon received either of these letters, noting at the time of discharge, Simon was homeless and there was an intervention order in place at the time prohibiting him from attending the Anakie property.
105. Barwon Health also sent a discharge letter to Simon's nominated GP at Lara Medical Centre. The letter detailed Simon's presenting complaint, treatment and ongoing follow up through the outpatient clinic at Barwon Health and requested ongoing opinion and management of Simon.¹⁰⁸ Records indicate Simon had not been seen at the clinic for over 3 years. There is no record of any further attendance by Simon at the Lara Medical Centre following his discharge from Barwon Health. Nor does it appear that he attended any other general practitioner.
106. Medicare & PBS records show Simon had no further interactions with public health services following his discharge from hospital on 12 December 2021. However, he filled his prescription for acamprosate on 13 December 2021 at a pharmacy in Ocean Grove, the day after his discharge from University Hospital Geelong. Simon was not otherwise contacted by any AOD service as was indicated would occur in the '*My Service Diary*' discharge document provided to him by Barwon Health. The management of Simon's discharge planning and outpatient and AOD follow up are discussed further in my comments below.

¹⁰⁶ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 864.

¹⁰⁷ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB pp 864, 867

¹⁰⁸ Second Coronial Brief, Barwon Health, Medical Discharge Summary to Lara Medical Centre dated 15 December 2021; Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 82.

Police interaction with Simon on 24 December 2021

107. Aside from filling the prescription for acamprosate in Ocean Grove on 13 December 2021, Simon's activities and movements in the week and a half immediately following his discharge from Barwon Health are unknown. However, on 24 December 2021, Simon was found by Amanda's partner in a cabin at their property in Anakie. As previously noted, there was an intervention order in place at the time which prohibited Simon from attending the property.¹⁰⁹
108. Police attended the property and conducted a field interview with Simon regarding an alleged contravention of the intervention order then in force. Simon was polite and cooperative and indicated he was at the residence to collect his belongings. Simon gave his address as '20 Epworth Street, Ocean Grove', which was his grandmother's former residence.¹¹⁰ However, it appears that this was subsequently incorrectly recorded in the Victoria Police Law Enforcement Assistance Program (LEAP) as '20 Omega Drive, Ocean Grove'.¹¹¹ Investigations have been unable to identify the reason for this.
109. Police transported Simon to a local railway station. Myki records indicate Simon boarded a train from the North Shore Railway Station and travelled to Geelong where he boarded a bus. He alighted at the stop next to the Riverview Family Caravan Park in Ocean Grove.
110. A summons was subsequently issued by police to Simon for Contravention of Intervention Order, with a court date listed at Geelong Magistrates' Court on 24 August 2022. The summons was sent via mail to the incorrect address listed on LEAP – 20 Omega Drive, Ocean Grove, and accordingly was never received by Simon.¹¹²

Events in the weeks prior to Simon's death

111. Investigations have enabled certain of Simon's movements in the weeks immediately preceding his death to be reconstructed.
112. In January 2022, Simon was observed by a local resident sitting on the main track running alongside the main beach at Ocean Grove in a deep sleep. The resident offered to wash

¹⁰⁹ First Statement of Amanda Gaskill, IB p 12; Certified Extract of Magistrates' Court Order dated 1 April 2021, IB pp 225-6.

¹¹⁰ Statement of Senior Constable James Hunter, CB p 71.

¹¹¹ Statement of Senior Constable James Hunter, IB p 72.

¹¹² Appendix I: Preliminary Brief of SC James Hunter, IB pp 252-258.

Simon's clothes and took him to Feed Me Bellarine and an Opportunity Shop in Ocean Grove to get Simon basic foods, clothes and reading materials.¹¹³

113. On 18 February 2022, Simon submitted an enquiry with an online company, 'What's My Claim Worth' requesting advice on a claim for total and permanent disability and access to superannuation.¹¹⁴
114. Later that day, Simon attended the Geelong Westfield Shopping Centre. Police were conducting an unrelated planned operation targeting weapons offences in a designated declared area in the Geelong CBD at that time, which included the Westfield Shopping Centre.¹¹⁵
115. At 5.05pm, members of the Public Order Response Team (**PORT**) conducted a foot patrol of the shopping centre and observed Simon sitting on the floor with a laptop in front of him which he was charging from a power point.
116. Detective Sergeant Wright (**D/Sgt Wright**) activated his BWC and approached Simon for the purposes of conducting a search for weapons. Simon was polite and cooperative. He provided his details to police, indicating he had no fixed place of abode and was camping. He indicated he was transferring some funds using his laptop and was using the power point to charge his laptop and phone as the power sockets at the camping ground were all in use. Simon consented to a search of his backpack, which contained a reasonably full wine cask bladder. Simon did not appear alcohol or drug affected and was not carrying any weapons or other items of concern. D/Sgt Wright did not have any concerns for Simon's immediate welfare, and after completing the search, left Simon where he was seated.¹¹⁶
117. On 23 February 2022, Simon attended an in-person appointment with job recruitment agency G-Force Recruitment as required to receive JobSeeker payments.¹¹⁷ During that appointment, it was noted there was no suitable activity for Simon at that time due to his homelessness, and inability to charge his electronic devices or have internet. Simon was offered and agreed to

¹¹³ Statement of Gabrielle Smales, IB pp 43-44.

¹¹⁴ Statement of Head of Partnerships, What's My Claim Worth, IB p 220.

¹¹⁵ Statement of Detective Sergeant Craig Wright, IB p 73.

¹¹⁶ Statement of Detective Sergeant Craig Wright, IB, p 74; Exhibit 27, BWC of Craig Wright dated 18 February 2022.

¹¹⁷ Statement of Christine Bernardo, G-Force Recruitment, IB p 85; Appendix Y: G-Force Case Notes for Simon Gaskill, IB p 436.

attend a work opportunity with Q-Labour, subsequently booked for 2 March 2022 at 8pm. However, Simon did not attend.

118. On 9 March 2022, in a subsequent telephone call with his recruitment consultant, Simon explained that he had missed the work opportunity due to his homeless status, and that he asked specifically for a dayshift, as he was unable to find somewhere to sleep during the day. He indicated he had an upcoming job interview in Warrnambool for a pick/pack role,¹¹⁸ but it is unclear what the outcome of that interview was. Simon indicated he was *“having a really hard time at the moment”* and requested a referral to an Allied Health specialist. This was subsequently arranged, and a face-to-face appointment with a G-Force Recruitment Allied Health specialist was booked for 15 March 2022, but Simon did not attend.¹¹⁹ Investigations have been unable to ascertain the reason for Simon’s non-attendance.
119. Enquiries undertaken by investigators of Simon’s bank accounts indicate that between 7 and 24 March 2022 (18 days), he purchased alcohol on fifteen occasions, with all but one of those purchases in the amount of \$14. This corresponded to the (then) price of a 5-litre cask of white wine. Simon also made other small transactions purchasing items primarily from businesses in Ocean Grove, including Coles, the Rolling Pin Bakery, and the Apco Service Station in Barwon Heads.¹²⁰
120. On 14 March 2022, Simon attended the Anaconda Geelong store and made two purchases, including of a green coloured Spinifex Vacay 2-person tent and cream-coloured Spinifex Dreamline Single sized airbed.¹²¹
121. On 16 March 2022, Simon attended the Australian Government Services branch at Corio Village Shopping Centre, Corio, to request replacement Concession and Medicare cards. He was provided with a temporary ‘Confirmation of Concession Card Entitlement’ valid to 30 March 2022 and a ‘Medicare Card Number Advice’ valid to 13 April 2022. These documents are provided to customers as proof of their concession card entitlement until a new card can

¹¹⁸ Appendix Y: G-Force Case Notes for Simon Gaskill, IB pp 436-7.

¹¹⁹ Appendix Y: G-Force Case Notes for Simon Gaskill, IB pp 437-8.

¹²⁰ First Statement of D/A/Sgt Leigh Smyth, IB p 193; Appendix T: NAB Account Transactions, IB p 300.

¹²¹ Statement of John Reimann, Anaconda Geelong, IB pp 76, 78; Appendix J: Anaconda VIP Records for Simon Gaskill, IB p 264.

be mailed to them.¹²² In Simon's case, both documents listed Simon's address as the Centrelink Corio Village service branch, likely due to his homeless status, and accordingly he would have needed to attend the branch in-person to pick up the cards once available. The temporary forms were subsequently found in Simon's belongings.

122. On 17 March 2022, Simon contacted G-Force Recruitment and apologised for missing the appointment with the Allied Health specialist and requested this be rescheduled.¹²³ The Allied Health specialist attempted to contact Simon by phone the following day to reschedule appointment, but there was no answer.¹²⁴
123. On 19 March 2022, Simon met up with a friend Klause Galbraith for a birthday celebration on the main street outside the Ocean Grove Pizza and Pasta shop.¹²⁵ Klause observed Simon had tremors from alcohol withdrawal and gave him Valium and a drink to help him.¹²⁶
124. On 21 March 2022, Simon had lunch with a friend, Cameron Miller at the Geelong Westfield Shopping Centre.
125. At 1.31pm, Simon spoke with the Head of Partnerships, from the 'What's My Claim Worth' company by phone to discuss his potential personal injury claim for total and permanent disability. This related to the enquiry made by Simon the previous month. The company had previously unsuccessfully attempted to contact Simon to discuss his claim throughout February and March 2022, and this was their first contact with him.
126. The Head of Partnerships briefly spoke with Simon to seek further information to ascertain whether his claim met their qualification criteria. It was determined Simon's circumstances did not meet the qualification criteria, and the call concluded shortly afterwards.¹²⁷
127. On 24 March 2022, Simon made an outgoing call from his mobile service at 2.51pm to G-Force Recruitment for approximately two minutes.¹²⁸ This was the last outgoing phone call

¹²² Statement of Ioka Fuamatu, Services Australia, IB pp 80-83; Appendix K: Concession Card Replacement Form for Simon Gaskill dated 16 March 2022, IB p 266; Appendix L: Medicare Card Replacement Form for Simon Gaskill, IB p 268.

¹²³ Appendix Y: G-Force Case Notes, IB p 438.

¹²⁴ Appendix Y: G-Force Case Notes, IB p 438.

¹²⁵ Statement of Klause Galbraith, IB p 103.

¹²⁶ Statement of Klause Galbraith, IB p 104.

¹²⁷ Statement of Head of Partnerships, What's My Claim Worth, IB p 219.

¹²⁸ First Statement of D/A/Sgt Leigh Smyth, IB p 201.

made from Simon's mobile phone service.¹²⁹ G-Force case notes confirm Simon called reception to request to speak with the Allied Health specialist and requested a call back after 2pm.¹³⁰ The Allied Health staff member attempted to call Simon on two occasions and sent a voicemail via SMS that afternoon but there was no response. A further appointment was scheduled for Simon with the Allied Health specialist for 29 March 2022.¹³¹

128. Shortly after 3pm, Simon made two small purchases from Coles and Rolling Pin Pies, along with a purchase from Liquorland in the sum of \$14.00, which corresponded to the (then) price of a 5-litre cask of wine.¹³² This was Simon's last known purchase of alcohol.

Police interaction with Simon on 25 March 2022

129. On 25 March 2022, at 1.23am, Bellarine Divisional van 310 (**Bellarine 310**) comprising Leading Senior Constables (**LSC**) Mark Wakeling and Tom Holmes, was dispatched to attend a residence in Ocean Grove to respond to a dispute. The resident of the unit (**the Complainant**) had contacted '000' to request assistance with removing a male – later identified as Simon – from her residence.¹³³
130. Bellarine 310 arrived at the residence at 1.52am after being cleared from their earlier task.¹³⁴ There is no BWC footage available of this incident and the officers had limited recall of the events that followed due to the passage of time.
131. Contemporaneous notes recorded in the electronic Patrol Duty Return (**ePDR**) indicate the members found the complainant and Simon heavily intoxicated and both admitted to cannabis use. On speaking with the Complainant and Simon, the attending officers determined no offences had been committed.¹³⁵ Simon was cooperative and agreed to leave the residence with police and requested they drop him off nearby in Ocean Grove.¹³⁶

¹²⁹ Statement of Senior Constable Laura Nichol, IB p 185.

¹³⁰ Appendix Y: G-Force Case Notes, IB p 439.

¹³¹ Appendix Y: G-Force Case Notes, IB p 439.

¹³² Appendix T: NAB Account Transactions, IB p 300; First Statement of D/A/Sgt Leigh Smyth, IB p 193.

¹³³ Statement of LSC Tom Holmes, IB p 94; Appendix M: Transcript of first 000 call of Janet Smith dated 25 March 2022, IB pp 271-2.

¹³⁴ Statement of LSC Mark Wakeling, IB p 92; Statement of LSC Tom Holmes, IB p 94; Exhibit 38b – Ocean Grove IRIS Tracking.

¹³⁵ Statement of LSC Mark Wakeling, IB p 92; Statement of LSC Tom Holmes, IB p 95; ePDR of Bellarine 310 dated 24 to 25 March 2022, IB pp 455-6.

¹³⁶ Statement of LSC Tom Holmes, IB p 95.

132. The officers were unable to recall where they dropped Simon when inquiries were subsequently made by DLSC Smyth in 2024.¹³⁷ No contemporaneous notes were documented at the time to indicate where Simon was dropped off, nor was this task conveyed to Police Communications.¹³⁸
133. CCTV footage from the rear pod of the divisional van confirms Simon was transported in the rear pod of the van between 2.05am to 2.10am. During transport, Simon is not handcuffed and, to the extent of the visual offered by the CCTV, appears well. The audio recording captures the police officers' discussion with Simon when he alights from the rear of the divisional van, and they confirm they are at the camping area of the Riverside Campground. The officers provided Simon with his backpack and made enquiries with Simon whether he was able to locate his campsite. Simon confirmed his campsite was nearby and that he was able to find it as he has a head lamp and thanked the officers for their concern.¹³⁹
134. An audit of the IRIS device being used by LSC Holmes that night confirms the divisional van stopped briefly at the entrance to the camping area to the west of the Barwon Riverside Campground, on the Barwon River side of Barwon Heads-Ocean Grove Road at 2.10am.¹⁴⁰
135. LSC Holmes indicated that he did not have any concerns for Simon's welfare at the time of leaving him at the campground. While Simon was intoxicated, he was able to stand, walk and communicate clearly. He appeared to be in a positive state of mind and reportedly declined referrals in relation to his homeless status.¹⁴¹ When last sighted on the CCTV footage from the divisional van, Simon appeared well, with no apparent injuries.¹⁴²
136. At about 11.00am, the Complainant attended the Bellarine Police Station to hand in Simon's phone and charging cable which he had left at her residence.¹⁴³
137. The Complainant spoke with Leading Senior Constable Simon McCarty (**LSC McCarty**) who was assisting with watch house duties that day. She informed LSC McCarty that Simon was the owner of the phone and that he was homeless.

¹³⁷ Statement of LSC Mark Wakeling, IB p 92; Statement of LSC Tom Holmes, IB p 95.

¹³⁸ Statement of LSC Tom Holmes, IB p 95.

¹³⁹ Exhibit 36a Divisional Van Pod Footage – Rear Door;

¹⁴⁰ Exhibit 37, IRIS Tracking LSC Tom Holmes; Exhibit 38a Overview IRIS Tracking.

¹⁴¹ Statement of LSC Tom Holmes, IB pp 95-6.

¹⁴² Exhibit 36a Divisional Van Pod Footage – Rear Door; Exhibit 36b – Divisional Van Pod Footage – Rear Wall.

¹⁴³ Statement of Constable Mitch Lay, IB p 112.

138. LSC McCarty completed a name check to confirm Simon's details and called the phone to establish that the phone belonged to the deceased. He subsequently asked a colleague to log the phone on the Victoria Police property system PALM later that afternoon, and the phone was placed in the Bellarine Police Station Interim Property Store.¹⁴⁴
139. Simon's phone was destroyed by police on 21 September 2022 after the closure of the first coronial investigation. The circumstances of that destruction are discussed further below.

Simon's last interactions

140. On 25 March 2022 at 1.13pm, Simon's bank records reflect that a purchase was made from the Rolling Pin Bakery in Ocean Grove, using Simon's NAB debit card in the amount of \$4.40.¹⁴⁵ Investigations have been unable to establish what the specific purchase was for.
141. This was the last recorded transaction made from Simon's bank account.¹⁴⁶ His balance after this purchase was \$0.67.¹⁴⁷ No further deposits were made into Simon's bank accounts until 11 April 2022, when a reduced Jobseeker payment was deposited but not accessed.¹⁴⁸
142. Myki records¹⁴⁹ indicate that on the afternoon of 25 March 2022 Simon took a bus trip from the Ocean Grove Shops to the stop at GMHBA Stadium in Moorabool Street, Geelong.¹⁵⁰
143. Klause Galbraith and Lisa Biggs state that they saw and spoke with Simon during this bus journey, having got onto the bus a few stops after Simon. They observed Simon had scratches on his face which they thought likely to have been caused by the scrub at the beach.¹⁵¹

¹⁴⁴ Statement of Constable Mitch Lay, IB pp 113-4; Statement of LSC Simon McCarty, IB pp 116-7.

¹⁴⁵ First Statement of D/A/Sgt Leigh Smyth, IB p 193; Appendix T: NAB Account Transactions, IB p 300.

¹⁴⁶ First Statement of D/A/Sgt Leigh Smyth, IB p 201.

¹⁴⁷ First Statement of D/A/Sgt Leigh Smyth, IB p 193.

¹⁴⁸ First Statement of D/A/Sgt Leigh Smyth, IB p 201; Appendix T: NAB Account Transactions, IB p 300.

¹⁴⁹ A public transport card was included amongst the items transported to VIFM CA&E with Simon's body, and subsequently released to the funeral director. *See*: Chain-of-Custody Evidence Transfer Record, IB p 213. While the evidence transfer record did not specify the number of the card, an unregistered Myki was subsequently located by Simon's sister Amanda, among the belongings released to her by the funeral director. This Myki card did not belong to any other member of Amanda's family and recorded travel via local buses in the Geelong region for the period from 25 February 2022 until 25 March 2022, consistent with Simon's travel under a Myki card registered in his name during an earlier period from 17 December 2021 to 18 February 2022. I accept that on the balance of probabilities it is established that the unregistered Myki was used by Simon during the relevant period. First Statement of D/A/Sgt Leigh Smyth, IB, p 193, 199; Third Statement of Amanda Gaskill, IB pp 20-21; Evidence of Amanda Gaskill, T-49 lines 4-12.

¹⁵⁰ First Statement of D/A/Sgt Leigh Smyth, IB p 199; Exhibit 46 – Myki Card records.

¹⁵¹ Statement of Klause Galbraith, IB p 104; Statement of Lisa-Jayne Biggs, IB p 109.

144. Simon reportedly told Klause and Lisa that he was going into Corio to get a health care card.¹⁵² As previously noted, Simon had obtained a temporary Confirmation of Concession Card Entitlement from the Corio Services Australia branch twelve days prior, on 16 March 2022 and may have had plans to return to the branch to pick up his new cards. However, the bus stop Simon alighted from was located in Geelong, approximately 10km from the Corio Services Australia branch. There is no record of Simon attending Corio Services Australia branch on either 25 or 26 March 2022.¹⁵³ Due to the passage of time, I am unable to resolve this discrepancy. Nevertheless, I accept that Simon travelled on a bus in the Geelong area on the afternoon of 25 March 2022, as corroborated by his Myki records.
145. On 26 March 2022, at 9.40am, Simon sent a message to his friend Cameron Miller via Facebook to reschedule a planned lunch they had that day.¹⁵⁴ According to Cameron, Simon would use his laptop to message on Facebook, rather than his phone. He would only use his phone for calls and SMS, and preferred to ring rather than send an SMS.¹⁵⁵
146. At 10.15am, Cameron suggested rescheduling to Tuesday 29th or Wednesday 30th March of the following week, to which Simon responded, "*Wednesday would be good*".¹⁵⁶ This was Simon's last recorded outgoing communication via Facebook.
147. On 29 March 2022, Simon did not attend a scheduled appointment with the G-Force Recruitment Allied Health specialist, and there was no response when the specialist attempted to contact him by phone.¹⁵⁷ As previously noted, Simon's phone had been handed in to Bellarine Police Station on the morning of 25 March 2022. Accordingly, he did not have access to his phone or means to call or respond to subsequent calls made to his mobile phone, only having access to his laptop as a means of communication.
148. Cameron sent a message to Simon via Facebook on the same day to confirm their plan to meet for lunch the following day, but there was no response.¹⁵⁸

¹⁵² Statement of Klause Galbraith, IB p 105; Statement of Lisa-Jayne Biggs, IB p 109.

¹⁵³ Per Statement of Ioka Fuamatu, Service Centre Manager, Services Australia, IB pp 80-81.

¹⁵⁴ Second Statement of Cameron Miller, IB p 122.

¹⁵⁵ Second Statement of Cameron Miller, IB p 123.

¹⁵⁶ Second Statement of Cameron Miller, IB p 122.

¹⁵⁷ Appendix Y: G-Force Case Notes for Simon Gaskill, IB p 439.

¹⁵⁸ Second Statement of Cameron Miller, IB p 122.

149. On 30 March 2022, Cameron had to cancel the planned lunch and sent a further message to Simon via Facebook but again received no response.¹⁵⁹
150. Forensic analysis subsequently undertaken of Simon's laptop indicated that Simon's Facebook account was last used at 4.52pm on Saturday 26 March 2022.¹⁶⁰ The last activity recorded on the laptop was the browsing access of images at 2.11pm on Sunday 27 March 2022.¹⁶¹ There was no further use of the laptop after that time.¹⁶²

MATTERS IN RELATION TO WHICH A FINDING MUST BE MADE

Circumstances in which the death occurred

151. On the afternoon of 15 April 2022, a walker found a body lying face down over a tree branch in heavy scrub in the sand dunes at Ocean Grove Beach, near the beach access marker 16W.¹⁶³ The body was found in an advanced state of decomposition, and it appeared the person had been deceased for some time.¹⁶⁴ The features were unrecognisable.¹⁶⁵
152. Emergency services were contacted, and police officers attended the scene shortly afterwards and immediately commenced a coronial investigation.¹⁶⁶ The Crime Scene Service and members of the Geelong CIU – DSC Hardisty, Detective Leading Senior Constable Benjamin Fox (**DLSC Fox**) and Senior Constable Mathew Wensley (**SC Wensley**) – also attended the scene to determine if there was any foul play involved.¹⁶⁷
153. The body was found face down, lying over a tree branch, wearing a black backpack, with some of the zips opened. Attending officers observed that some of the contents of the backpack appeared to have fallen out, including a Powerade bottle and a notebook, but no signs that anyone had tampered with the scene or belongings.¹⁶⁸

¹⁵⁹ Second Statement of Cameron Miller, IB p 123.

¹⁶⁰ First Statement of D/A/Sgt Leigh Smyth, IB p 199; Appendix V: Laptop Facebook Browser History, IB p 311.

¹⁶¹ First Statement of D/A/Sgt Leigh Smyth, IB p 199; Appendix W: Laptop Image Browser History, IB p 428.

¹⁶² First Statement of D/A/Sgt Leigh Smyth, IB p 199.

¹⁶³ Statement of Samuel Kelly, IB p 126.

¹⁶⁴ Statement of Senior Constable Rick Paltridge, IB p 128; Statement of Senior Constable Regina Basten, IB p 142; Statement of LSC Benjamin Fox, IB p 146.

¹⁶⁵ Statement of Senior Constable Regina Basten, IB p 142.

¹⁶⁶ Statement of Samuel Kelly, IB pp 126-7.

¹⁶⁷ Statement of Detective Leading Senior Constable Benjamin Fox, IB p 145; Statement of Senior Constable Mathew Wensley, IB p 148.

¹⁶⁸ Statement of Senior Constable Rick Paltridge, IB p 129; Statement of LSC Benjamin Fox, IB p 146. The notebook referred to does not appear to have been subsequently retained by police for the coronial investigation.

154. A green Spinifex Vacay two-person tent was located close by. The inner opening of the tent was zipped closed. A number of personal effects were located inside and nearby the tent. This included medication prescribed to one Simon Gaskill¹⁶⁹, as well as two headlamps located under a branch nearby. Empty wine cask bladders were found in a black garbage bag outside the tent,¹⁷⁰ along with a cooking set up, which suggested the person had lived there for some time.¹⁷¹
155. The immediate surrounds were overgrown with thick vegetation, bushes and trees. There was no clear path to the campsite, which was located approximately 50 metres from the main path.¹⁷² However, police observed string or elastic tied to some of the trees which was believed may have been a way to mark the path into the area.¹⁷³
156. No suspicious circumstances were identified, and there were no obvious injuries identified.¹⁷⁴
157. After examining the scene, Geelong CIU made further inquiries to attempt to identify the deceased. They attended the address listed on the Victoria Police Law Enforcement Assistance Program (**LEAP**) for Simon, being 20 Omega Drive, Ocean Grove. However, this address was found to not exist. They also reviewed BWC from the earlier police interaction with Simon on 24 December 2021. This footage showed Simon wearing the same clothing as the deceased, including distinctive brown Blundstone-style boots.¹⁷⁵ Based on this information, Geelong CIU were satisfied the deceased was Simon Gaskill,¹⁷⁶ and his details were subsequently listed in electronic Patrol Duty Returns and Incident Fact Sheet for the event.¹⁷⁷
158. Due to his death being reportable to the Coroner, Simon's body was transported to the Victorian Institute of Forensic Medicine (**VIFM**) for forensic medical examination, along

¹⁶⁹ Statement of Sergeant Michael Knight, IB p 140.

¹⁷⁰ Statement of Senior Constable Regina Basten, IB p 143; Statement of LSC Benjamin Fox, IB p 146.

¹⁷¹ Statement of Senior Constable Rick Paltridge, IB p 129.

¹⁷² Statement of Senior Constable Rick Paltridge, IB p 129; Statement of LSC Glenn Kelly, CB p 131; Statement of Senior Constable Regina Basten, IB p 142; Statement of LSC Benjamin Fox IB p 146; First Statement of DSC Mitchell Hardisty, IB p 167.

¹⁷³ Statement of Senior Constable Rick Paltridge, IB p 128.

¹⁷⁴ Statement of Senior Constable Rick Paltridge, IB pp 128-9; Statement of Senior Constable Mathew Wensley, IB p 149.

¹⁷⁵ Statement of LSC Benjamin Fox, IB p 146; Statement of DSC Scott Chandler, IB pp 152-3; First Statement of DSC Mitchell Hardisty, IB p 168.

¹⁷⁶ Statement of LSC Benjamin Fox, IB p 146; First Statement

¹⁷⁷ ePDR of Bellarine 252 (Sgt Knight), IB p 467.

with his personal effects which included his backpack, laptop, bank card, Myki card and other personal papers. For an unknown reason, and contrary to Victoria Police policy to ensure all evidence is collected and to record full details of all property retained, (including any items conveyed with the body to VIFM),¹⁷⁸ these items were not collected by police for the investigation, and only limited information was documented in the custody transfer records of the items conveyed to VIFM with Simon's body.¹⁷⁹ The items were subsequently provided to the funeral director by VIFM and thereafter provided to Simon's family who retained them and later provided them to Victoria Police for the investigation of his death. I will return to this below.

159. As outlined above, evidence indicates that Simon was last sighted in-person on a bus to Geelong on the afternoon of 25 March 2022. He last communicated with his friend Cameron via Facebook Messenger on the morning of 26 March 2022. The last recorded activity on Simon's laptop occurred at 2.11pm on 27 March 2022. There is no further record of Simon's laptop being used after that time, nor did Simon have any further communications either in-person or via his electronic devices. He did not attend a scheduled appointment on 29 March 2022, nor respond to messages sent to him by his friend Cameron on Facebook on 29 and 30 March 2022 with whom he usually corresponded regularly.
160. Having regard to this evidence, and the level of decomposition at the time Simon was located, and while noting his laptop would have lost charge at some point, I consider it is likely Simon died at some time between his last recorded laptop activity at 2.11pm on 27 March 2022 and 29 March 2022.¹⁸⁰

Identity of the deceased

161. On 27 April 2022, the body of Simon Peter Gaskill, born 2 September 1971, was formally identified following DNA comparison.¹⁸¹

¹⁷⁸ VPM Deceased persons – updated 19 July 2021, [10.1], [11], IB pp 656-7.

¹⁷⁹ Namely, the Chain-of-Custody Evidence Transfer Record completed on 15 April 2022 documents that property received with Simon's body at VIFM were: 'paperwork in name of GASKILL, Simon; 1 folder; 1 pen; 1 bank card in name of Simon GASKILL; 1 charger; assorted cables; 1 laptop; 1 earphones; \$1.10 in coins', IB p 214.

¹⁸⁰ I am satisfied on the balance of probabilities that the laptop data indicates use of the laptop by Simon, and not another person.

¹⁸¹ Report of Scientific Testing, IB p 166.

162. I am satisfied that the identity of the deceased is not in dispute and requires no further investigation.

Medical cause of death

Post-mortem examination

163. On 21 April 2022, Forensic Pathologist Dr Judith Fronczek from the VIFM (**Dr Fronczek**) conducted an autopsy on the body of Simon Christopher Gaskill.

164. Prior to autopsy, Dr Fronczek reviewed the Form 83, preliminary examination form, VIFM contact log, scene photos and a post-mortem CT scan. Dr Fronczek was also provided with medical records from Barwon Health following the autopsy.

165. Dr Fronczek provided a written report of her findings dated 22 July 2022.¹⁸²

166. The autopsy identified advanced decomposition changes, with loss of skin, subcutaneous tissue and organs. There were no visible signs of injury and no apparent fractures on examination of the post-mortem CT scan.¹⁸³ A severe maggot infestation was observed but no forensic entomological testing was undertaken at the time.¹⁸⁴

167. Due to the significant decomposition, ancillary investigations to assist in identifying the cause of death were limited. There was no blood or urine available for toxicological analysis, nor any material for vitreous humour biochemistry.¹⁸⁵ Liver and hair specimens were tested for, but did not detect, any common drugs and poisons. However, Dr Fronczek noted that decomposition can change the concentration of drugs and poisons and the presence of decomposition substances can prevent the detection of drugs and poisons.¹⁸⁶

168. Histological examination of the liver showed steatosis (fatty liver) consistent with Simon's history of chronic alcohol excess.¹⁸⁷

¹⁸² Autopsy Report, IB pp 156-161.

¹⁸³ Autopsy Report, IB pp 158, 160.

¹⁸⁴ Email from Dr Judith Fronczek regarding time of death and entomological testing dated 28 August 2024, IB pp 873-4.

¹⁸⁵ Autopsy Report, IB p 157.

¹⁸⁶ Toxicology Report, IB p 162.

¹⁸⁷ Autopsy Report, IB p 157.

169. Dr Fronczek explained that the rate of decomposition is influenced by many factors, making it impossible to give a time or date of death. However, Dr Fronczek considered that in this case, death had occurred multiple days to multiple weeks prior to being located.¹⁸⁸
170. Dr Fronczek opined that the cause of death is ‘*1(a) unascertained*’.

Entomological investigations

171. On 19 February 2026, Dr Fronczek provided the Court with a supplementary report dated 18 February 2026 concerning forensic entomological investigations subsequently undertaken by Dr Melanie Archer (**Dr Archer**) shortly before Inquest.
172. Dr Archer examined the physical maggot specimen that was initially taken at the time of autopsy, as well as the post-mortem CT scan and scene and mortuary photographs pertaining to the case.
173. After considering the larval instar state of maggots located on Simon’s body, Dr Archer estimated that the minimum postmortem interval lies between 4 and 21 days. However, Dr Archer informed Dr Fronczek that an estimate at the upper end was more likely given the degree of tissue destruction.

Evidence at inquest

174. To assist me in determining, as far as possible, the medical cause of death, I heard oral evidence at inquest from Dr Fronczek. She was an impressive witness.
175. Dr Fronczek expanded upon the comments in her report of 22 July 2022 that advanced decomposition changes in Simon’s body had placed limitations on investigations that could have otherwise assisted in establishing a cause of death. Dr Fronczek explained that:
- (a) due to the fact the body was not complete and some organs were missing, she was unable to investigate those organs to determine whether there was the possibility of natural disease that may have caused or contributed to death;

¹⁸⁸ Email from Dr Judith Fronczek regarding time of death and entomological testing dated 28 August 2024, IB pp 873-4.

- (b) there were no appropriate specimens for toxicological analysis, which means that a toxicological cause or contribution to death (e.g. alcohol toxicity) could not be excluded or investigated; and
 - (c) it was not possible to adequately investigate any traumatic injuries – for example, while there were no acute bony injuries apparent on the post-mortem CT scan, she could not exclude traumatic injuries to the skin, subcutaneous tissues and blood vessels that may have caused or contributed to death.¹⁸⁹
176. Dr Fronczek also gave evidence that a number of other potentially fatal conditions could not be excluded, such as seizure. She stated that a seizure cannot be diagnosed at autopsy even where decomposition is not a factor, and that it certainly cannot be excluded as a cause of Simon’s death where any potential secondary indications of a seizure (e.g. a tongue bite) were not able to be investigated due to decompositional changes.¹⁹⁰ Dr Fronczek stated that a seizure could be fatal in its own right or may also be contributory to death where someone has a seizure that leads to trauma (such as that resulting from a fall). She further confirmed that it is possible to die from a seizure related to alcohol withdrawal even in the absence of a traumatic event.¹⁹¹
177. In response to questions from Counsel for the Family, Dr Fronczek stated she could not exclude stroke or heart-related conditions, or the co-existence of a chronic natural health condition and an unnatural factor (such as a snake bite or stabbing).¹⁹² Similarly, a fall with head strike could not be excluded.
178. Accordingly, Dr Fronczek confirmed her opinion that the cause of Simon’s death remains unascertained as there are multiple possibilities that cannot be properly investigated due to the level of decomposition.
179. Dr Fronczek also opined that Simon’s level of decomposition at the time he was found aligns with a likely time of death between 27 March 2022 and 29 March 2022, which is the timeframe put forward by DLSC Smyth based on the last known use of Simon’s computer

¹⁸⁹ Evidence of Dr Judith Fronczek, T-136 line 3 to T-137 line 8.

¹⁹⁰ Evidence of Dr Judith Fronczek, T-139 lines 10-22.

¹⁹¹ Evidence of Dr Judith Fronczek, T-148 lines 7-26.

¹⁹² Evidence of Dr Judith Fronczek, T-147 line 27 to T-148 line 6.

and failure to respond to the Facebook message of his friend Cameron Miller (detailed elsewhere in this finding).¹⁹³

Conclusion on medical cause of death

180. The Coroners Act requires me to make a finding, if possible, as to the cause of death.¹⁹⁴ The cause of death is ultimately a question of fact to be determined by the Coroner after weighing all the evidence.
181. I had considered prior to Inquest whether it might be possible to provide additional context to the existing cause of death formulated by Dr Fronczek (*'unascertained'*) by including a descriptor relating to Simon's known longstanding alcohol dependency – such as *'unascertained in the setting of chronic alcohol use'*. Relevantly, one of the remaining organs that was present for examination – the liver – demonstrated upon histological examination that Simon had hepatic steatosis (fatty liver), which was noted to be consistent with his chronic abuse of alcohol.
182. While Dr Fronczek could not opine on whether the fatty liver was mild, moderate or severe due to the level of decomposition, the fact that Simon had fatty liver was well-established on the evidence. Given that Simon was not known to suffer from certain of the other diseases that can give rise to fatty liver (such as obesity), I remain reasonably satisfied that, considered in conjunction with the evidence of Barwon Health records and statements regarding Simon's longstanding alcoholism, the fatty liver seen at autopsy relates to Simon's chronic alcohol use.¹⁹⁵
183. However, Dr Fronczek also opined that, as she could not exclude a traumatic, toxicological or other natural cause for Simon's death, she was unable to say anything about the relevance of the fatty liver to Simon's death, based on the medical evidence.¹⁹⁶
184. Therefore, while I consider that Simon's death clearly occurred in the setting of his longstanding and chronic issues with alcohol and there is a distinct possibility that his cause

¹⁹³ Evidence of Dr Judith Fronczek, T-146 lines 19-26. *See also* evidence of DLSC Leigh Smyth T-119 line 7-13.

¹⁹⁴ Coroners Act, s 67(1)(b).

¹⁹⁵ See in this regard Evidence of Dr Judith Fronczek, T-150 line 26 to T-151 line 15.

Further, Dr Fronczek gave evidence that even where there is no issue of acute alcohol intoxication, it is possible to die suddenly from chronic alcohol misuse (e.g. where chronic alcohol use has given rise to metabolic derangement, seizures, changes to the heart muscles that can lead to fatal cardiac arrhythmias, etc).

¹⁹⁶ Evidence of Dr Judith Fronczek, T-138 lines 10-17.

of death may be linked to same, I have determined to leave the cause of death as formulated by Dr Fronczek, namely '*unascertained*'.

185. I understand that this finding may be distressing to Simon's family, but I consider that any distress may be held alongside the fact that the '*unascertained*' cause of death is clearly not representative of any failure in the forensic medical investigation. Dr Fronczek conducted a thorough autopsy, sought assistance from a specialist colleague for entomological testing (with VIFM having preserved the relevant specimens in the laboratory for almost four years) and conducted histological testing of available tissue. She confirmed, in response to questions from Counsel for the Family, that there was no further testing or assessment that could have been done,¹⁹⁷ and that the absence of a cause of death was entirely due to factors relating to decomposition rather than any other factor.
186. I am satisfied that a thorough investigation into Simon's medical cause of death has been conducted and that, while unable to confirm the specific cause of Simon's death, the Inquest yielded valuable evidence about the possible causes of his death that has been of great assistance to my investigation, and I hope, to Simon's family.

FURTHER INVESTIGATIONS

187. The Court has conducted extensive enquiries in the furtherance of my statutory functions to provide a clearer picture of the circumstances in which Simon's death occurred to provide answers to Simon's family and identify if there are any opportunities for practice improvements, consistent with the Court's mandate to comment on and make recommendations on matters connected with the death directed to improving public health and safety and the administration of justice.
188. In investigating Simon's death (following the initial circumscribed police investigation) a wider field of inquiry was undertaken than might ordinarily have been the case, to better understand the factors which may have contributed to death given the uncertainty as to the cause of death and circumstances in which the death occurred. This included examination of Simon's physical and mental health at the time of his passing and his proximate contact with health services and government agencies insofar as those matters appeared to have potential

¹⁹⁷ Evidence of Dr Judith Fronczek, T-149 lines 18-23.

relevance to the cause and circumstances in which the death occurred. I also investigated concerns identified with the thoroughness of the initial police investigation into Simon's death, as discussed in my comments further below, as those matters are relevant the discharge of my statutory functions in this case and, more broadly, to the proper administration of justice in the investigation of reportable deaths.

189. In making the comments that follow, I acknowledge that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*potentially distorting prism of hindsight*".¹⁹⁸ I make observations about services that had contact with Simon proximate to his death to assist in identifying any areas of improvement to public health and safety and to ensure that any future prevention opportunities are appropriately identified and addressed. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and Simon's death.

Barwon Health submissions on jurisdiction

190. Relatedly, in the immediate lead-up to the Inquest, Barwon Health made submissions that, *inter alia*, I lacked jurisdiction to make (adverse) findings or recommendations in relation to the care provided to Simon at Barwon Health, advancing that, in Barwon Health's submission, the care was: (a) appropriate; and (b) in any event, not sufficiently proximate to or causal of death.¹⁹⁹ These submissions were expanded upon at Inquest, with the premise of the submissions being challenged by Counsel Assisting, a position also adopted by Counsel for the Family.²⁰⁰

¹⁹⁸ *Adamczak v AlSCO Pty Ltd (No 4)* [2019] FCCA 7, [80].

¹⁹⁹ See Submissions on behalf of Barwon Health dated 20 February 2026, referring to *Harmsworth v The State Coroner* [1989] VR 989 (*Harmsworth*). I note for completeness that Barwon Health made no submissions on the scope of inquest or witness list (which included, relevantly, a scope item concerning the coordination and management (including discharge planning) for patients who face barriers to accessing treatment and support services due to homelessness, alcohol dependence and/or mental illness directly relevant to Simon's admission Barwon Health in the months immediately before his death, and the inclusion of Professor Verma as a witness at inquest in respect of that scope item) and that no objection was made by Barwon Health to providing statements from two witnesses – Dr McAulay-Powell, and later Professor Verma – to assist my investigation into Simon's death.

²⁰⁰ See T-251 line 53 to T-270 line 31.

191. For reasons outlined during the Inquest, I am satisfied that the portion of the investigation and Inquest assessing the care provided to Simon by Barwon Health sits comfortably within my coronial powers.
192. The case of *Priest v West*²⁰¹ enshrines the well-established principle that, in investigating a death, the coroner must pursue all reasonable lines of enquiry, be an active investigator and discover all they can about the circumstances surrounding the death. Investigating the care provided to Simon some four months prior to death in relation to his alcohol-related presentation and considering whether there are opportunities for systems improvements in circumstances where he was discharged by the hospital to homelessness, is entirely appropriate and consistent with this principle.
193. I will not rehearse the long exchange on this issue that was held at Inquest, suffice to say that I am satisfied that reviewing the care at Barwon Health – including by way of hearing evidence from its Chief Medical Officer, Professor Verma, and notwithstanding the ‘unascertained’ cause of death, was appropriate, within power, and was indeed required to assist in the discharge of my statutory functions.
194. The investigation of any related systems improvements, as reflected by way of any comment or recommendation, is also consistent with relevant case law including, as submitted by Counsel Assisting, that of *Thales Australia Ltd v Coroners Court of Victoria* [2011] VSC 133, in which Justice Beach rejected the proposition that uncertainty regarding the cause of death precludes the coroner from making comment or recommendations.²⁰² Further, the language of s 67(3), that a comment be on ‘any matter connected with the death’ provides the coroner with a wide power to comment, which is not limited to matters ‘directly connected with’ the death.²⁰³
195. Having accepted the submissions of Counsel Assisting that review of Simon’s care at Barwon Health is within the scope of my investigative powers, and if indicated, my power to make comments and recommendations,²⁰⁴ I shall proceed to detail such review.

²⁰¹ *Priest v West* (2012) 40 VR 521 at 521], [525] and [560].

²⁰² *Thales Australia Ltd v Coroners Court of Victoria* [2011] VSC 133, at [71].

²⁰³ *Ibid*, [74-75].

²⁰⁴ For clarity, I qualify that I consider that *Harmsworth* is still clearly applicable and stands for the proposition that a coroner may not conduct a wide-ranging enquiry with a view to exploring any suggestion of a causal link, however

REVIEW OF CARE AT BARWON HEALTH

196. Prior to Inquest, I requested the Coroners Prevention Unit (CPU) review the care provided to Simon by Barwon Health, given the proximity of his hospital admission in December 2021 to his death, less than four months later.
197. The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists coroners with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas, including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.
198. The focus of CPU's review was on Simon's inpatient care, discharge planning and follow-up through outpatient services, in the context of his alcohol dependence and homelessness.
199. As part of this review, and at my direction, the CPU requested and obtained a further statement from Barwon Health addressing queries concerning the process of referral to AOD services, and the management of Simon's outpatient treatment and communications with patients who have no fixed abode. This statement was provided by Professor Verma, Chief Medical Officer of Barwon Health, who also gave evidence at inquest, and supplemented an earlier statement provided on behalf of Barwon Health by Dr McAuley-Powell concerning Simon's treatment and discharge planning.

Inpatient care at Barwon Health

200. The CPU reviewed the inpatient care provided to Simon during his admission at University Hospital Geelong from 5 to 12 December 2021.
201. The CPU noted that Simon was appropriately referred to neurology and psychiatry teams, and appropriate investigations were undertaken over the course of Simon's admission in respect of the differential diagnoses considered. This included an MRI of his brain (which was normal) and comprehensive (repeat) blood tests. After ceasing benzodiazepines and

tenuous, between some act, omission or circumstance and a person's death, however I accept Counsel Assisting's submissions referring to her Honour Coroner Jamieson's Finding with Inquest into the Passing of Matthew Luttrell at [243] that are relevant to the consideration of *Harmsworth* some 37 years after it was decided, available [here](#).

antipsychotics, Simon's cognition and behaviours improved, and it was deemed unlikely that the seizure and confusion was due to an organic cause such as encephalitis.

202. The CPU opined that the services provided to Simon as an inpatient were reasonable and appropriate in the circumstances and aligned with the expected standard of care. However, the CPU also identified opportunities for improvement in the communication and follow up of planned outpatient care and AOD services following discharge.

Communication and follow up of outpatient clinic appointments

203. As noted above, in the days and months immediately following his discharge from University Hospital Geelong, Barwon Health arranged several appointments for Simon. This included appointments for a liver (or abdominal) ultrasound and DEXA scan via the radiology department, as well as a review by the General Medical Clinic in the outpatient clinic.
204. The CPU identified that Simon's experience as an outpatient post-discharge from Barwon Health, as a person of no fixed abode, highlighted inadequacies with the (then-existing) standard of communication to patients who have vulnerabilities and/or barriers to attending follow up, and require outpatient follow up and treatment, as occurred in Simon's case.

Radiology department

205. On 13 December 2021, the Barwon Health radiology department contacted Simon via his mobile telephone number to inform him of his appointment scheduled for 17 December 2021 to undergo an ultrasound.²⁰⁵ The usual practice of the Barwon Health radiology department is to send a letter to the address recorded on the patient's file. However, Simon was called by the radiology department in this instance due to the proximity of the appointment date.²⁰⁶ This was entirely appropriate in the circumstances, to ensure Simon was aware of the details of the appointment prior to its scheduled time.
206. Simon did not attend the scheduled ultrasound appointment and there was no further follow up by the radiology department to reschedule this appointment. In the absence of any follow up, Simon's reasons for his non-attendance at the ultrasound appointment remain unknown.

²⁰⁵ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 867.

²⁰⁶ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 867; Evidence of Professor Verma, T-193, lines 16-25.

207. In his statement and at Inquest, Professor Verma explained that it is not the practice of the radiology department to attempt to contact patients after a non-attendance as patients often have their scans carried out by another external provider if a more suitable date is available, as the referral can be used with any imaging provider.²⁰⁷
208. However, there is no evidence that Simon was provided with a referral form on discharge that would have enabled him to attend an external provider for the scans.²⁰⁸ Rather, the ‘*My Service Diary*’ document provided to Simon on discharge states that Barwon Health would contact him to arrange an appointment for the ultrasound and DEXA scan (as occurred – albeit in the case of the DEXA scan via a letter sent to Simon’s former address, as discussed further below). In the absence of a referral form – and as conceded by Professor Verma at inquest – there was no means for Simon to independently arrange for a scan at an external provider.²⁰⁹ Accordingly, without any follow up by the radiology department, Simon did not have the means or opportunity to undergo the required investigations. This is particularly relevant given his vulnerabilities and existing barriers to attendance due to his homelessness and alcohol use disorder.
209. Radiological investigations are a critical tool for identifying and managing a patient’s health conditions.²¹⁰ While a patient may elect to undergo investigations via an external provider, this should not be assumed by a health service, particularly where a patient has been directly referred following an inpatient admission and where a referral form has not been provided to the patient (as appears to have occurred here).
210. Since these events, Barwon Health has updated its policies to reflect new guidance published by the Department of Health concerning health service’s responsibility to ensure equitable access to non-admitted specialist (outpatient) services for patients. These updated policies – which reflect the need to ensure appropriate follow up to meet the needs of patients who face disparities in access to healthcare – are discussed further below.

²⁰⁷ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 866; Evidence of Professor Verma, T-194, lines 11-16

²⁰⁸ At Inquest, Professor Verma gave evidence at Inquest that it is the practice of Barwon Health to provide patients with the referral form on discharge, but agreed that there is no evidence scanned to the system that that occurred on this occasion: Evidence of Professor Verma, T-194, lines 25-31.

²⁰⁹ Evidence of Professor Verma, T-194, lines 23-24.

²¹⁰ Evidence of Professor Verma, T-192-3, lines 27-1.

Appointment Letters to Former Address

211. On 17 December 2021 and 14 January 2022, Barwon Health sent letters to Simon informing him of scheduled appointments for the DEXA scan (on 14 April 2022) and the General Medicine outpatient clinic (on 18 February 2022). Both letters were directed to the address recorded on Simon's medical record – being his former address at his sister's property in Anakie²¹¹ – notwithstanding that Simon was known by Barwon Health to be homeless at that time, and was estranged from his sister and prohibited from attending the property.
212. Following Simon's non-attendance at the Outpatient General Medical Clinic on 18 February 2022, Barwon Health rescheduled the appointment to 13 May 2022 and sent a further letter to him informing him of the new appointment time and informing him that it was important he attend the clinic and if he did not attend, he would be discharged from the clinic and removed from the waiting list. This letter was again sent to him via his former address.²¹²
213. At inquest, Professor Verma accepted that at the time the letters were sent to Simon's former address, Barwon Health had information that this was not the correct address for Simon.²¹³ Incongruently, each of the letters sent by Barwon Health to Simon via his former address stated that *"It is your responsibility to notify us of a change of address or phone number"*.²¹⁴ Simon had notified Barwon Health of his change of address, and that he did not have any fixed place of abode at the time of his in-patient admission, but his patient record had not been updated to reflect this.
214. This was a significant failure in patient communication, as it meant Simon did not receive notification of important medical appointments that had been scheduled with him to appropriately investigate and manage his medical conditions.
215. Professor Verma informed me that the usual practice of the Barwon Health outpatient administration team is to attempt to call or text a patient following their non-attendance at an initial outpatient clinic. Professor Verma acknowledged there is no record of these attempts on Simon's medical record and explained that these attempts are not always recorded on a

²¹¹ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB pp 864-5.

²¹² Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 865.

²¹³ Evidence of Professor Verma, T-198, lines 2-17.

²¹⁴ Letters from Barwon Health to Simon Gaskill notifying of Outpatients Appointments, IB pp 871, 872.

patient's medical record.²¹⁵ However, the clinic will attempt to contact a patient via telephone prior to discharging them from the clinic and removing them from the waiting list.²¹⁶

216. It is concerning that attempts to contact a patient are not always captured on the patient's record. In the absence of these records, there is no means to verify what attempts have been made (if any), or if it is appropriate to remove a patient from the waiting list. This may create a risk for a patient, a proposition with which Professor Verma agreed at Inquest and identified as an area for strengthening in Barwon Health procedures.²¹⁷ Accordingly, I have made a recommendation to Barwon Health to review and amend its outpatient clinic procedures to ensure all attempts to contact a patient are documented in the patient record.
217. Professor Verma further explained that where an outpatient of Barwon Health is known to have no fixed abode, the outpatients administration team will attempt to call the patient if there is a mobile number listed in their medical record instead of sending a letter. As there was an address recorded on Mr Gaskill's medical record, the outpatient administration team did not know that he was of no fixed abode.²¹⁸
218. Since Mr Gaskill's death, Barwon Health's General Medicine team has amended its process for patients who have been referred for an outpatient appointment, and who may be difficult to contact with an appointment time following their discharge (such as those of no fixed abode). Such patients are now provided the time and date of any planned outpatient appointment verbally and in written form prior to discharge, and it is expected that this is also documented in the medical records.²¹⁹ As noted above, Barwon Health has also updated its procedures for the management and booking of outpatient clinic appointments. These new procedures are discussed further below.
219. Barwon Health has also reviewed the failure to change Mr Gaskill's address in his medical record. Professor Verma informed me that in a situation where a patient is not able to engage with administrative staff in the Emergency Department for checking of contact and other

²¹⁵ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 865; Evidence of Professor Verma, T-200, lines 14-26

²¹⁶ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 865.

²¹⁷ Evidence of Professor Verma, T-201, line 9 to T-202, line 8.

²¹⁸ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 869.

²¹⁹ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 869.

details, ward clerks have been asked to ensure that they verify these with the patient prior to discharge.²²⁰

220. I commend Barwon Health for implementing measures to ensure the accuracy of a patient's contact details and to improve patient access to key appointment information. However, it is unclear to me whether these measures have been incorporated into relevant hospital process guides or procedures to ensure all staff are aware of these requirements on an ongoing basis in the future. It is imperative that patient contact details be verified on discharge to ensure their accuracy. I have made a relevant recommendation to Barwon Health to review relevant processes and procedures to incorporate these expectations and requirements accordingly.

Department of Health Managing Referrals Policy

221. The CPU explained that it is a health service's responsibility to provide health services that meet the needs of the community and drew my attention to the Department of Health's 'Managing referrals to non-admitted specialist services in Victorian public health services' policy (**Managing Referrals Policy**).²²¹ This policy contains pertinent guidance on the Department's expectations regarding access to non-admitted specialist services, and the responsibility of health services to (amongst other matters) ensure appropriate, equitable access to services for patients based on their clinical need, related psychosocial factors and any disparities in access to healthcare.²²²
222. At Inquest, Professor Verma stated that the Managing Referrals Policy outlines '*the Victorian Department of Health expectations for non-admitted specialist services in terms of managing referrals and provides the authorising environment for hospitals and health services to develop the local policies that are congruent with the intent of the policy*'.²²³

²²⁰ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 869.

²²¹ Department of Health 'Managing referrals to non-admitted specialist services in Victorian public health services' (**Managing Referrals Policy**) published 9 January 2023, available: <https://www.health.vic.gov.au/publications/managing-referrals-to-non-admitted-specialist-services-in-victorian-public-health>; Also tendered at Inquest as AM-8.

²²² Managing Referrals Policy, p 20. It is self-evident that there is no expectation Barwon Health ought to have acted in accordance with this policy at the time of its involvement with Simon's care from December 2021 given the policy was not then in existence, but I considered it was relevant to my subsequent assessment of whether there are any outstanding opportunities for system improvements.

²²³ T-203 lines 11-17. See also AM9-3 – 'All Barwon Health acute non-admitted specialist clinic services must comply with the requirements of the Department of Health's *Managing referrals to non-admitted specialist services in Victorian public health services* policy'.

223. I acknowledge that the Managing Referrals Policy was first published in January 2023, after Simon's death. Accordingly, the expectations set out in the policy were not in force at the time of Simon's admission and I make no adverse finding against Barwon Health for any discrepancies as may be found between outpatient policies and procedures at the time of Simon's admission and current Department of Health expectations. Indeed, Barwon Health are to be commended for the steps they have taken since Simon's death to improve its processes to improve their systems and processes, and have also updated their procedures to give effect to the Managing Referrals Policy, as described further below. Nonetheless, the policy was of relevance to my investigation insofar as it highlighted additional systems opportunities to address disparities in access to healthcare for patients experiencing homelessness and/or alcohol dependence, as occurred in Simon's case.
224. Of note, the Managing Referrals Policy highlights issues regarding disparities in access to care, and the physical, psychosocial and structural barriers faced by certain groups in accessing services. Groups identified as facing structural barriers to accessing health services include homeless people, people experiencing socioeconomic disadvantage, people living in remote, or rural and regional locations, and people with mental illness.²²⁴ Simon fulfilled each of these criteria, being homeless, with limited financial resources, living in regional Victoria, and with alcohol use disorder, anxiety and depression.
225. The Managing Referrals Policy sets out expectations that health services:
- (a) must provide written information to the patient about referrals, including how the patient can indicate their preferred method of communication, how their appointment will or can be scheduled, the implications of failing to attend a scheduled appointment and the patient's responsibilities including how to notify the health service of changes in their contact details and if they are unable to attend a scheduled appointment.²²⁵
 - (b) should remove the request for a service if the patient has not accessed required investigations on two consecutive occasions.²²⁶

²²⁴ Managing Referrals Policy, pp 8-9.

²²⁵ Ibid, p 34-5.

²²⁶ Ibid, p 38.

- (c) must contact the referring clinician to identify alternative contact details before removing the request for a service where a patient has failed to complete the required tests or investigations.²²⁷
- (d) should exercise discretion to avoid disadvantaging patients in cases of genuine hardship, misunderstandings and unavoidable circumstances.²²⁸

Barwon Health Outpatient Appointments Procedures

226. Prior to Inquest, I foreshadowed to Barwon Health that I was considering making a recommendation that Barwon Health review its existing processes concerning non-attendances of patients and to ensure its policies align with expectations set out in the Managing Referrals Policy to support access to care.

227. Following the close of *viva voce* evidence, Barwon Health sought leave to tender three documents via Counsel Assisting which detailed Barwon Health's current procedures for booking and managing appointments to non-admitted (i.e. outpatient) Acute Specialist Clinics. These three documents were published on 25 July 2023, and comprised:

- (a) Barwon Health Non-admitted Acute Specialist Clinics Booking Appointments;
- (b) Barwon Health Non-admitted Acute Specialist Clinics Managing Appointment Cancellation and Rescheduling; and
- (c) Barwon Health Non-admitted Acute Specialist Clinics Managing Appointments.

(together, the **Barwon Health Outpatient Appointments Procedures**).

228. These procedures were developed by Barwon Health in response to the Victorian Department of Health's Managing Referrals Policy in 2023.²²⁹ They are aimed to operationalising the requirements of the Department of Health's Managing Referrals Policy in respect of booking and rescheduling appointments. They had been described in evidence by Professor Verma in a general way and thus I allowed them to be tendered.²³⁰

²²⁷ Ibid, p 38.

²²⁸ Ibid, p 38.

²²⁹ Each of the Barwon Health Outpatient Appointments Procedures directly references the requirements of the Department of Health's Managing Referrals Policy. See AM-9, p 3, 10, 15.

²³⁰ Included as an adjunct to the Coronial Brief as Additional Material 9 (**AM-9**).

229. Due to the timing of the production and tendering of these documents, neither the Court or interested parties had an opportunity to review the documents or question Professor Verma on their contents. Nonetheless, they have been of assistance in understanding Barwon Health's current procedures for Outpatient Appointments and I have given careful consideration to their contents, in the context of considering my comments, and the recommendations which follow.
230. The Booking Appointments Procedure provides that specialist clinics must:
- (a) ensure each patient referred to Barwon Health is treated in turn, based on their clinical need, related psychosocial factors and disparities in access to care. Certain exemptions to this principle include relevantly, where a patient's physical, psychological or social situation impedes their equitable access to care.²³¹
 - (b) ensure the booking process for appointments should consider the patient's needs and circumstances – such as disabilities, social and geographic factors.²³²
 - (c) confirm the scheduled time and date with the patient in writing, unless the agreed appointment date is three days or less from the booking date, in which case the patient should be contacted by telephone.²³³
 - (d) send invitations for patients to contact the specialist service unit to make an appointment, using the patient's nominated communication method.²³⁴
 - (e) have appointment reminder processes to minimise the occurrence of missed appointments and short-notice cancellations.²³⁵
 - (f) irrespective of the communication medium, communication with patients must (amongst other requirements), be in plain English, suitable for people with English literacy below level 1, have accessible options for patients with a visual or hearing impairment, and consider the communication, language and cultural needs of groups

²³¹ Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 3.

²³² Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 4.

²³³ Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 4.

²³⁴ Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 4.

²³⁵ Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 4.

that encounter disparities in access to care, including Aboriginal people, refugees and asylum seekers.²³⁶

- (g) patients should be offered individual appointment times which accommodate – amongst other matters – the patient’s reliance on transport or accommodation assistance, if the patient has complex or multiple health conditions, and the patient’s preferred appointment times that improve accessibility and engagement.²³⁷

231. In respect of non-attendances, the Managing Appointments and Rescheduling Procedure acknowledges that a ‘did-not-attend’ can be associated with poor communication with patients (amongst other reasons).²³⁸ Where a patient has failed to attend an initial appointment, clinical consideration should be given, and:

- (a) where a patient is assessed ‘as a risk’ (undefined) the patient should be phoned to determine the reason for non-attendance, their registration details be confirmed and appointment rescheduled if required;
- (b) if it is not possible to reach the patient by phone or SMS, their registration details should be checked and a letter advising of their rescheduled appointment date should be sent to the patient;
- (c) if the patient fails to attend two booked initial specialist clinics appointments for the same clinic without adequate reason of notification beforehand, the patient may be removed from the appointment list.
- (d) the specialist clinic unit must ensure they have attempted to contact the patient by their preferred method of communication;
- (e) if the patient cannot be contacted, the referrer/GP and patient must be advised in writing that the patient is being removed from the appointment list after failing to attend two consecutive appointments.²³⁹

232. The Procedure requires that where there is a failure to attend two initial specialist clinic appointments, the clinic must ensure “*a clinician has reviewed the case with the view to*

²³⁶ Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 5.

²³⁷ Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 5.

²³⁸ Barwon Health Non-Admitted Acute Specialist Clinics Booking Appointments, AM-9, p 11.

²³⁹ Barwon Health Non-Admitted Specialist Clinics Managing Appointment Cancellation and Rescheduling, AM9-11.

remove the patient from the specialist clinic's waiting".²⁴⁰ On a plain reading of this requirement, it appears the clinical review of a patient in these circumstances is directed towards the removal of the patient from the waiting list, rather than in identifying and addressing whether there are barriers or impediments which may be precluding the patient from attending the appointment and accessing care.

233. Further, there is nothing in the procedure to provide guidance on what steps ought to be followed if a patient has not been contacted by their preferred method of communication, or if there are any other barriers to receiving notifications of appointments, or attending the specialist clinic (such as notifications being sent to an incorrect former address).
234. In addition, the Barwon Health Procedure does not make any specific provision for communications regarding appointments with patients experiencing homelessness, which is one of the categories of people referred to in the Managing Referrals Policy as facing a specific physical, psychosocial and/or structural barrier to accessing services, and was a factor impacting Simon at the time of his discharge in December 2021, a fact with which Professor Verma agreed during Inquest.
235. It is evident that patients with no fixed place of abode are likely to have significant barriers to accessing healthcare, attending follow up appointments and require additional support and assistance to support them in accessing equitable health care. The CPU noted and I agree that Simon would have benefited from care-co-ordination from the hospital that extended to the community, including assistance accessing outpatient appointments, and housing, which were critical to successfully managing his health needs, including his alcohol use disorder with seizures.
236. However, Professor Verma appeared to suggest that there were limited existing options that he was aware of via Barwon Health to facilitate attendance at outpatient appointment for vulnerable patients (e.g. via a social worker) once they had left an inpatient setting.²⁴¹

²⁴⁰ Barwon Health Non-Admitted Specialist Clinics Managing Appointment Cancellation and Rescheduling, AM9-11.

²⁴¹ See evidence of Professor Verma regarding facilitating attendance at out-patient referrals - T-214 lines 23-29 and T-217 lines 4-7.

237. I consider there to be further opportunities to strengthen attendance of vulnerable patients at outpatient appointments and make further comments concerning post-discharge coordination of care and associated recommendations below.
238. I note that the Barwon Health Outpatient Appointments Procedures appear to be due for review by 25 July 2026. This may be an opportune time for Barwon Health to consider whether there are opportunities to strengthen these procedures – in light of the findings made following this inquest – and to ensure they fully reflect the policy intent of the Managing Referrals Policy. I have made a recommendation accordingly.

Referral to Alcohol and Other Drug Services

239. The CPU noted Simon was at higher risk for community-based withdrawal due to his risk of seizures, even with co-ordinated support and temporary housing. The inpatient medical and psychiatric teams appropriately recommended a AOD review for Simon, recognising the risks related to his alcohol use disorder.
240. As outlined above, Simon was initially interested in a referral, but subsequently declined a referral on the first day of his hospital admission. However, as his condition improved over the course of his admission, he expressed a desire to be linked in with drug and alcohol services. A plan was arranged for inpatient review with an AOD clinician in the week of 13 December 2021. Unfortunately, this was not proceeded with as Simon was discharged prior to the planned review.
241. The CPU explained that an inpatient review by the AOD clinician would likely have focused upon discussions about the various outpatient services available in the community. Simon may have met the criteria for inpatient residential rehabilitation. However, waiting lists for this service are extended, as available beds are substantially below demand, and unfortunately may not have been a realistic option for Simon at the time, even if considered.
242. The CPU noted that although an AOD outpatient referral was planned, and documented in Simon’s discharge paperwork, there is no evidence an outpatient referral to AOD services was made for Simon.

243. In his statement, Professor Verma clarified the process for referral to Barwon Health’s Drug and Alcohol Services (**DAS**).²⁴²
244. Professor Verma explained that patients are not referred directly to DAS as there are multiple alcohol and other drugs (**AOD**) providers in the community which provide different interventions according to the individual needs of the patient. Instead, if an inpatient is referred to the Consultation Liaison (**CL**) psychiatry service, a clinician will review the patient admitted to a ward for alcohol and substance use issues to discuss ongoing treatment options. An AoD screening tool can be completed and forwarded to an appropriate AOD provider for ongoing interventions. Should the patient decline, or wish to consider their options further, they may be given contact details by the CL psychiatry clinician to self-refer. It is also standard practice for a patient’s admitting unit (i.e. the General Medical team in Mr Gaskill’s case) to provide the patient with a business card that contains the Barwon Health Mental Health Drug and Alcohol Services triage phone number at the time of their discharge to make a self-referral.²⁴³
245. Professor Verma explained that, once a patient is discharged from a hospital, they do not require a referral to engage with Barwon Health’s DAS. The usual process is for patients to self-refer themselves by calling the 24-hour phone number or attending the DAS walk-in clinic. The onus is placed on the patient with respect to engaging with AoD services as their motivation and cooperation with the services is necessary.²⁴⁴
246. Professor Verma was unable to confirm whether Simon was provided with the Mental Health DAS triage phone number at the time of his discharge, but noted Simon had previously presented to the walk-in clinic on a number of occasions between February 2016 and May 2019, indicating he was familiar with the process of initiating self-referral.²⁴⁵ However, at the time of Simon’s engagement with those services, Simon’s family had been instrumental in supporting Simon with engaging with AOD services. Amanda gave evidence at Inquest that

²⁴² Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 868.

²⁴³ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 868.

²⁴⁴ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 868.

²⁴⁵ Statement of Professor Ajai Verma, Chief Medical Officer, Barwon Health, IB p 868.

at times, Simon needed assistance to attend appointments in order to ensure his ongoing engagement with treatment.²⁴⁶

247. By December 2021, Simon had become estranged from his family and no longer had access to the same community supports that would have supported him in initiating self-referral to these services. The circumstances of Simon's case highlight the need for wraparound post-discharge care coordination, to take into account the vulnerabilities and barriers to accessing care for persons in Simon's position.
248. Professor Verma informed me that it is the responsibility of the General Medical Team to ensure that at the time of Simon's discharge, he was advised of the usual process for engaging with DAS as an outpatient by calling the relevant phone number or by attending the DAS walk-in-clinic and provided with relevant contact information.
249. I note that this expected process appears at odds with the information that was provided to Simon in his discharge paperwork and understood by treating clinicians. Simon's '*My Service Diary*' indicated that the AOD Psych service would contact him to arrange an appointment.²⁴⁷ Professor Verma conceded at inquest that the information provided to Simon in his My Service Diary on discharge indicated that Simon was told he should await further contact for an appointment with the DAS.²⁴⁸ Further, the understanding of Dr McAulay-Powell was that a patient can be referred by a clinician using a form that is sent to DAS.²⁴⁹
250. This confusion in whose role and responsibility it is for initiating or arranging an outpatient appointment with the DAS service is clearly undesirable, particularly where a patient has been identified as facing barriers to engaging with and attending follow up, and has expressed a desire to be linked with such services.
251. Professor Verma agreed at Inquest that it can be beneficial to assist patients facing AOD issues – and who may have fluctuating motivation to address them – to make AOD appointments or other related arrangements at the time they are agreeing to a referral and demonstrating

²⁴⁶ See evidence of Amanda Gaskill, T-37, lines 4-9, in the context of Simon attending rehabilitation – '*he did need our assistance to get places. He didn't have a car or a licence at that stage I think on the second time he went in. But he did need um - he did need a little bit of assistance and encouragement to keep going to - to follow things up*'.

²⁴⁷ Barwon Health Medical Records, UR 219723 DMR 15.4.21 to 11.4.24, p 291.

²⁴⁸ Evidence of Professor Ajai Verma, T-223, line 23 to T-224 line 9.

²⁴⁹ Statement of Dr Christopher McAulay-Powell, Baron Health, IB p 70.

motivation.²⁵⁰ That did not happen for Simon and was a lost opportunity to engage him when he had agreed he needed help (and where there appeared to be at least some ongoing motivation on his part, evidenced by the fact that he filled his prescription for acamprosate post-discharge). In this context, it is difficult to comprehend how Simon was assessed as medically fit for discharge prior to seeing an AOD clinician, per the initial plan, though it appears that there was a perception that an appointment would be made for him for AOD review regardless of the decision to discharge.

252. While I consider this state of affairs to be concerning, I am unable to say whether an AOD review, either as an inpatient or outpatient, would have resulted in a different outcome for Simon.
253. Nonetheless, I consider there is scope for Barwon Health to improve its processes for referral to the DAS for at risk patients. Where a patient has agreed to referral to DAS, this referral should be made by the treating team, with an appointment scheduled and communicated to the patient verbally and in writing prior to discharge. This process should be clearly documented, and education provided to treating clinicians to ensure they are aware of relevant processes. I have made a recommendation accordingly.

Conclusions regarding health care

254. I accept the opinion of the CPU that, overall, the services provided to Simon by Barwon Health as an inpatient were reasonable and appropriate in the circumstances and aligned with the expected standard of care.
255. However, the CPU also identified opportunities for improvement – which were borne out in the evidence heard at Inquest – in the communication and follow-up of planned outpatient care and AOD services following discharge. I consider this is amplified in circumstances where patients are identified as facing multiple barriers to accessing health and related services. Relevantly for Simon, those barriers included his homeless status, his ongoing struggle with severe alcohol use disorder and mental ill health, his precarious and limited financial means, and living in a regional setting. These barriers are likely to have intersecting

²⁵⁰ T-234 lines 18-24.

and compounding impacts on patients seeking to access health services, even where they have demonstrated an awareness of how to access such services in the past, as Simon had.

256. Barwon Health submitted that there was no want of care to Simon on its part either in an inpatient or outpatient setting. It submitted to the Court that, *‘after his inpatient admission arising from his fall sometime around 5 December 2021, Barwon Health had compiled an accurate clinical picture, had treated him accordingly, had identified his housing status, had accurately recorded his mobile phone number and had appropriately recommended a course of post-discharge action as a voluntary out-patient to address his long standing alcohol use disorder’*, and further, that following discharge, *‘Simon understood the plan and had been provided with all necessary information to action it’*.²⁵¹
257. I accept that during his inpatient admission, Barwon Health compiled an accurate clinical picture and treated him accordingly, and appropriately developed a post-discharge plan, which was set out in his My Service Diary.
258. I do not consider any adverse comments or findings are indicated in relation to Barwon Health’s inpatient care for Simon, and do not consider there to be any causal connection between his treatment and subsequent discharge from Barwon Health in December 2021 and the ultimate tragic outcome.²⁵² I have carefully considered Barwon Health’s submissions in this regard.
259. However, I do not accept that Simon had been provided with all necessary information to action his discharge treatment plan, in circumstances where details of relevant outpatient appointments were sent to him via letter to his former address, and where his records were not appropriately updated to ensure his homeless status was known to the outpatient administration team. While Simon may have previously accessed certain services provided by Barwon Health, I consider that at the time of his discharge, he faced additional intersecting barriers to doing so (such as homelessness, addiction and mental health issues) which ought to have factored in to his discharge planning to ensure that any additional supports required

²⁵¹ Submissions of Barwon Health, 20 February 2026.

²⁵² It is relevant to note that at the time of discharge, Simon had capacity and was able to make decisions for himself regarding medical care, including the extent to which he sought to engage with it.

were explored. I consider that there should be clear processes to accommodate the support needs of vulnerable patients like Simon in these circumstances moving forward.

260. Following from this, and consistent with my mandate to comment on, and make recommendations to improve public health and safety (and consistent with the principles in *Thales*), I have made a number of recommendations to strengthen outpatient referral processes and supports for vulnerable Victorians who may need extra supports to access health services. This is consistent with the principles of substantive equality embedded in the human right to access to health, a principle that I have commented upon in other inquest proceedings.²⁵³

REVIEW OF POLICE CONDUCT AND INVESTIGATION

Family Concerns

261. Following the compilation of the First Coronial Brief, Simon's sister Amanda wrote to the Court to raise concerns about the adequacy of the Victoria Police investigation into his death. These were concerns that I shared. They were highly relevant to my investigation insofar as, without an adequate investigation into Simon's death by the coronial investigator (a police member), I would not be in a proper position to discharge my statutory functions under the Act nor to fulfil my own role as an active investigator in Simon's death.²⁵⁴
262. Exploring potential deficiencies in the initial investigation was also relevant to my statutory tasks insofar as it concerns the proper administration of justice in the investigation of reportable deaths. Accordingly, I considered it appropriate to investigate and publicly ventilate the concerns raised. Further, given its temporal proximity to Simon's death, I have also considered the police response during their interaction with Simon on 25 March 2022 and the attending members' compliance with relevant policies and procedures.
263. In examining the police response, I have had regard to the findings of the two internal investigation reports²⁵⁵ completed by Victoria Police in response to the concerns raised. Those investigations identified multiple investigative and duty failings in the police response and

²⁵³ See for example *Finding into the death of Bridget Erin Flack* (COR 2020 006727, 29 August 2024), available [here](#), pp. 133-135.

²⁵⁴ *Priest v West* (2012) 40 VR 521 (*Priest v West*) is relevant here insofar as it enshrines the well-established principle that, in investigating a death, the coroner must pursue all reasonable lines of enquiry, be an active investigator and discover all they can about the circumstances surrounding the death (at [521], [525] and [560]).

²⁵⁵ Final Investigation Report and Supplementary Investigation Report, IB pp 846-863.

initial investigation, as well as breaches of applicable policies for the activation of BWC and recording of duties in the police attendance on 25 March 2022, as discussed further below. While these reports have informed my investigation, the coronial investigation is independent, and I have formed my own view on the evidence before me including the evidence given by Amanda Gaskill and DLSC Smyth at inquest.

Assessment of Police Conduct in the interaction with Simon on 25 March 2022

264. The circumstances of the police interaction with Simon on 25 March 2022 are discussed in detail in the ‘Background’ section of this Finding above. My review of the police response to this incident identified concerns in relation to compliance with applicable policies and procedures for the activation of body worn cameras (**BWC**) and recording of duties by Bellarine 310 (LSC Wakeling and LSC Holmes).

Activation of Body Worn Cameras

265. The Victoria Police Manual (**VPM**) Body Worn Cameras in force as at 25 March 2022 required members to start a recording when attending an ESTA (now Triple Zero Victoria) task resulting in a public contact, and when attending to the public in need of assistance.²⁵⁶ This remains Victoria Police policy,²⁵⁷ and the expectation for police officers to record the majority of operational incidents during their shift is reinforced in the BWC Practice Guide first published in December 2022, and updated in July 2023.²⁵⁸

266. Given the circumstances of the reported incident between the complainant and Simon on 25 March 2022, and as identified in the Final Investigation Report²⁵⁹, both members of Bellarine 310 ought to have activated their BWC. Where a BWC recording is not made in accordance with the activation framework, the responsible members are required to record the circumstances of the attendance in their electronic Patrol Duty Return (**ePDR**), initial action pad or official diary, and provide enough detail to later account for the omission. No such detail was recorded proximate to the event, and there was no reference made in the ePDR,

²⁵⁶ VPM Body worn cameras updated 17 February 2022, [3.2], IB p 592.

²⁵⁷ See VPM Body worn cameras updated 21 August 2024, IB p 736.

²⁵⁸ BWC Practice Guide, IB p 754.

²⁵⁹ Final Investigation Report, IB p 857.

notes or police radio communications to document that the unit had transported Simon, or the location of where he was transported to.

267. Interrogation of Victoria Police systems confirms LSC Holmes activated his BWC at 2.45am during an attendance at another incident shortly after Simon was dropped off at the campground. LSC Wakeling had also activated his BWC in on other nights that week.²⁶⁰ In these circumstances, I agree with the opinion of the coronial investigator, DLSC Smyth that it is likely both members of Bellarine 310 had access to functioning BWCs at the time of dealing with Simon but that they failed to activate them.²⁶¹
268. Due to the passage of time, neither member of Bellarine 310 was able to recall or provide an explanation for the absence of BWC footage of their attendance at this incident.²⁶²
269. In his supplementary statement, LSC Holmes acknowledged that the most likely explanation for the absence of BWC footage was that he and LSC Wakeling failed to activate their BWC during the interaction. He explained that:
- (a) the BWC requires manual activation and because BWCs were not standard for most of his career, it is “*not an automatic muscle memory function*” and he must actively remember to activate the BWC when attending each job;
 - (b) at times it is “*very easy and common*” to forget to activate the camera, especially when distracted or under stress.
 - (c) on previous occasions, he had observed a technical issue where, after completing the required actions for activating the BWC, the camera had not activated and this was not discovered until later.²⁶³
270. As has been highlighted in a number of coronial findings²⁶⁴, the use of BWC significantly increases transparency in relation to the conduct of Victoria Police members and interactions with members of the public. They are of great assistance in coronial and criminal jurisdictions in objectively capturing and recording the precise occurrence of events.

²⁶⁰ First Statement of DLSC Smyth, IB p 190.

²⁶¹ First Statement of DLSC Smyth, IB p 190.

²⁶² Supplementary Statement of LSC Holmes, IB pp 99-100.

²⁶³ Supplementary Statement of LSC Holmes, IB p 100.

²⁶⁴ See for example COR 2020 3809, ‘Finding into death after inquest of Gabriel Messo’ delivered on 1 December 2022 by State Coroner Judge Cain (as he then was), [351].

271. In the four years that have passed since these events, BWCs have become a standard feature of uniform policing. In my role as Coroner, I have observed improved compliance with the VPM Body Worn Cameras, which now appears to have become an ‘automatic muscle function’ for many police officers responding to incidents with members of the public. I anticipate that future attendances at similar events will now be fully documented by attending police officers via their BWC, as required under Victoria Police policy.²⁶⁵
272. Nonetheless, members may benefit from further guidance on strategies to embed use of BWC as a daily practice to ensure that all events are appropriately recorded, particularly where members may be under increased stress or cognitive loading. I also consider there may be benefit to establishing a pathway for members to report technical issues in activation of their BWC where this is identified, to enable appropriate steps to be taken to investigate and address these issues as they arise, and have made a recommendation accordingly.
273. Notwithstanding their failure to activate their BWC during the event, Bellarine 310 activated the CCTV of the rear pod divisional van during Simon’s transport from the residence to the campground, a manual process which requires two switches to be activated.²⁶⁶ The CCTV footage depicts Simon for the duration of the transport, and captures audio of his conversation with the police members when he was dropped off at the campground, confirming Simon appeared to have no injuries and appeared to be well at the time of leaving police presence. While it is not a substitute for BWC footage, which would have provided a clearer view of Simon and better audio of the conversations conducted with him, it has given me some comfort in my investigation that Simon appeared well when dropped off by police in the sand dunes in the early hours of the morning.

Recording of Duties

274. The VPM ‘Operational duties and responsibilities’ requires members to record and report on operational duties in the patrol duty return, official diary and/or incident fact sheets.²⁶⁷ Employees on patrol are expected to ensure that task narratives adequately describe the actions taken and explain the recorded disposition of tasks.²⁶⁸ The purpose of these record

²⁶⁵ VPM Body Worn Cameras updated 21 August 2024; BWC Practice Guide updated July 2023, IB p 754.

²⁶⁶ Supplementary Statement of LSC Holmes, IB p 101.

²⁶⁷ VPM Operational duties and responsibilities updated 26 July 2021, IB pp 526-7.

²⁶⁸ VPM Operational duties and responsibilities updated 26 July 2021, IB pp 526-7.

keeping requirements are to ensure appropriate accountability for the performance of operational duties, protect and assist employees on all occasions of future reference to their duties and conduct, and provide information to supervisors on the duties carried out.²⁶⁹

275. Following their attendance at the complainant's residence on 25 March 2022, Bellarine 310 documented in their ePDR that Simon had been "*moved on*". However, there was no reference in their ePDR or official diaries to indicate that they had transported Simon from the residence to the campground.²⁷⁰ This information was critical to understanding Simon's movements immediately before his death, particularly in the absence of any contemporaneous record of Simon's transport by the attending officers.
276. This was an unfortunate oversight in circumstances where there was a possibility this contact may have been Simon's last interaction prior to his death. The Court's investigations have since clarified that Simon subsequently travelled to Geelong via public transport later that day and met with and communicated with friends in the 36 hours post this incident. However, the absence of records documenting the actions taken by Bellarine 310 created additional challenges in reconstructing Simon's movements in the days immediately prior to his death which may have been resolved earlier with clear and accurate record keeping.
277. It is also deeply concerning that this interaction did not come to light until several years after Simon's death, despite staff from the same police station (Bellarine) having been subsequently involved in the police investigation when Simon's body was located, and LSC Wakeling having taken a statement from the walker who located Simon's body on 15 April 2022.²⁷¹ I will return to this issue further below.
278. I accept that the operational policing environment is dynamic and this can create challenges for patrol members responding multiple incidents during a shift to accurately record and document all activities. It is only with the benefit of hindsight that the significance of this interaction, in the context of Simon's untimely death, has become apparent. I acknowledge

²⁶⁹ VPM Operational duties and responsibilities updated 26 July 2021, IB p 522.

²⁷⁰ ePDR of Bellarine 310, IB p 455.

²⁷¹ See Statement of Samuel Kelly, taken and witnessed by LSC Wakeling on 15 April 2022, IB p 127. LSC Wakeling was unable to recall the incident on 25 March 2022, and did not make the connection between the discovery of the deceased in the dunes on 15 April 2022, and the earlier interaction.

the members of Bellarine 310 did not, and could not know, at the time of dropping Simon at the campground, that this would be one of the last interactions with Simon prior to his death.

279. Nonetheless, this highlights the importance of police documenting and recording all interactions with members of the public. I have made a relevant recommendation to the Chief Commissioner of Victoria Police to remind uniform police members of the requirements of the VPM ‘Operational duties and responsibilities’, particularly in circumstances where a member of the public has been or is to be transported via police vehicle.

Conclusion regarding police response on 25 March 2022

280. As detailed above, I have identified deficiencies in the conduct of Bellarine 310 in respect of the activation of their BWC and recording of duties in respect of the incident on 25 March 2022. These issues were also identified by Victoria Police in the subsequent Final Investigation Report completed by D/Sgt Tink following Amanda’s complaint to Professional Standards Command.²⁷²
281. As relevant contemporaneous audiovisual and documentary evidence of the police response is unavailable, and given the passage of time has compromised the officers’ recall of this incident, I am unable fully assess the police response on this date.
282. However, having regard to the evidence that is available, including the brief notes in the ePDR and CCTV footage from the rear of the divisional van, I am satisfied that Simon appeared well at the conclusion of his interactions with police and that there is no evidence that the actions of the police officers had any direct causal link with his death.²⁷³ Simon agreed to leave the residence, and Bellarine 310 assisted in transporting Simon to his nominated drop off point at the campground. The officers made appropriate enquiries with Simon when they dropped him at the campground to ascertain whether he was able to locate his tent. In response, Simon confirmed he had his headlight and declined further assistance.

²⁷² Final Investigation Report, IB pp 856-7.

²⁷³ Simon agreed to leave the residence, and Bellarine 310 assisted in transporting Simon to his nominated drop off point at the campground. The officers made appropriate enquiries with Simon when they dropped him at the campground to ascertain whether he was able to locate his tent. In response, Simon confirmed he had his headlight and declined further assistance. He otherwise appeared well when the police left the scene.

283. Nonetheless, the circumstances of this case highlight the importance in activation of BWC by police for all attendances, to provide transparency in relation to the conduct of Victoria Police members in their interactions with members of the public.

Assessment of Police Investigation into Simon's death on behalf of the Coroner

284. Police members have specific roles and responsibilities in the investigation of reportable deaths, including to:

- (a) investigate whether a crime has been committed and, where applicable, charge offending persons;
- (b) investigate the death on behalf of the Coroner under the Coroners Act to assist in determining how and why a person died;
- (c) to assist with the identification of the body;
- (d) to notify relevant authorities about the death, and where applicable, work jointly with such authorities; and
- (e) to provide advice and referral information for families.²⁷⁴

285. In assisting the Coroner's investigation the person (usually a police officer) who reported the reportable death must give the Coroner any information or other assistance the Coroner requests for the purposes of the Coroner's investigation.²⁷⁵ Further, a member of the police force who has information that may be relevant to an investigation by a Coroner into a death or a fire must give that information to the Coroner to assist the Coroner in their investigation of the death or fire.²⁷⁶

286. My investigation identified significant deficiencies in the police response to, and initial investigation of Simon's death in respect of:

- (a) delay in assisting in identification of Simon and notification to his senior next of kin;
- (b) failure to ensure all relevant evidence was collected and documented at the scene;

²⁷⁴ VPM Deceased persons updated 19 July 2021, IB p 638.

²⁷⁵ Coroners Act, s 32.

²⁷⁶ Coroners Act, s 36.

- (c) destruction of Simon’s phone without notification to Simon’s next of kin;
 - (d) failure to disclose critical information to the Coroner concerning proximate police contact with Simon; and
 - (e) failure to conduct appropriate enquiries to establish a timeline prior to death.
287. These issues impacted the trajectory of the coronial investigation into Simon’s death and, more broadly, are relevant to the proper administration of justice and the adequacy of police investigations into reportable deaths and were appropriately matters requiring further scrutiny. These issues were also identified by Victoria Police in their internal investigation into the police response. I have referred to relevant findings from the Final Investigation Report and Supplementary Investigation Reports below.

Identification of Simon and notification to the senior next of kin

288. The VPM ‘Deceased Persons’ sets out the responsibilities of police members in coronial investigations.²⁷⁷ This includes, relevantly, requirements to assist with and arrange for the identification of the body,²⁷⁸ and to identify and notify the next of kin of the death, ‘as a matter of urgency’²⁷⁹.
289. If the identity of the senior next of kin is not known at the time the Form 83 is submitted to Coronial Admissions and Enquiries (**CA&E**), it remains the responsibility of the coronial investigator to make reasonable enquiries to identify the senior next of kin, and at the earliest opportunity advise CA&E with that persons’ details, or where the senior next of kin has not been able to be identified, to submit a form to CA&E outlining the nature and extent of enquiries conducted.²⁸⁰
290. Where there is any uncertainty over what steps may be required in progressing identification or notification to the next of kin, police members are instructed to liaise with CA&E which operates 24/7. In addition, police members may also seek guidance from the Victoria Police

²⁷⁷ VPM Deceased Persons updated 19 July 2021, IB p 638.

²⁷⁸ VPM Deceased Persons updated 19 July 2021, [1.1], IB p 639.

²⁷⁹ VPM ‘Deceased persons’ updated 19 July 2021, [8.1], IB p 654.

²⁸⁰ VPM ‘Deceased persons’ updated 19 July 2021, [8.3], IB p 655.

Coronial Support Unit (**CSU**), a specialist unit within the Victoria Police Prosecutions Division, which helps coroners in relation to coronial investigations.

291. The VPM Deceased Persons has undergone a series of updates since 2022 but remains substantially the same in respect of requirements in respect of police members' roles and responsibilities to identify the deceased and their senior next of kin and to deliver notification of death to the deceased's relatives.
292. On 15 April 2022, LSC Kelly completed a Form 83 in respect of Simon's death and filed this with the Coroners Court. The Form 83 *Police Report of Death for the Coroner* (**Form 83**) is usually the first written communication from Victoria Police to the Coroners Court, notifying the investigating coroner of a reportable death. The 'Deceased' and 'Next of Kin' details on the Form 83 were left blank by LSC Kelly, on advice of his supervisor, Sgt Knight.²⁸¹ No steps were taken by police after the filing of the Form 83 to assist in formally identifying Simon, nor to notify his family of his suspected death over the following three days.
293. It was only on 19 April 2022 – over three days after Simon's body was discovered, and after staff from the CA&E contacted the Geelong CIU to seek confirmation as to whether Simon's (believed to be) family had been notified of the death – that police took steps to notify Simon's believed to be next of kin.²⁸² SC Wensley and Detective Senior Constable Simon Powley (**DSC Powley**) subsequently attended the family's home and notified Simon's father (in-person) and sister (by phone) of Simon's suspected death, and obtained a DNA sample from Simon's father.²⁸³
294. Sergeant Simonne Corin (**Sgt Corin**) was performing upgraded duties as the Acting Senior Sergeant at Bellarine Police Station at the time and made inquiries with Geelong CIU and LSC Kelly to ascertain what had occurred regarding the apparent miscommunication in responsibility to assist in identifying the deceased and to notify the senior next of kin.²⁸⁴ LSC Kelly indicated that he had been on leave, was awaiting confirmation of identification or further direction from the Court, and that he believed CIU involvement was required.²⁸⁵ Sgt

²⁸¹ Statement of LSC Glenn Kelly, IB p 134.

²⁸² Statement of Senior Constable Mathew Wensley, IB pp 149-50.

²⁸³ Statement of Senior Constable Mathew Wensley, IB p 150.

²⁸⁴ Statement of Sergeant Simonne Corin, IB p 441.

²⁸⁵ Email between LSC Glenn Kelly, SC Mathew Wensley and Sgt Simonne Corin dated 21 April 2022, IB p 447.

Corin confirmed that, as the matter was not deemed suspicious, responsibility for investigation fell within the duties of uniform officers and Bellarine Uniform would have carriage of the investigation.²⁸⁶

295. LSC Kelly explained in his statement that, at the time of completing the Form 83, he did not have any idea who the deceased was, and there was “*nothing in the tent to identify him*”,²⁸⁷ And on the advice of his supervisor Sgt Knight, left the identity of the deceased blank in the Form 83 submitted to the Court.
296. Medication had been found at the scene in Simon’s name at the scene, and this information was documented in the ‘Circumstances’ section of the Form 83. However, Sgt Knight stated that he did not consider this sufficient to confirm the deceased’s identity. He explained that, in his experience, there have been incidents where medications have been found in the possession of persons other than the person it was prescribed.²⁸⁸
297. Sgt Knight stated he believed that Geelong CIU had primacy of the investigation to identify the deceased.²⁸⁹ However, this is inconsistent with the requirements of the VPM ‘Deceased persons’, which provides that a uniform member is responsible for the investigation into a death, unless suspicious circumstances exist,²⁹⁰ and which was confirmed by DLSC Smyth at Inquest.²⁹¹ No suspicious circumstances had been identified by the attending uniform or CIU members in respect of the death, and accordingly primacy of the investigation resided with Bellarine Uniform.
298. I am unable to reconcile the assessment of LSC Kelly and Sgt Knight as outlined in their statements with the evidence of Geelong CIU who were satisfied – based on the evidence at the scene, enquiries of LEAP, and review of BWC footage – that, subject to formal identification processes being conducted on behalf of the Coroner, the deceased was Simon.

²⁸⁶ Email correspondence between SC Wensley and Sgt Corin dated 20 April 2022, IB p 444.

²⁸⁷ Statement of LSC Glenn Kelly, IB p 134.

²⁸⁸ Statement of Sergeant Michael Knight, IB p 140.

²⁸⁹ Statement of Sergeant Michael Knight, IB p 140.

²⁹⁰ VPM ‘Deceased Persons’ updated 19 July 2021, [4.1], IB p 642.

²⁹¹ T-56 line 28 to T-61 line 3.

299. Geelong CIU informed Sgt Knight of their findings upon returning to the scene on the afternoon of 15 April 2022,²⁹² and understood Bellarine Uniform would compile reports for the coroner and undertake investigation including notification of next of kin,²⁹³ consistent with the requirements of the VPM ‘Deceased persons’.
300. Contemporaneous notes corroborate Geelong CIU’s assessment. Notably:
- (a) Sgt Knight’s ePDR documents the details of the deceased person as Simon.²⁹⁴
 - (b) Constable Amanda Sheedy noted in the ePDR for Bellarine 302 record that “*Deceased possibly Simon GASKILL*”.²⁹⁵
 - (c) attending members of Bellarine Uniform – SC Basten, DSC Fox and SC Wensley – documented in their daybook notes that while the deceased was unable to be identified visually, investigators had located medication at the scene prescribed to Simon and review of BWC from recent police involvement depicted Simon wearing the same clothing as the deceased.²⁹⁶
 - (d) the Incident Fact Sheet (IFS) report completed by Sgt Knight at 6.12pm on 15 April 2022 documented that “*Medications located at the site indicated his identity as Simon GASKILL. Yet to be confirmed but highly likely.*”²⁹⁷ At 8.51pm, Sgt Knight made a further notation on the IFS that “*Coroner located bank card in the name of Simon GASKILL located on the body*”.²⁹⁸
301. Simon’s body was not suitable for visual identification due to the level of decomposition of his body upon discovery. However, there was sufficient circumstantial evidence available at the scene to indicate it was reasonably likely the deceased was Simon, noting that:
- (a) investigators had located prescription medication in Simon’s name at the scene;²⁹⁹

²⁹² Statement of DLSC Benjamin Fox, IB p 146; First Statement of DSC Mitchell Hardisty, IB p 168; Supplementary Statement of DSC Mitchell Hardisty, IB p 169.

²⁹³ Statement of DLSC Benjamin Fox, IB p 146; First Statement of DSC Mitchell Hardisty, IB p 168; Supplementary Statement of DSC Mitchell Hardisty, IB p 169.

²⁹⁴ ePDR of Bellarine 252 (Sgt Knight), IB p 467.

²⁹⁵ ePDR of Bellarine 302 (Constable Sheedy and SC Paltridge), IB p 477.

²⁹⁶ Notes of SC Regina Basten dated 15 April 2022, IB p 489; Notes of DSC Benjamin Fox dated 15 April 2022, IB p 493; Notes of SC Mathew Wensley dated 15 April 2022, IB p 494.

²⁹⁷ Incident Report VP-2022-011870 dated 15 April 2022, IB p 503.

²⁹⁸ Incident Report VP-2022-011870 dated 15 April 2022, IB p 505; Evidence of DLSC Smyth, T-73, lines 1-31

²⁹⁹ Statement of Liz McKiterick, St Johns Ambulance Transport Officer, IB p 211.

- (b) other items belonging to Simon, including his laptop and personal paperwork and a bank card were at the scene and subsequently transported with Simon's body to VIFM, and could have been interrogated to assist in his identification;
 - (c) investigators confirmed distinctive clothing worn by the deceased matched that worn by Simon in an encounter with police recorded on BWC four months earlier; and
 - (d) there was no evidence to indicate the deceased was anyone other than Simon.
302. Remarkably, evidence also emerged during Inquest that Simon's birth certificate was also in a folder of documents that were with his body at the time his body was recovered and returned to Amanda via the funeral director. DLSC Smyth confirmed his understanding of this,³⁰⁰ although attending members made no record or mention of the same.
303. The Final Investigation Report found, and I agree, that LSC Kelly should have undertaken certain steps as part of his investigation into Simon's death, including notification in person to the person believed to be next of kin as a matter of urgency and formal identification of the deceased via fingerprints and/or a DNA sample from the next of kin.³⁰¹ The wealth of circumstantial information located at the scene pointed clearly to the identity of the deceased likely being Simon, and urgent steps should have been taken on 15 April 2022 to notify his family of his suspected death and to take steps to arrange for formal identification of his body.³⁰² It ought not to have been left to CA&E to follow up with police some days after the report of death to confirm if family had been informed of the death.
304. I acknowledge that LSC Kelly, along with other uniform officers who attended the incident and assisted in recovering Simon's body on 15 April 2022, was on leave for the two days immediately following the incident.³⁰³ However, the roster for the fortnight commencing 10 April 2022 confirms that Sgt Knight was rostered for work on each of the three subsequent days of 16, 17 and 18 April 2022.³⁰⁴ As noted in the Supplementary Investigation Report, as LSC Kelly's direct supervisor, Sgt Knight was responsible for ensuring that LSC Kelly's

³⁰⁰ Evidence of DLSC Smyth, T-169 line 31 to T-170 line 9.

³⁰¹ Final Investigation Report, IB p 850.

³⁰² Final Investigation Report, IB p 850.

³⁰³ Email between LSC Glenn Kelly, SC Mathew Wensley and Sgt Simonne Corin dated 21 April 2022, IB p 447.

³⁰⁴ Victoria Police Professional Standards Command, Supplementary Investigation Report, IB p 862.

investigation was completed to a satisfactory standard.³⁰⁵ It remains unclear to me why Sgt Knight did not take any further steps over the weekend to progress the investigation to confirm Simon's identity during LSC Kelly's absence to ensure the next of kin was notified as a matter of urgency as required under Victoria Police policy. Had it not been for CA&E's intervention, the delay in notification may have extended further, causing additional distress to Simon's family.

305. I find there was no proper basis to delay notification to Simon's family of his suspected death, nor to progress requesting a sample for DNA profiling to confirm same. Indeed, it is striking that no additional evidence or information came to light concerning Simon's identity between the time CA&E informed Sgt Knight on the evening of 15 April 2022 that they had located a bank card in Simon's name, and when Geelong CIU ultimately delivered the death message to Simon's family on 19 April 2022 and obtained a DNA sample from Simon's father.
306. The VPM 'Deceased persons' provides that, where identification is not made or is not likely to be made within three days, CIU members are to take over the investigation.³⁰⁶
307. DLSC Smyth opined at Inquest that this is too long a period of time for a deceased person to remain unidentified, for two reasons. Firstly, if suspicious circumstances arise, such a time frame may impact any ensuing criminal investigation. Secondly, it is also too long a time for loved ones to find out their relative has died – *'if it was my relative that was deceased, I wouldn't want to be waiting 72 hours to find out, if it can be done earlier'*. Family should have been notified on the day Simon's body was discovered, as a matter of basic dignity for family to know that a person believed to be their loved one had passed away. Further, this is an important investigative step as family may have critical information that may assist in confirming the identity of the deceased, and in respect of the circumstances in which the death occurred.
308. To address these issues, DLSC Smyth opined that detectives (i.e. the Criminal Investigation Unit) should be consulted if someone cannot be identified by the end of the reporting member's shift, or at least within 24 hours.³⁰⁷

³⁰⁵ Victoria Police Professional Standards Command, Supplementary Investigation Report, IB p 862.

³⁰⁶ VPM 'Deceased persons' updated 19 July 2021, [7.3], IB p 654.

³⁰⁷ T-63 lines 4-16 and T-175 line 9 to T-176 line 2.

309. I acknowledge that police members may have limited familiarity with coronial processes as they may only infrequently be tasked with reporting a death to the Coroner or assigned as Coronial Investigator. In many of these cases, identity is clear and can be verified at the scene or shortly thereafter by someone known to the deceased through a statement of visual identification. Only a small proportion of deaths reported to the Coroner will involve the death of a person with unconfirmed identity, requiring DNA analysis or fingerprint or dental comparison. In these circumstances, it is understandable an individual police member may not immediately be familiar with the relevant procedures to be followed. However, I consider the VPM ‘Deceased persons’, which is easily accessible to members, ought to be adverted to as a source of guidance.
310. This characterisation of the VPM is consistent with the view expounded by DLSC Smyth at Inquest, who stated of the VPM *‘it’s not something that you’d read regularly, but it is a source that if you’re unsure of something that’s where you would go. You should know - if you don’t know, you should know where to look’*.³⁰⁸
311. Further, the process of a police members obtaining DNA from a ‘believed to be’ family member of a person who has died will necessarily likely involve delivering a ‘death message’ to that family member, conditional upon the person being positively identified as a family member of the deceased through forensic testing. Such a message cannot be delayed because a deceased person not yet been formally identified as it would otherwise lead to an impasse where the family could not be notified of the death of their loved one without formal identification, but where DNA (or other information from family such as details of the deceased’s dentist) may be required from the family member in order to confirm the deceased’s identity. Where family DNA is required to formally establish identity, contact with family (and the taking of a DNA sample) must occur as a precondition to establishing identity, so family contact evidently cannot be delayed because someone has yet to be formally identified.³⁰⁹
312. Therefore, while the current VPM provides guidance to members on their responsibilities in assisting in identification of the deceased and notification to next of kin, given the difficulties

³⁰⁸ T-54 lines 8-12.

³⁰⁹ This sits in contrast with the submissions of the CCP on this issue, which appear to misunderstand the process by which DNA identification occurs, and which I do not accept – see para 22 of CCP Costs Submissions.

that may attend on such processes, and the deficiencies identified in this matter and in others before me, I will make a recommendation to the Chief Commissioner of Victoria Police, in consultation with the Coroners Court of Victoria and the Coronial Admissions and Enquiries Office, to review relevant guidance provided to police members on identifying and notifying next of kin where identity cannot be confirmed at the scene (or shortly thereafter) to determine whether there is scope to improve processes or guidance material to reduce the risk of a similar event occurring in the future.

Failure to retain property for the coronial investigation

313. The VPM ‘Deceased Persons’ provides clear direction to police members requiring the collection of evidence from the scene, and retention and recording of the deceased’s property. At the time of these events, the policy relevantly provided that:

- (a) unless the coroner directs otherwise, the duty patrol supervisor must ensure that evidence is collected from the scene as soon as possible.³¹⁰
- (b) property may be seized or taken into possession at the scene where an attending member determines it is relevant to the death, or if there is no relative or next of kin at a death scene, and should be recorded and handled as an exhibit.³¹¹
- (c) where police are not escorting the body (as occurred here), the attending member must ensure that any property is removed from the body, or record full details of any property conveyed with the body if the property cannot be removed.³¹²
- (d) when returning property in relation to deceased persons, police members are instructed to follow the guidance set out in the VPM Property and exhibit management and VPM ‘Seized property and special property types’.³¹³

314. On examination of the scene, attending police observed personal belongings which had potential evidentiary value for the coronial investigation, including Simon’s laptop, prescribed medication, a bank card, and paperwork in Simon’s name. These exhibits were of key importance to the investigation, and informed inquiries later undertaken by DLSC Smyth

³¹⁰ VPM ‘Deceased Persons’ updated 19 July 2021, IB p 656, [10.1].

³¹¹ VPM ‘Deceased Persons’ updated 19 July 2021, IB p 657, [12.1]

³¹² VPM ‘Deceased Persons’ updated 19 July 2021, IB p 657, [11].

³¹³ VPM ‘Deceased Persons’ updated 19 July 2021, IB p 657, [11].

to assist in establishing the timeline of events leading up to Simon's death. Some items found at the scene, such as the notebook, were never retained or recovered for the investigation.

315. Despite the clear requirements of the VPM, the attending members did not take these items into their possession, nor properly record or document the property which was conveyed with the body to CA&E.³¹⁴ As noted by D/Sgt Tink in the Final Investigation Report, the steps expected to be undertaken by police members as part of their investigation of a reportable death include examination of any personal belongings and/or exhibits which may afford evidence, and appropriate exhibit handling to provide continuity of exhibits.³¹⁵ As relevant exhibits were not seized by police at the scene, this compromised the chain of custody and continuity of the investigation with respect to exhibits.
316. It is fortuitous that, after the property was released to Amanda via the funeral director, she kept this property. Had Amanda not retained the property, many of the lines of inquiry – including examination of the laptop, Myki and bank records – subsequently undertaken as part of DLSC Smyth's investigation would not have been possible. This would have had serious consequences for the investigation and represents a significant failing in the initial investigation. Moreover, while family members often hold key information in relation to a loved one who has died, they ought never to be in the position of retaining and providing police with key exhibits that police members have failed to gather in the initial stages of the investigation. This undermines confidence in the ensuing proceedings.

Destruction of Simon's phone

317. Simon's phone came into the custody of Victoria Police on 25 March 2022, three weeks before his body was found and his death being reported to the Court on 15 April 2022.
318. LSC McCarty initially had carriage of the phone when it was handed in to Bellarine Police Station. He took appropriate steps to identify the owner of the phone in accordance with Victoria Police policy and arranged for details of the phone and Simon's details to be logged into the Victoria Police property management system PALM.³¹⁶

³¹⁴ The Custody of Transfer Form appears to have been completed by a Transport Officer of St John Ambulance, which provides transport services to the Coroners Court of Victoria for the transport of deceased persons.

³¹⁵ Final Investigation Report, IB p 850.

³¹⁶ Statement of FC Mitch Lay, IB p 114; Statement of LSC Simon McCarty, IB p 117; PaLM Notes regarding the mobile phone of Simon Gaskill, IB p 517; VPMG 'Lost property reports' updated 21 October 2019, IB p 602, VPM

319. It does not appear LSC Kelly was aware the phone was in possession of police at the time of his initial report of and investigations into Simon's death. Nor does it appear any inquiries were undertaken on PALM to ascertain whether police had any property belonging to Simon.
320. On 14 September 2022, LSC McCarty was contacted by property administration staff seeking an update on the status of the phone. It was noted Simon was now deceased, and it was queried whether there was a next of kin to contact or if the phone could be destroyed.³¹⁷
321. On 20 September 2022, LSC McCarty completed a property disposal form requesting the mobile phone and charger be destroyed. LSC McCarty included comments on the form that:
- “Simon GASKILL who is now deceased, there is no NOK. He has some siblings but they both had IVO's against him with no contact. The phone can be destroyed”.*³¹⁸
322. In seeking a disposal order, LSC McCarty checked the box for *“The item(s) has no known owner and are no longer required as exhibits. They are no longer required and can be disposed as per station procedures”* and included *“REASON: DECEASED – NO NOK”*.³¹⁹
323. On 20 September 2022, Senior Sergeant Stanton approved the destruction of the phone, which was destroyed the following day.³²⁰
324. At the time LSC McCarty sought approval for disposal of the phone, he stated he was unaware of the circumstances of Simon's death or that his death had been subject of a coronial investigation.³²¹ No coronial investigation was on foot at this time as it had been finalised two months prior. In these circumstances, there was no impediment to police disposing of the property in accordance with their usual processes and procedures.
325. However, it is concerning that, in seeking destruction of the phone, it was incorrectly stated that there was no next of kin.³²² There was a next of kin – being Simon's father Christopher

'Seized property and special property types' updated 25 January 2022, [2.3], IB p 609, VPM 'Property and exhibit management' updated 21 July 2021, [2], IB p 626.

³¹⁷ PaLM Notes regarding the mobile phone of Simon Gaskill, IB p 519.

³¹⁸ Statement of LSC Simon McCarty, IB p 117; Seized Property Disposal Form signed 20 September 2022, IB p 521.

³¹⁹ Seized Property Disposal Form signed 20 September 2022, IB p 521. For clarity, I note that the acronym 'NOK' is shorthand for 'next of kin', which differs slightly to the formulation used in the Coroners Act, 'senior next of kin'.

³²⁰ Statement of LSC Simon McCarty, IB p 117.

³²¹ Statement of LSC Simon McCarty, IB p 118.

³²² Evidence of DLSC Smyth, T-111, lines 7-11.

– for whom there was no intervention order in place. Further, notwithstanding the existence of the intervention order in place with Amanda, this did not prevent enquiries whether Amanda wished the phone to be returned to her. DLSC Smyth gave evidence that it was “*totally inappropriate*” for the phone to be destroyed on the basis that an intervention order being in place.³²³

326. The VPM ‘Property and exhibit management’ provides direction and support to employees in relation to management of property in police possession.³²⁴ Property in the possession of police is required to be recorded, handled, stored, audited and disposed of in a manner to ensure safekeeping and compliance with legislative requirements.³²⁵ Relevantly, employees are required to appropriately record property in the Victoria Police property management system PALM, including a full description of the property/exhibit, record any investigations made to locate an owner or return an item, and retain any disposal authorising paperwork.³²⁶
327. Section 5 of the VPM ‘Property and exhibit management’ provides that where the owner of property in police investigation is unknown or in doubt, an employee must be nominated to locate the rightful owner and take any follow-up action. The investigator must conduct LEAP property checks and exhaust all avenues of enquiry in order to identify the rightful owner, and record these inquiries within the PALM file.³²⁷ If no owner is located, the property may be treated as unclaimed once the period of retention has expired (one month for found property).³²⁸ Unclaimed mobile phones and digital devices are required to be submitted for disposal within PALM and approved by a work unit manager before disposal.³²⁹
328. The Bellarine Police Station did not have any station-specific procedures for the disposal of property relating to a coronial investigation, relying upon the VPM ‘Deceased persons’ which applies to the return of property in relation to deceased persons.³³⁰ However, the advice outlined in that policy concerns the seizure, storage and disposal of exhibits seized in relation

³²³ Evidence of DLSC Smyth, T-109, lines 9-23.

³²⁴ VPM ‘Property and exhibit management’ updated 21 July 2021, IB p 623.

³²⁵ VPM ‘Property and exhibit management’ updated 21 July 2021, IB p 623.

³²⁶ VPM ‘Property and exhibit management’ updated 21 July 2021, IB p 626.

³²⁷ VPM ‘Property and exhibit management’ updated 21 July 2021, [5.1], IB pp 630-1.

³²⁸ VPM ‘Property and exhibit management’ updated 21 July 2021, [5.2], IB p 631; [6.6], IB p 633.

³²⁹ VPM ‘Lost property reports updated 12 September 2023, [7.3], IB p 792.

³³⁰ VPM ‘Property and exhibit management’ updated 21 July 2021, p6.4[, IB p 632.

to a coronial investigation,³³¹ and does not provide clear guidance on the steps to be taken by members where deceased property comes into the possession of police prior to a coronial investigation, but which may have relevance to or bearing on the conduct of that investigation and/or where the deceased's next of kin may have an interest in the property but are unaware of its existence.

329. In the circumstances, I consider police members may benefit from further guidance to clarify expectations on the management of a deceased person's property where the death is under investigation by the Coroner. I have made a pertinent recommendation to address this issue.

Failure to disclose critical information to the Coroner about proximate police contact

330. A key and gravely concerning issue that arose in the investigation was the failure of the attending police members to disclose pertinent information to the Coroner about the proximate contact police had with Simon on 25 March 2022. This was vital information necessary to enable a proper evaluation to be undertaken as to whether the death ought to be classified at the time of its initial report as a 'police contact death'.³³²
331. The Form 83 did not include any information about when Simon had last been sighted alive, nor was there any reference to recent police contact with Simon in the weeks immediately before he was located deceased. Further, when the First Coronial Brief was filed with the Court, the summary made no mention of Simon's interaction with police on 25 March 2022, nor that Simon's phone had been handed to police later that day and had been in the possession of police from that time until subsequently destroyed in September 2022.
332. The summary detailed that analysis of Simon's call charge records showed "*this phone number was connected and in use at the time [Simon] was located deceased*" and that the mobile phone had been used by the "*accused*" up until 6:31am on 4 April 2022.³³³ It further stated that "*From that time all phone activity was incoming which would indicate [Simon] did not use data, make an outgoing phone call or message from that date and time*".³³⁴ This

³³¹ VPM 'Deceased persons' updated 19 July 2021, [12.2], IB p 658.

³³² Defined under Practice Direction 3 of 2021 as including '*circumstances where a Police Officer's conduct immediately preceding the death* requires further investigation by the coroner under the Act (as determined by the investigating coroner).

³³³ First Coronial Brief, Summary of Coronial Investigator, [20-21]. 'The accused' is a term used in criminal briefs of evidence to describe a person charged with ('accused of') a criminal offence and was an unfortunate choice of language.

³³⁴ First Coronial Brief, Summary of Coronial Investigator, [21].

information was patently incorrect, given the phone had been in the possession of Victoria Police since 25 March 2022.

333. The existence of details regarding the police interaction with Simon on 25 March 2022 (and the earlier contact on 18 February 2022) were readily identifiable through a search of Victoria Police NEO Intelligence Management system (**NEO system**), which validates data from across multiple data sources, including LEAP, Interpose, ePDRs, Traffic Incident System, Second Hand Dealers Registration and VicRoads information.³³⁵ Both contacts were registered on the relevant ePDRs of the attending members. In these circumstances it is inexplicable why the contact with Simon on 25 March 2022 was not reported to the Coroner in the initial stages of the investigation, though at Inquest, DLSC Smyth could not say for sure which members have access to the NEO system, which may explain in part why the information received by the Court was not comprehensive in nature until he took carriage of the coronial investigator.³³⁶
334. As part of the investigations conducted by DLSC Smyth in preparation of the Second Coronial Brief, and at my direction, enquiries were made with DSC Hardisty seeking to address the issue of why the police contact on 25 March 2022 was not included in the First Coronial Brief or otherwise notified to the Court. DSC Hardisty did not provide any detailed explanation but acknowledged simply that this was “*A failure on my part*”.³³⁷ Suffice to say, I found this to be a disappointing response, which failed to illuminate the reasons why this police contact was not identified or disclosed to the Court, as might be expected in accordance with the obligations he then had under s 36 of the Coroners Act.³³⁸
335. The failure to identify and disclose the proximate police contact with Simon (and subsequent receipt of Simon’s phone), either in the Form 83 or in the First Coronial Brief, meant that the first time the Court became aware of this incident and the fact this was a potential ‘police

³³⁵ This search was undertaken by DLSC Smyth in the days immediately after he was appointed Coronial Investigator in late August 2024. The search identified the two police contacts with Simon on 18 February 2022 and 25 March 2022. First Statement of Detective Acting Sergeant Leigh Smyth, IB pp 189-190.

³³⁶ Evidence of DLSC Smyth, T-176 line 18 to T-177 line 16.

³³⁷ First Statement of D/A/Sgt Leigh Smyth, IB p 200; Appendix X: Email chain between D/A/Sgt Leigh Smyth and LSC Mitchell Hardisty, IB p 431.

³³⁸ S 36 Coroners Act requires ‘*A police officer who has information that may be relevant to an investigation by a coroner into a death or a fire must give that information to the coroner to assist the coroner in his or her investigation of the death or the fire*’. I emphasise however that there is no evidence that DSC Hardisty deliberately misled the Court by failing to produce the information about the recent police conduct.

contact death'³³⁹ was in August 2024, over two years after Simon's death. This had significant consequences for the trajectory of the investigation and led to the loss of evidence concerning the interaction due to the passage of time.

336. It is critical that the Coroner is provided a precis of all relevant facts and circumstances surrounding the death at the earliest opportunity so that appropriate directions can be made as to the relevant investigative steps which may need to be undertaken and to ensure any relevant evidence is preserved. Consistent with this requirement, section 36 of the Act mandates that a police officer who has information that may be relevant to an investigation by a coroner into a death must give that information to the coroner to assist the coroner in his or her investigation of the death. This places an obligation on police officers to proactively provide any information they hold that may be relevant to an investigation to the coroner.
337. As is clear from my investigation, uniform police members at Bellarine Police Station had information that ought reasonably to have been considered relevant to the investigation of Simon's death and which ought to have been provided to the Coroner, including that:
- (a) a Bellarine divisional van had attended an incident involving Simon on 25 March 2022, a few weeks prior to his body being discovered (and likely very close in time to when he died).
 - (b) the Bellarine divisional van dropped Simon at a campground in the vicinity of where he was subsequently found deceased.
 - (c) Simon's phone had been handed in to Bellarine Police Station later on 25 March 2022 and remained in the possession of Victoria Police when his body was found.
338. The failure to inform the Coroner of this information was a significant one. As noted by D/Sgt Tink in the Final Investigation Report:

“If the contact with Police on 25th of March 2022, and the existence of the mobile phone had been discovered following the location of [Simon] on the 15th of April 2022, it would have afforded timely answers for the family and not led to

³³⁹ Defined under Practice Direction 3 of 2021 as including 'circumstances where a Police Officer's conduct immediately preceding the death requires further investigation by the coroner under the Act (as determined by the investigating coroner).

*speculation concerning suspiciousness of his final movements and the possible use of his mobile phone post-death”.*³⁴⁰

339. I agree with this assessment.
340. Steps ought to have been taken by investigating officers at the time Simon’s body was located and reported to police to ascertain who last saw him alive and to report any recent police contact with Simon and to report this to the Coroner, particularly in circumstances where it was apparent Simon had been deceased for some time, and it was not readily apparent when Simon had last been sighted alive.
341. Since these events, the Form 83 has been amended and now specifically requires members to specify whether the death occurred in ‘recent police contact’.
342. Further, information sharing arrangements between Victoria Police and the Coroners Court have recently been strengthened to facilitate early identification and notification of any incident involving a suspected police contact death. This process ensures that an investigating coroner is provided with all relevant facts and circumstances surrounding a death in a timely manner, to enable evaluations in respect of whether a matter is to be classified as a ‘police contact death’, and to facilitate the early identification and securing of evidence. I commend this initiative, which in my experience has already assisted in ensuring the Court is notified at an early stage when a death may involve proximate police contact, with appropriate and valuable information being provided by Victoria Police at a very early stage of the investigation.
343. However, it is unclear whether such notification would have been made in this case, in circumstances where the proximate police contact was not identified or reported by investigating officers in a timely manner after the death. I consider there is scope to amend existing policies for the investigation of reportable deaths to expressly require investigating members to conduct checks of relevant police databases (including the Victoria Police NEO Intelligence Management database) to ascertain whether there has been police contact proximate to death, and to include this information in the Form 83.

³⁴⁰ Final Investigation Report, IB p 858.

344. Such a requirement could mirror the existing requirement under the VPM ‘Deceased Persons’ for officers to conduct a search of the Traffic Incident System (TIS) database to check for recent involvement of the deceased in a vehicle collision within the preceding 30 days and for notifications to be made to relevant authorities where necessary.³⁴¹
345. I consider that officers should also undertake searches of police databases for any recent police contact with the deceased to ensure the Coroner is apprised of any proximate police contact and so that, where relevant, the Coroner can make directions for further investigative steps and preservation of relevant evidence as may be required for the investigation. I have made a pertinent recommendation accordingly.

Failure to conduct appropriate enquiries to establish the circumstances of Simon’s death

346. The Final Investigation Report identified inadequacies in the investigations undertaken by LSC Kelly and DSC Hardisty in relation to Simon’s death.
347. D/Sgt Tink found that LSC Kelly ought to have taken steps to:
- (a) establish a timeline prior to death;
 - (b) attempt to establish the last person to see the deceased alive;
 - (c) examine any personal belongings and/or exhibits which may afford evidence;
 - (d) appropriately handle exhibits to provide continuity of exhibits; and
 - (e) notify his supervisor and/or the CIU if any suspiciousness or complexity was identified.³⁴²
348. In the Supplementary Investigation Report, D/S/Sgt Bingham noted that Sgt Knight was the supervisor responsible for ensuring LSC Kelly’s investigation was completed to a satisfactory standard. He formed the opinion that Sgt Knight failed to adequately supervise LSC Kelly during the initial investigation to ensure the above steps were completed. He considered that but for these deficiencies, the need for subsequent investigations, multiple coronial reviews

³⁴¹ VPM Deceased Persons updated 19 July 2021, [3.3], [4.2], IB pp 641-3; VPM Deceased Persons updated 24 December 2024, [3.5], [4.3], IB pp 817-8.

³⁴² Final Investigation Report, IB p 850.

and the associated exasperation and embarrassment caused could have largely been avoided.³⁴³

349. Neither Sgt Knight nor LSC Kelly had an opportunity to respond to the criticisms levelled against him in respect of his supervision of LSC Kelly, having retired from the police force. As acknowledged by D/S/Sgt Bingham this has meant it was not possible to provide any objective assessment of the supervision of LSC Kelly throughout the investigation.³⁴⁴
350. D/Sgt Tink also opined that it was not appropriate for DSC Hardisty to be appointed the coronial investigator when the coronial investigation was reopened given he had been involved in the initial attendance at the scene. D/Sgt Tink observed that this influenced the thoroughness of the investigation undertaken by DSC Hardisty.³⁴⁵ He opined that, given the issues with the brief ultimately prepared by DSC Hardisty, a more independent choice of coronial investigator may have paved the way for an objective perspective on the investigation, free from any potential cognitive biases or perceived conflict that may have arisen as a result of being involved in the initial attendance at the scene.
351. DLSC Smyth took another position on this issue at Inquest. He gave evidence that, in his view *'[i]t was natural that someone at Geelong would be tasked with that and natural that someone who actually attended the scene would be tasked'*.³⁴⁶ I consider there is merit to this position.
352. In my experience, in the absence of an established conflict or circumstances of certain 'police contact' deaths, an officer who has attended the scene of a reported death, has a significant forensic advantage in the investigation of a death as generally, they will have directly observed the deceased *in situ*, observed relevant evidence at the scene that sheds light on the cause and circumstances of the death, and may have observed or spoken to key witnesses at the scene. The value of a 'site view' to enhancing an investigator's understanding of relevant events is well known to coroners, and for this reason, it is expected that the State Coroner or Duty Coroner will attend the scene of certain deaths.³⁴⁷ Regardless of the assignment of the

³⁴³ Supplementary Investigation Report, IB p 862.

³⁴⁴ Supplementary Investigation Report, IB p 862.

³⁴⁵ Final Investigation Report, IB p 849.

³⁴⁶ T-120 lines 28-29.

³⁴⁷ Coroners Court of Victoria, Practice Direction 6 of 2020 - Aboriginal Passings in Custody, updated May 2024 [3.1].

police investigator, I would expect an independent, objective and thorough investigation to be conducted, in accordance with the VPMs and directions of the investigating coroner when a full brief of evidence is requested.

353. In these circumstances, I do not criticise the decision to appoint a member of the Geelong CIU to investigate Simon’s death when the investigation was reopened. Had the proximate police contact with uniform members of Bellarine Police Station been known at the time the investigation was reopened, it may have been considered preferable for an officer without any connection to, or involvement in the initial investigation to have been appointed the coronial investigator. However, this is a matter of speculation, and I note the relevant members involved in the police contact were from the uniform section of Bellarine Police Station, and not the Geelong Crime Investigation Unit.
354. In respect of the preparation of the First Coronial Brief, D/Sgt Tink considered DSC Hardisty ought to have:
- (a) identified that police had been in contact with Simon on 25 March 2022 and transported him to another location.
 - (b) identified relevant ePDR, 000 call, radio communications and police and other witness accounts of the incident on 25 March 2022.
 - (c) identified police had possession of Simon’s mobile phone at Bellarine Police Station since 25 March 2022.
 - (d) correctly analysed the phone records and ensured correct information was provided about Simon’s phone records and phone usage;
 - (e) attempted to contact any relevant witnesses via Simon’s phone records; and
 - (f) thoroughly analysed Simon’s laptop computer as relevant to the circumstances of Simon’s death.³⁴⁸
355. D/Sgt Tink noted that these investigative failures *“had a significant ripple effect on the interpretation of the circumstances relating to the death of Simon GASKILL, and certainly*

³⁴⁸ Final Investigation Report, IB pp 850-851.

*from the family's perspective provided little answers and increased the speculation that his death may have had a suspicious aspect".*³⁴⁹

356. D/S/Sgt Bingham also reviewed the supervision provided to DSC Hardisty in preparation of the First Coronial Brief. As DSC Hardisty's supervisor, D/Sgt Radley was DSC Hardisty's supervisor and was responsible for checking the coronial brief and ensuring the investigation was completed to a satisfactory standard.
357. D/Sgt Radley participated in the internal review and provided – to the best of his recollection – information about his supervision of DSC Hardisty in preparation of the coronial brief, and his review of the coronial brief. He recalled checking the coronial brief, including the statement of Cameron Miller, and was satisfied that he was the most likely person to have seen Simon alive. He formed the assessment at the time that a person living alone in the sand dunes was unlikely to have had much contact with family or friends. He was unaware at the time that Simon's mobile phone was in police possession.
358. D/S/Sgt Bingham concluded that D/Sgt Radley was the "*unfortunate final link*" in a chain of investigative failings, and was presented with and relied upon evidence provided by DSC Hardisty which subsequently proved to be unreliable. D/S/Sgt Bingham considered that – short of reinvestigating the matter – there was no other way to satisfy himself of the thoroughness of the inquiries undertaken. D/S/Sgt Bingham concluded D/Sgt Radley did not fail in his duty to adequately supervise DSC Hardisty.³⁵⁰
359. With the exception of the issue noted above as to the allocation of DSC Hardisty as the coronial investigator, I acknowledge and accept D/Sgt Tink's conclusions.

Conclusions regarding police investigation

360. There were significant deficiencies in the initial investigation of Simon's death. These investigative failings compromised the investigation and caused additional distress for Simon's family who understandably sought to understand the circumstances in which their loved one died.

³⁴⁹ Final Investigation Report, IB p 851.

³⁵⁰ Supplementary Investigation Report, IB p 863.

361. The distress was compounded by the approach of initial investigator DSC Hardisty who was described by Amanda as dismissive, arrogant and discourteous in his communications with the family, and reportedly left Amanda in the foyer of the police station on two occasions on the same day, waiting for an appointment that DSC Hardisty requested in relation to matters related to Simon's laptop and then failed to attend in a timely way.³⁵¹ While I do not have DSC Hardisty's version of events in relation to these interactions, and make no findings as to the specifics thereof, I consider that the evidence before me as a whole is sufficient to establish that DSC Hardisty's overall approach led to Simon's family feeling alienated, dismissed and disempowered, and deeply lacking faith in the approach of police investigators.
362. This resulted in a protracted investigation, with significant resource burdens being incurred by Victoria Police and the Court in reviewing and reconstructing relevant events in circumstances where incorrect or incomplete information had been provided to the Court in the First Coronial Brief. These issues may have been avoided had a comprehensive investigation been undertaken at the outset to confirm the identity of the deceased, and the circumstances in which the death occurred, including when Simon was last sighted alive, a proposition with which DLSC Smyth agreed at Inquest.³⁵²
363. It remains that there is scope for further training and guidance to support police members undertaking the role of coronial investigator, which I have outlined in this finding.³⁵³
364. To be clear, the criticisms of police members in this finding do not extend to D/Sgt Tink or DLSC Smyth, who were of great assistance to the Court in identifying the gaps in the initial police investigation. They worked diligently to address those deficiencies in a thorough and timely manner in order to give comprehensive answers to Simon's family and to assist the Court in the exercise of its functions. I acknowledge and commend their efforts – and particularly that of DLSC Smyth – in ensuring all relevant evidence has been bought before the Court.

³⁵¹ Evidence of Amanda Gaskill, T-43 and T-44. The reason for discussing the contents of the laptop appeared to be due to the purported existence of material on the laptop that was unrelated to the coronial investigation and which I do not consider to be fruitful to be detailed in my finding, despite the otherwise valuable evidence on this at the inquest.

³⁵² Evidence of DLSC Smyth, T-170, lines 10-19.

³⁵³ T-178 lines 16-23, in which DLSC Smyth also noted that a training package for police members on being a coronial investigator, such as in the form of a pre-recorded video, could also be of great assistance to police members undertaking a role that might be less familiar to them than other everyday duties.

365. I further acknowledge the robust and comprehensive internal review conducted by Victoria Police in response to the family's concerns. The reviews undertaken by D/Sgt Tink and D/S/Sgt Bingham were of great benefit in narrowing the issues for examination at inquest and streamlined the process of making findings. I acknowledge the difficulties inherent in scrutinising the conduct of other police officers and colleagues. Nonetheless, I considered the reports were conducted with frank candour, and appear to have presented all relevant facts to assist the investigation.
366. Together with the evidence provided by DLSC Smyth by way of the Inquest Brief and, critically, at the Inquest itself, these reports assisted me greatly in the discharge of my statutory functions and, for Simon's family, appeared to restore a kernel of faith in a process that had been hitherto plagued by failures, delays, and misinformation.

FINDINGS AND CONCLUSIONS

367. Having investigated the death of Simon Christopher Gaskill, and having held an inquest in relation to Simon Christopher Gaskill's death on 23 and 24 February 2026, I make the following findings pursuant to section 67(1) of the Coroners Act:
- (a) the identity of the deceased was Simon Christopher Gaskill, born 2 September 1971;
 - (b) Simon died at Ocean Grove Beach, Ocean Grove, Victoria on or between 27 March 2022 and 29 March 2022 from unascertained causes;
 - (c) Simon died in the circumstances described in this Finding at paragraphs [151] to [160] above.
368. Taking into account all available evidence, and having considered all the circumstances, I find that Simon's death occurred in the context of an extended history of excessive alcohol consumption, although the precise cause of his death cannot be determined due to the state of his body when he was discovered some two to three weeks after his death. Despite the 'unascertained' cause of death, I am satisfied that forensic pathologist Dr Judith Fronczek (**Dr Fronczek**) and her colleagues at the Victorian Institute of Forensic Medicine conducted a thorough forensic medical investigation in which no stone was left unturned.
369. I further find that, while Dr Fronczek could not rule out a traumatic cause of death, there was no evidence of injury that would have caused death (albeit due to limitations on the usual types of investigations that are able to be conducted in the absence of decomposition) nor of third-party involvement or suspicious circumstances. I note that there were no acute bony injuries detected on CT scan and nothing else on the available evidence to suggest suspicious circumstances. However, and while it is unlikely, I cannot conclusively determine the absence of suspicious circumstances, given the state of decomposition in which Simon's body was found, and given that little is known about the days immediately before Simon's death.
370. I am satisfied, after the rigorous investigation conducted by DLSC Smyth, that Victoria Police, at my direction, has exhausted all reasonable lines of enquiry and further investigations are unlikely to materially shift the state of evidence regarding medical cause of death or circumstances in which Simon's death occurred. Despite the Herculean efforts of DLSC Smyth, certain questions regarding Simon's death may never be able to be answered.

371. However, some key questions about the lead-up to Simon’s death have now been answered via DLSC Smyth’s and other police members’ subsequent investigative efforts. I can now find, and so find, that:
- (a) Simon’s death followed recent contact with police in the early hours of 25 March 2022. This contact was not reported to the Coroner until over two years after Simon’s death, an issue which I have commented upon elsewhere in this finding with utmost concern;
 - (b) Simon was reported to have been seen by two persons on a bus on 25 March 2022, some hours after his contact with police, at which time he was reported to appear relatively well; and
 - (c) while Simon’s death occurred temporally proximate to and following police contact, there is no evidence that this contact had any direct causal connection to, or bearing on, his death some days later.
372. I am unable to say whether Simon’s death could have been prevented where the cause is unknown. However, Simon’s issues with alcohol were pervasive and longstanding, and he went through periods of rehabilitation and abstinence, along with periods of excessive alcohol use that resulted in long-term health issues that were not fully investigated at the time he died.
373. There is no evidence to indicate Simon’s treatment and discharge from Barwon Health in December 2021 had any direct causal link with his death at the end of March 2022, and I make no adverse comments or findings about the care he received as an in-patient. However, my investigation has yielded valuable evidence about ways in which Simon’s discharge planning could have been optimised in the context of his homelessness and alcohol use disorder that give rise to pertinent comments and recommendations.
374. In this connection, having made comments about homelessness and alcohol-related harm in the Victorian community, I consider that the circumstances of Simon’s death bring into focus a range of broader prevention opportunities which I will now turn to. In canvassing these prevention opportunities, it is worth recalling the words of Amanda, Simon’s sister, that ‘*Simon was not “just a homeless guy”*’, or just someone with an alcohol addiction – he was loved, he had a family, he was cared for, and he deserved dignity in death as he did in life, despite the struggles he faced.

COMMENTS

Pursuant to section 67(3) of the Coroners Act, I make the following comments in connection with the death and relating to public health and safety:

1. This inquest was not about finding any person or entity upon whom to attribute blame for Simon's death. It was about understanding the cause and circumstances of Simon's death, and learning from the circumstances of his death and the subsequent investigations to identify opportunities to improve public health and safety and the administration of justice.

The prevalence of alcohol-related harm in Victoria

2. My investigation has been unable to identify with any level of certainty the medical cause of death. However, a significant feature in Simon's history was his ongoing struggle with alcohol dependence, which had persisted for many years prior to his death and had consequential harms on his social, emotional and physical wellbeing. Although Simon attempted to cease alcohol use on multiple occasions, he suffered significant adverse effects on withdrawal including seizures, which required medical treatment.
3. As I have noted in recent findings into the death of Kathleen Arnold³⁵⁴ and others,³⁵⁵ in my role as a coroner, I regularly encounter the direct and indirect harms and fatal consequences associated with alcohol use in the Victorian community.
4. In Victoria, more than 150 deaths involving the acute toxic effects of alcohol are reported to the Coroners Court of Victoria each year. At least another 100 deaths reported each year are caused by the chronic effects of alcohol use. However, these deaths represent only a proportion of all alcohol-related deaths, as most deaths resulting from chronic alcohol use are not reportable under the Act, given they are largely classified as deaths that are due to 'natural causes' and therefore will not usually be reported to the coroner, unless they are also

³⁵⁴ Coroner Ingrid Giles, [Finding into death of Kathleen Arnold without inquest](#), Coroners Court of Victoria, COR 2023 5162, delivered 11 February 2025.

³⁵⁵ Coroner Ingrid Giles, [Finding into death of Mr HS without inquest](#), Coroners Court of Victoria, COR 2023 002689, delivered 18 March 2025; Coroner Ingrid Giles, [Finding into death of Mr RJ without inquest](#), Coroners Court of Victoria, COR 2023 003988, delivered 18 March 2025; Coroner Ingrid Giles, [Finding into death of Mr GS without inquest](#), Coroners Court of Victoria, COR 2023 004983, delivered 18 March 2025; Coroner Ingrid Giles, [Finding into death of Mr RT without inquest](#), Coroners Court of Victoria, COR 2023 005203, delivered 18 March 2025.

‘unexpected’ or otherwise fall into one of the specific categories of reportable deaths under the Coroners Act.

5. Alcohol is one of the top 10 avoidable causes of disease and death in Victoria. Individuals who chronically consume alcohol in excessive amounts are at an increased risk of sudden death from alcohol withdrawal syndrome, seizures, and cardiac arrhythmias (abnormal heart rhythms). It is also a risk factor for the development of malnutrition and infections. Excess alcohol use causes a range of preventable diseases, including cancer, stroke and liver cirrhosis along with injury and violence experienced by communities across the State. In Victoria, alcohol products cause more than 1200 deaths and nearly 40,000 hospitalisations each year.³⁵⁶
6. Alcohol is also a factor in a myriad of deaths in the absence of the complications of chronic consumption. Such circumstances include homicides where alcohol use was implicated; suicides of people who had a history of alcohol use and/or who were alcohol affected; fatal motor vehicle collisions where a driver or other involved person was affected by alcohol; drownings of people intoxicated by alcohol; and many others.
7. Data published by the Victorian Department of Health on alcohol related harms indicates the proportion of adults who consume alcohol at lifetime risk of harm in Victoria trended upwards from 2015 to 2019 from 58.9 to 59.4%. That increase is more pronounced in men, with 67.7% of men who consume alcohol at lifetime risk of harm in 2015, and 69.0% in 2019.³⁵⁷
8. Further, Local Government Area (**LGA**) data indicates that the proportion of adults who consume alcohol at lifetime risk of harm in the Barwon LGA – where Simon lived – was significantly greater than state-wide (80.5%, compared with the state-average of 59.5%).³⁵⁸
9. These statistics are a concerning indication of the prevalence of alcohol-related harms in Barwon and the need for a targeted response.

³⁵⁶ VicHealth, ‘Alcohol harm prevention’, available [here](#).

³⁵⁷ Department of Health, ‘Victorian public health and wellbeing outcomes’ report on proportion of adults who consume alcohol at lifetime risk of harm, Victoria 2015 to 2019, available [here](#).

³⁵⁸ Department of Health, ‘Victorian public health and wellbeing outcomes’ report on proportion of adults who consume alcohol at lifetime risk of harm, Local Government Areas in Barwon SW LPHU, 2017, available [here](#).

Alcohol and other Drug Strategy 2025-2035

10. Following my finding into the death of Kathleen Arnold, I recommended the Victorian Government, led by the Department of Health, develop a new Alcohol Action Plan or program of work (including specific actions, timeframes, accountabilities, and public reporting on implementation and evaluation) to address alcohol-related harms in Victoria.
11. On 8 May 2025, in response to that recommendation, the Secretary for the Department of Health informed the Court that the Victorian Government was developing an Alcohol and other Drug (AOD) Strategy in partnership with stakeholders and the community. An AOD Ministerial Advisory Committee was being established to strengthen oversight and deliver expert advice on AOD system priorities including delivery of this strategy.³⁵⁹
12. The Secretary also noted that in accordance with the *Public Health and Wellbeing Act 2008*, the Victorian Government develops a Public Health and Wellbeing Plan every four years to guide Victorian Government departments, funded agencies and other partners to implement activity that aims to prevent illness and promote and protect health and wellbeing. The Victorian Public Health and Wellbeing Outcomes Framework provides measures against which public health and wellbeing plans are monitored, including harmful alcohol consumption.³⁶⁰
13. The Secretary drew the Court's attention to work of the Victorian Health Promotion Foundation (known as 'VicHealth') in promoting good health and promoting programs to minimise alcohol-related harm. VicHealth has a number of functions including to:
 - a. invest in health protection and promotion interventions to prevent people from becoming unwell;
 - b. fund innovative research to gain critical knowledge about what leads to preventable disease so we can understand the changes needed to promote better health;
 - c. advise media and the government on health promotion evidence and best practice;

³⁵⁹ Response of the Secretary for the Department of Health to the Finding into death without inquest into the death of Kathleen Arnold, COR 2023 5162, dated 8 May 2025, available [here](#).

³⁶⁰ Ibid.

- d. work with communities and drive campaigns and initiatives to improve health and prevent chronic disease.³⁶¹
14. On 5 December 2025, the Victorian Government published the Victorian AOD Strategy 2025-35 (**AOD Strategy**), a health-led approach which aims to address drug-related harm in Victorian community over the long term by ensuring Victorians can access the right information, support and care at the right time.³⁶² The AOD Strategy focuses on five key areas: information and access; harm reduction, treatment and system design; culturally safe, self-determined responses for Aboriginal Victorians; system innovation and continuous improvement; and integration across intersecting systems.³⁶³
15. Notably, the AOD Strategy identifies that some groups experience disproportionately high rates of AOD-related harm including people with co-occurring issues such as mental health issues or homelessness.³⁶⁴ It highlights that AOD treatment is most successful when it is tailored to individual needs, including flexible access to post-intervention services following initial or intensive treatment.³⁶⁵
16. The Victorian Government has committed to strengthening the AOD system to provide high-quality treatment and care that allows for consumer choice, including making sure the needs of diverse communities are met by ensuring mainstream services are accessible and appropriate, as well as through specific AOD services for targeted cohorts where needed.³⁶⁶ This work will be undertaken with people with lived and living experience of substance use to ensure services and supports are person-centred, trauma-informed and facilitate community connection and long-term relationship building.³⁶⁷ The strategy will also build and improve connections with intersecting systems, including expanding the places where AOD support, direct referral and intake can occur, and improving collaboration across the health, mental health, social, legal and justice systems.³⁶⁸

³⁶¹ See VicHealth, 'About Us: What we do' website page, available [here](#).

³⁶² Victorian alcohol and other drugs strategy 2025-2035, p 7, available [here](#).

³⁶³ Ibid, p 8.

³⁶⁴ Ibid, p 28.

³⁶⁵ Ibid, p 29.

³⁶⁶ Ibid, p 29.

³⁶⁷ Ibid, p 29.

³⁶⁸ Ibid, p 37.

17. Action items identified in support of these objectives include to embed post-intervention services as core elements of AOD services and supports, and strengthen the capacity of AOD services and supports to deliver services that meet a wide range of diverse community needs.³⁶⁹ Further, to explore opportunities for Victorian public hospitals and community-based health providers to deliver harm reduction initiatives, including intervention and treatment services and direct referrals into the AOD system.³⁷⁰
18. The Strategy is intended to be developed in three phases between 2025 to 2035. The first phase of initiatives over the first three years of the strategy, from 2025 to 2028, is focussed on strengthening existing AOD services and identifying opportunities for future actions. Initiatives currently underway include enhanced outreach, the care coordination model, wraparound supports, expanded access to pharmacotherapy and Salvation Army health clinic in Melbourne's CBD.³⁷¹
19. The Victorian Government has committed to implementing monitoring and accountability mechanisms to track progress against the AOD Strategy using clear, measurable milestones and outcomes.³⁷² However, it is presently unclear what those mechanisms will look like, how the milestones and outcomes will be identified and measured, or if they will be publicly reported on.
20. As I highlighted in my finding without inquest into the death of Kathleen Arnold, the program of work led by the Victorian Government to address alcohol-related harms in the community should incorporate public reporting on implementation and evaluation of the actions taken to address alcohol-related harms.
21. Setting a clear program of work, with the specific actions to be undertaken, the timeframes within which they should be implemented, who is responsible for them, and how they will be evaluated for effectiveness is critical to ensuring the ambitious goals of the AOD Strategy are met in addressing and reducing the harms associated with use of alcohol and other drugs. This

³⁶⁹ Ibid, p 29. Actions 2.2.2 and 2.2.4.

³⁷⁰ Ibid, p 37. Action 5.1.5.

³⁷¹ Ibid, p 46.

³⁷² Ibid, p 47.

work must be undertaken as a matter of urgency and include public reporting on relevant monitoring and accountability measures. A pertinent recommendation will follow.

Homelessness as a context in death

22. Simon is one of many members of the Victorian community who experience homelessness. In the 2021 Census – held four months after Simon’s death – 30,660 Victorians were reported to be without a home, a quarter of the entire homeless population in Australia.³⁷³
23. I note with the deepest of concern that the gross number, and rate, of Victorians experiencing homelessness has increased at each census from 2006 to 2021. During this period, the rate of Victorians experiencing homelessness has increased from 35.3 to 47.1 per 10,000 of the population, an increase of over 33% in 15 years.³⁷⁴ Victoria now has the second highest rate of homelessness in Australia, second only to the Northern Territory, which in contrast has decreased its rate of persons experiencing homelessness by over 28% over the same period.
24. As identified by my colleagues in a number of recent coronial findings,³⁷⁵ homelessness is intrinsically linked to poorer health outcomes and is as an independent risk factor for premature mortality. Research has repeatedly found that people who experience homelessness have higher rates of premature mortality than the general population, and are at higher risk of non-natural deaths such as suicide, homicide and overdose, as well as deaths from natural causes such as infectious diseases, coronary artery disease and cancer.³⁷⁶

³⁷³ Australian Bureau of Statistics, [Estimating homelessness: Census, 2021](#), Table 1.3 State and Territory of Usual Residence, Number of homeless persons, by selected characteristics, 2006, 2011, 2016 and 2021.

³⁷⁴ Ibid, Table 1.5 State and Territory of Usual Residence, Rate of homeless persons per 10,000 of the population, by selected characteristics, 2006, 2011, 2016 and 2021.

³⁷⁵ Coroner McGregor, [Finding into death of Sacha Timothee Louis Lefebvre without inquest](#), Coroners Court of Victoria, COR 2024 007013, delivered 27 March 2026; Coroner McGregor, [Finding into death of Jay Joseph Harrison without inquest](#), Coroners Court of Victoria, COR 2023 006521, delivered 24 September 2025; Judge John Cain, (then) State Coroner, [Finding into death of Bekkie-Rae Curren without inquest](#), Coroners Court of Victoria, COR 2019 006509, delivered 14 October 2024.

³⁷⁶ See for example Slockers M et al, “Unnatural death: a major but largely preventable cause-of-death among homeless people?”, *The European Journal of Public Health*, 28(2), 2018, pp 248-252; Aldridge RW et al, “Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England”, *Wellcome Open Research*, 2019, 4:49; Nilsson SF et al, “Life-years lost in people experiencing homelessness and other high-risk groups in Denmark: a population-based, register-based, cohort study”, *Lancet Public Health*, 10(1), 2025, pp 762-773; Fornaro M et al, “Homelessness and health-related outcomes: an umbrella review of observational studies and randomized controlled trials”, *BMC Medicine*, 2022, 20(1), p.224; Seastres RJ et al, “Long-term effects of homelessness on mortality: a 15-year Australian cohort study”, *Australian and New Zealand Journal of Public Health*, 44(6), 2020, pp.476-481; Woodman L et al, “Rates and causes of mortality among the homeless in Sydney”, *Australasian Psychiatry*, 31(4), 2023, pp.469-474; Zordan R et al, “Premature mortality 16 years after emergency department presentation among homeless and at risk of homelessness adults: a retrospective longitudinal cohort study”,

25. As explained in a recent study published in the *Lancet Public Health*:³⁷⁷

Several mechanisms might contribute to the reduced life expectancy among people experiencing homelessness. Substance misuse, particularly untreated drug and alcohol use disorders, increases the risk of overdose, unintentional injuries, suicide, and liver disease. Delayed treatment and undetected psychiatric and somatic conditions are also likely to have a role, as individuals experiencing homelessness are less likely to receive timely care for serious disorders such as cardiovascular conditions. Frequent emergency department visits without adequate follow-up suggests a cycle of acute care rather than long-term management. Additionally, stigma might reduce health-care use, worsening both mental and physical health outcomes.

26. While my investigation has been unable to determine Simon’s cause of death, it is evident that many of the mechanisms identified as contributing to reduced life expectancy among people experiencing homelessness were present in his case, including untreated alcohol use disorder, liver disease, and lack of adequate health-care follow-up following his discharge from University Hospital Geelong. At the time of his death, Simon was 50 years old, and died 17 years before the life expectancy of a male born in Australia in 1971 (Simon’s year of birth).³⁷⁸
27. In recent years, the Court has observed a significant increase in the number of deaths reported to the coroner of persons recorded as having no fixed address (that is, where the deceased person experiences primary³⁷⁹ or absolute³⁸⁰ homelessness proximal to death). Data compiled by the CPU indicates that the annual number of deaths of this cohort has more than doubled in the past three years, from 40 deaths in 2023 to 81 in 2025. These figures do not include the

International Journal of Epidemiology, 52(2), 20-23, pp.501-511; Tuson M et al, “Tracking deaths of people who have experienced homelessness: a dynamic cohort study in an Australian city”, *BMJ Open*, 14(3), 2024, e081260; Australian Institute of Health and Welfare, “[Health of people experiencing homelessness](#)”, 13 February 2025, accessed 26 February 2026; Australian Institute of Health and Welfare, “[People with a history of specialist homelessness services support who have died](#)”, 22 October 2025, accessed 26 February 2026.

³⁷⁷ Nilsson SF et al, “Life-years lost in people experiencing homelessness and other high-risk groups in Denmark: a population-based, register-based, cohort study”, *Lancet Public Health*, 10(1), 2025, p 772.

³⁷⁸ The life expectancy at birth in Australia for males born between 1970 and 1972 is 67.8. Australian Institute of Health and Welfare, [Life expectancy & deaths in Australia](#), accessed 9 April 2026.

³⁷⁹ Primary homelessness encompasses people without conventional accommodation, for example rough sleepers and people in improvised dwellings.

³⁸⁰ Absolute homelessness is where the person has no adequate physical shelter and either sleeps rough or in an improvised dwelling (for example, a tent, shack, humpy, under a bridge, in a stairwell or similar).

deaths of persons experiencing relative³⁸¹ homelessness (including secondary³⁸² or tertiary³⁸³ homelessness). Nor does it include the deaths of persons experiencing homelessness whose deaths are not reported to the Coroner, where the death is due to ‘natural causes’ and not otherwise reportable under the Coroners Act.

28. There have been numerous inquiries into homelessness in Victoria and across Australia in recent years, which have explored the scale of, and social, economic and health consequences of homelessness and need for reforms.³⁸⁴
29. As highlighted in the Victorian Legislative Council Legal and Social Issues Committee Final Report on its Inquiry into homelessness in Victoria

Homelessness is not just a statistic. It is an event in a person’s life, often recurring, that can have a lasting and traumatic effect. Homelessness can result in a variety of physical deprivations relating to a lack of or inadequate shelter, physical safety or access to suitable hygiene and health services. Pre-existing health issues can be exacerbated in situations of homelessness, where individuals are unable to access or afford essential services.

Furthermore, homelessness is more than just a lack of housing. Not having a space to call one’s own can have significant impacts on a person’s agency, resilience and sense of security. This can have acute and lasting effects on a person’s mental health and their connection to community and public life; becoming exacerbated where the conditions of a person’s homelessness are ongoing.³⁸⁵

30. The Victorian Government supported the Inquiry’s key findings and committed to a long-term strategic approach across five pillars to address homelessness.³⁸⁶

³⁸¹ Relative homelessness is where the person has access only to temporary or insecure accommodation; this includes people who are couch surfing and who are staying in rooming houses and emergency accommodation.

³⁸² Secondary homelessness encompasses people who move frequently between temporary shelter or accommodation arrangements, such as those in crisis accommodation and who are couch surfing.

³⁸³ Tertiary homelessness encompasses people who reside in accommodation that is insecure and substandard, for example boarding houses and caravan parks.

³⁸⁴ See e.g. Parliament of the Commonwealth of Australia, House of Representatives Standing Committee on Social Policy and Legal Affairs Final Report ‘Inquiry into homelessness in Australia’ dated July 2021, available [here](#); Parliament of Victoria, Legislative Council, Legal and Social Issues Committee Final Report, ‘Inquiry into homelessness in Victoria’ dated 4 March 2021, available [here](#).

³⁸⁵ Parliament of Victoria, Legislative Council, Legal and Social Issues Committee Final Report, ‘Inquiry into homelessness in Victoria’ dated 4 March 2021, p xvii.

³⁸⁶ Victorian Government response to the Legal and Social Issues Committee Inquiry into Homelessness in Victoria dated February 2024, available [here](#), p 3.

31. In their findings into the deaths of Bekkie-Rae Curren³⁸⁷ and Jay Harrison,³⁸⁸ then-State Coroner Judge Cain and Coroner Simon McGregor made certain recommendations directed towards addressing these issues, including that the Victorian Government give special consideration to building additional new public housing dwellings by 2034, in line with projected demands, and that the Victorian Government include the right to housing in the *Victorian Charter of Human Rights and Responsibilities Act 2006* (Vic).
32. This latter recommendation was reiterated most recently by Coroner McGregor in a finding last month³⁸⁹ in which he made the slightly nuanced recommendation that the Victorian Government consider including the right to adequate housing in the *Charter of Human Rights and Responsibilities Act 2006*, which follows the text set out in article 11(1) of the International Covenant on Economic, Social and Cultural Rights (**ICESCR**), which Australia ratified in 1975 noted in his Honour’s finding.³⁹⁰
33. I endorse these recommendations of Judge Cain and Coroner McGregor and consider this human rights lens ought to and must be viewed as highly relevant to Simon’s experience of the healthcare system as a man experiencing homelessness.

Integrated health and housing programs post-discharge

34. In this connection and as highlighted in Coroner McGregor’s *Finding into the death of Sacha Timothee Louis Lefebvre without inquest*³⁹¹ people experiencing homelessness often face barriers, including stigma or exclusion, when accessing primary health care.
35. A housing led healthcare model, such as that recently established by the Victorian Government through the ‘Better Health and Housing Program (**BHHP**)’ through a partnership

³⁸⁷ Judge John Cain, (then) State Coroner, [Finding into death of Bekkie-Rae Curren without inquest](#), Coroners Court of Victoria, COR 2019 006509, delivered 14 October 2024 [53-63]

³⁸⁸ Coroner McGregor, [Finding into death of Jay Joseph Harrison without inquest](#), Coroners Court of Victoria, COR 2023 006521, delivered 24 September 2025;

³⁸⁹ Coroner McGregor, [Finding into death of Sacha Timothee Louis Lefebvre without inquest](#), Coroners Court of Victoria, COR 2024 007013, delivered 27 March 2026.

³⁹⁰ International Covenant on Economic, Social and Cultural Rights, opened for signature 16 December 1966, 993 UNTS 3 (entered int force 3 January 1976): “The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for [them]self and [their] family, including adequate food, clothing and housing, and to the continuous improvement of living conditions”. *See also* United Nations Committee on Economic, Social and Cultural Rights, General Comment No 4: The Right to Adequate Housing (art 11(1)), UN Doc E/1992/23 (13 December 1991) at [8] regarding “affordability”.

³⁹¹ Coroner McGregor, [Finding into death of Sacha Timothee Louis Lefebvre without inquest](#), Coroners Court of Victoria, COR 2024 007013, delivered 27 March 2026

with Launch Housing, St Vincent’s Hospital Melbourne and the Brotherhood of St Laurence, provides a key opportunity for people experiencing chronic homelessness to stabilise and address their health needs and transition to secure housing with wrap-around healthcare supports. Innovative programs such as these deliver improved health outcomes for this cohort of vulnerable Victorians, as well as wider socioeconomic benefits for the community in reducing strain on health, welfare and justice programs.³⁹²

36. The BHHP commenced in 2022, and provides supported integrated care for individuals experiencing chronic homelessness and co-occurring health conditions in a stable residential setting. BHHP aims to break the cycle of chronic homelessness and poor health, improving residents’ quality of life and reducing strain on health, welfare and justice programs.³⁹³
37. The service is currently available to persons aged 30 years and over, with additional priority to residents aged over 40 years, who are experiencing chronic homelessness, have physical or mental health issues that prevent them from thriving in unsupported accommodation and the health issue is anticipated to be able to be addressed during their stay, and have expressed a readiness for change, seeking support for these issues and agree to engage in their own goal directed care during their stay.³⁹⁴ Participants are supported for a period of three to six months by a multi-disciplinary team, including St Vincent’s care coordinators and lived experience workers, alongside Launch Housing support workers and case workers. Residents are also provided with up to three months of support following exit from the facility to support the high-risk time of transition to their new health and housing arrangements to assist in ensuring gains made are sustained. The BHHP focuses on capability building, genuine opportunities and resident goal-directed care planning driven by the resident.³⁹⁵
38. Evaluations of the program have found notable improvements in the wellbeing and health of participants and benefits for the wider Victorian community, including:

³⁹² Ibid, [40-43].

³⁹³ <https://www.svhm.org.au/health-professionals/gp-liaison/community-and-home-services/better-health-and-housing-program>

³⁹⁴ <https://www.svhm.org.au/health-professionals/gp-liaison/community-and-home-services/better-health-and-housing-program>

³⁹⁵ <https://www.svhm.org.au/newsroom/news/integrating-healthcare-and-housing-to-improve-patient-outcomes>

- a. resolution and sustained improvements in management of health conditions, with more than a quarter of residents resolving a health condition while living at BHHP, and a 51% increase in health conditions being actively managed from entry to exit.
 - b. significant enhancements in subjective wellbeing as measured on the Personal Wellbeing Index.
 - c. improved suitable housing outcomes, with 91% of residents with planned exits securing a housing outcome.
 - d. reduced emergency department presentations (76% decrease in total number of presentations) and reduced utilisation of the homelessness system
 - e. improved utilisation of community mental health services and high levels of linkage and engagement with mental health services, including after exit.
 - f. significant reductions in long-term government costs, with cost savings estimated to be between \$200,700 to \$314,800 per participant over 10 years.³⁹⁶
39. However, the BHHP service is limited to Metropolitan Melbourne, with the residential facility located in Fitzroy. There are some similar integrated health and housing supports available in the Barwon region, such as the Accommodation & Psychosocial Supports Initiative (AAPS)³⁹⁷ jointly run by Barwon Health and The Salvation Army. This program is of a more limited duration (up to 12 weeks) and is only offered to patients at high risk of homelessness upon discharge from the acute mental health inpatient unit. As Simon was under the care and treatment of the general medical team, it does not appear he would have been an eligible candidate for this type of service, although he was offered details for the Salvation Army Specialist Homelessness Service.
40. As identified in this investigation, Simon may have benefited from care coordination from the hospital, extending into the community with assistance to access outpatient appointments and housing, to better manage his health needs, including his alcohol use disorder and withdrawal symptoms. It is not possible to determine whether Simon would have agreed to access a

³⁹⁶ ‘[The Better Health and Housing Program’ Evaluation](#) completed in 2023; [Better Health and Housing Program: Impact Evaluation and Economic Analysis](#) published October 2024.

³⁹⁷ https://www.barwonhealth.org.au/images/BBC_Awards_Poster_2021_AAPS_Accommodation_and_Psychosocial_Supports_Initiative.pdf

service like BHHP if it were offered in the Barwon region. However, this type of service may have provided the best means of supporting Simon to overcome his alcohol use disorder in a secure and supportive environment with coordinated support and housing security.

41. I support Coroner McGregor’s recommendation to the State of Victoria to review the suitability of the BHHP programme for further rollout in conjunction with other public hospitals and specialist homelessness sector providers. This model of care aligns with the objectives of the AOD Strategy to explore opportunities for Victorian public hospitals and community-based health providers to deliver harm reduction initiatives, including intervention and treatment services and direct referrals into the AOD system,³⁹⁸ and I consider there would be benefit in expanding the BHHP program across the State, particularly to areas of need such as the Barwon region, to improve patient outcomes. I have made a recommendation to the Victorian Government accordingly.

RECOMMENDATIONS

I make the following ten recommendations connected with the death under section 72(2) of the Coroners Act:

1. That the **Chief Commissioner of Victoria Police**:
 - (a) conduct a review of police members’ compliance with the body worn camera activation framework under the Victoria Police Manual (VPM) ‘Body worn cameras’;
 - (b) consider incorporating refresher training for members in annual Operational Safety Tactics Training (OSTT) to provide guidance on strategies to embed use of body worn cameras as a daily practice to ensure all events are appropriately recorded, particularly where members may be under increased stress or cognitive loading; and
 - (c) consider establishing a pathway for members to report technical issues in activation of body worn cameras where this is identified, to enable appropriate steps to be taken to investigate and address issues as they arise.

³⁹⁸ Ibid, p 37. Action 5.1.5.

2. That the **Chief Commissioner of Victoria Police** remind uniform police members of the requirements of the VPM ‘Operational duties and responsibilities’ to record and report on operational duties, including to ensure that:
 - (a) task narratives adequately describe the actions taken and explain the recorded disposition of tasks;
 - (b) when a member of the public is transported in a police vehicle, this should be documented in the electronic Patrol Duty Return, including the location and time of pick up and drop off and the demeanour of the person at the time they leave police presence; and
 - (c) Police Communications Centre are notified when transport of a member of the public occurs (unless reasons otherwise exist) to ensure Patrol Supervisors are aware of tasks being carried out by units under their supervision.

3. That the **Chief Commissioner of Victoria Police** review relevant policies and guidelines for the management of seized property to determine whether further clarification needs to be provided to police officers on retention and disposal of property which has come into police possession and where the owner of that property subsequently dies and the death has been reported to the coroner. This may incorporate guidance for police officers on appropriate steps that should be taken in respect of informing the coroner of the existence of the property and guidance on making a request to the Coroner prior to property being released or disposed of.

4. That the **Chief Commissioner of Victoria Police** consider amending the Victoria Police Manual (VPM) ‘Deceased Persons’ to require that when a death is reported to the coroner, police officers must:
 - (a) conduct a search of relevant accessible Victoria Police databases, such as the Victoria Police Law Enforcement Assistance Program (LEAP), Victoria Police NEO Intelligence Management database and Axon Evidence.Com database, to check whether the deceased had involvement or contact with police before death;

- (b) if the deceased had recent contact with police, this information should always be documented in the Form 83 ‘Police Report of Death to the Coroner’; and
 - (c) ensure that any relevant body worn camera footage of such interactions be retained until otherwise directed by the Coroner.
5. That the **Chief Commissioner of Victoria Police**, in consultation with the Coroners Court of Victoria, the Coronial Support Unit (formerly known as the Police Coronial Support Unit), and the Coronial Admissions and Enquiries Office of the Victorian Institute of Forensic Medicine, review guidance materials provided to police members on unidentified human remains to clarify the processes to be followed where the identity of the deceased is suspected, but cannot be formally identified at the scene, and where forensic identification tests are required to be undertaken. This should include information about the steps to be taken for notifying family members of the suspected death where the identity of the deceased is believed to be (‘BTB’) a particular person (including requests for DNA samples) and should include consideration of DLSC Smyth’s evidence about the timeframes in which notification to family should occur, and when escalation to criminal investigation units must be initiated.
6. That **Barwon Health** review and, if necessary, amend the existing processes of its outpatient clinics (including the radiology department) concerning non-attendances to ensure that they are fully consistent with the stated policy aims of the Victorian Department of Health’s *‘Managing referrals to non-admitted specialist services in Victorian public health services’* policy. This ought to be done with a view of ensuring specific procedures are in place that are responsive to the various stated barriers to accessing services highlighted in this policy under *‘Disparities to access in care’*, in particular for persons experiencing homelessness, and who are, or may be, discharged to homelessness.
7. That **Barwon Health** review its policies, procedures and training to staff on providing care to, and communicating with patients experiencing (or at risk of) homelessness to:

- (a) ensure staff verify an admitted patient's address and contact details with the patient on admission and at the time of discharge and make any necessary changes to the patient record as required;
 - (b) ensure staff clearly document in the patient record when a patient is homeless or at risk of homelessness, and identify a suitable method of communication with the patient following planned discharge where they have no fixed place of abode;
 - (c) ensure that, where possible, planned outpatient appointments are scheduled prior to discharge and that these appointments are documented in the patient's My Service Diary or other preferred communication method as nominated by the patient;
 - (d) ensure staff document all contacts and attempted contacts with patients in respect of outpatient clinic appointments in the patient's record; and
 - (e) explore opportunities to enhance supports for outpatients experiencing homelessness through integrated housing and health programs or allied health professionals.
8. That **Barwon Health** review its process for referral to outpatient Drug and Alcohol Services (**DAS**) for at risk patients who are due to be discharged from hospital following an in-patient admission and who agree to a referral to, where appropriate:
- (a) facilitate direct referral to DAS;
 - (b) schedule an outpatient appointment with DAS and communicate the time and date of the appointment to the patient prior to discharge;
 - (c) ensure clinicians in the General Medical and Psychiatry teams are aware of the process for referral to DAS, including where the patient may be directly referred or self-referred, and how this is to be communicated to the patient.
9. That the **Victorian Government**, led by the **Victorian Department of Health**, consider as a matter of priority, funding an expansion of the Better Health and Housing Program to areas of need in Victoria, including in the Barwon region, to provide integrated health and housing support on discharge from hospital for people experiencing chronic homelessness and complex health needs including substance use issues (in particular severe alcohol use disorder) and mental illness.

10. That the **Victorian Government**, led by the **Victorian Department of Health**, as a matter of priority, develop and publish the monitoring and accountability mechanisms that will be used to track progress against the Victorian Alcohol and Other Drugs Strategy 2025-35 (**AOD Strategy**). This document should set out the measurable milestones and outcomes to be achieved in each phase of the AOD Strategy, by reference to empirical data, and incorporate regular public reporting on the implementation and evaluation of actions taken to address and reduce alcohol and other drug-related harms.

ACKNOWLEDGMENTS

I convey my sincerest sympathy to Simon's family and friends. I acknowledge the grief and devastation that you have endured as a result of your loss. I read and listened carefully to the coronial impact statement provided by Simon's sister Amanda on behalf of the family members, and watched as her father Chris stood and supported her to read it out. I was greatly assisted and moved by the personal reflections made in that statement. I thank Amanda, Chris and Louella, and Simon's family more broadly, for their active participation and assistance in these proceedings and I acknowledge their tireless advocacy in requesting a comprehensive investigation into Simon's death – a role they should never have had to take on.

I also thank in particular Counsel Assisting, Gemma Cafarella, for her exceptional assistance throughout these proceedings, as well as the counsel and solicitors who represented the interested parties, for their assistance, comprehensive submissions and collegial approach to these proceedings. I also acknowledge and thank Ms Elizabeth Morris, Senior Legal Counsel at the Coroners Court, for the invaluable assistance and support she has provided throughout this investigation. I also thank the CPU for its contribution to these proceedings and DLSC Leigh Smyth, ultimately appointed to be my investigator, for his dedication, compassion and high-quality assistance during the investigation.

ORDERS AND DIRECTIONS

A ruling and order with respect to Ms Gaskill's application for costs will be published on the Coroners Court website here: <https://www.coronerscourt.vic.gov.au/inquests-findings/orders-and-rulings>.

Pursuant to section 73(1) of the Coroners Act, this finding must be published on the Internet in accordance with the rules. I direct that a copy of this finding be provided to the following:

Family of Simon Gaskill c/Robinson Gill

Mike Bush CNZM, Chief Commissioner of Victoria Police, c/Hall & Wilcox

Professor Ajai Verma, Chief Medical Officer, Barwon Health, c/Moray & Agnew

Independent Broad-based Anti-Corruption Commission (**IBAC**)

Jenny Atta PSM, Secretary of the Department of Health

Deborah Di Natale, Council to Homeless Persons

Detective Leading Senior Constable Leigh Smyth, Coronial Investigator

Detective Sergeant Adam Tink, Ballarat SOCIT, Victoria Police

Inspector Ilena Pucar, Professional Standards Command, Victoria Police

Signature:



**INGRID GILES
CORONER**

Date: 17 April 2026



NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
